

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Form V, S. No. 5. 12½ M. 7-24-11

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics
File No. 23571
Registered No. 13

1. PLACE OF DEATH. Registration District No. 30
County of Owyhee Primary Registration District No. 2123
City of D. L. ... (No. _____, _____ St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Albert Richard Hawes

If death occurred in a hospital, institution or camp give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX Male 4. COLOR OR RACE White 5. SINGLE, MARRIED, WIDOWED OR DIVORCED. Single
(Write the word.)

6. DATE OF BIRTH Oct. 13 1913
(Month) (Day) (Year)

7. AGE 2 mos. 24 ds. IF LESS than 1 day how many _____ hrs. or _____ min?

8. OCCUPATION

(a) Trade, profession or particular kind of work. _____
(b) General nature of industry business or establishment in which employed (or employer) _____

9. BIRTHPLACE

(State or Country) Idaho

10. NAME OF FATHER

John S. Hawes

11. BIRTHPLACE OF FATHER

(State or Country) Owyhee Co. Idaho

12. MAIDEN NAME OF MOTHER

May Hughes

13. BIRTHPLACE OF MOTHER

(State or Country) Chicago Ills.

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) John S. Hawes

(Address) D. L. ...

15.

Filed Jan 4 1913

Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH

Jan. 4 1913
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from Oct 13 1913 to Jan 4 1913

that I last saw him alive on Jan 4 1913 and that death occurred on the date stated above, at 10 A.M.

The CAUSE OF DEATH* was as follows:

Premature birth

(Duration) 2 mos. 24 ds.

Contributory (Secondary) Premature

(Duration) 2 mos. 24 ds.

(Signed) T. D. ... M. D.

Jan 4 1913 (Address) D. L. ...

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death _____ yrs. _____ mos. _____ ds. In the _____ State _____ yrs. _____ mos. _____ ds.

Where was disease contracted,

If not at place of death?

Former or

usual residence.

19. PLACE OF BURIAL OR REMOVAL DATE OF BURIAL

Masonic Cemetery Jan 6 1913

20. UNDERTAKER

ADDRESS

John. Grete Shelby City Idaho

MARGIN RESERVED FOR BINDING
WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
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Form V. S. No. 5 20M.1-16-12

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH

Registration District No. 15

County of Latah

Primary Registration District No. 1508

City of Moscow

(No. , St.)

File No. 3649

Registered No. 135

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

John A. Josephlund

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX

M

4. COLOR OR RACE

White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED.

Married
(Write the word.)

6. DATE OF BIRTH

June 22 1854
(Month) (Day) (Year)

7. AGE

58 yrs. 6 mos. 14 ds.

IF LESS than 1 day
how many hrs. or mins.?

8. OCCUPATION

(a) Trade, profession or particular kind of work

Bookkeeper

(b) General nature of industry business, or establishment in which employed (or employer)

9. BIRTHPLACE

(State or Country)

Sweeden

10. NAME OF FATHER

Arvid Johnson

11. BIRTHPLACE OF FATHER

(State or Country)

Sweeden

12. MAIDEN NAME OF MOTHER

Karen Nelson

13. BIRTHPLACE OF MOTHER

(State or Country)

Sweeden

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

Otto M. Nelson

(Address)

Troy Idaho

15.

Filed Jan 6th 1913

W. L. Linder

Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH

Jan 3 1913
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from

Nov. 4 1913 to Jan 5 1913

that I last saw him alive on Jan 5 1913

and that death occurred on the date stated above, at 2 P. M.

The CAUSE OF DEATH* was as follows:

Pericious Aneurism

(Duration) 2 yrs. mos. ds.

Contributory
(Secondary)

General Debility

(Duration) yrs. mos. ds.

(Signed)

Joseph Aspray M. D.

Jan 1913 (Address) Moscow, Ida.

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death yrs. mos. days. In the State yrs. mos. days.

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL

Moscow

DATE OF BURIAL

Jan 8 1913

20. UNDERTAKER

Geo. Stutz

ADDRESS

Moscow

(Property)

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Form V. S. No. 5 20M.1-16-12

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH

Registration District No. 16

County of Latah

Primary Registration District No. 108

City of Moscow

(No. St.)

File No. 3642

Registered No. 449 138

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

Elizabeth M. Carithers

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX

Female

4. COLOR OR RACE

White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED

Married

6. DATE OF BIRTH

March 14 1863
(Month) (Day) (Year)

7. AGE

48 yrs. 9 mos. 24 ds.

IF LESS than 1 day
how many hrs. or mins.?

8. OCCUPATION

(a) Trade, profession or particular kind of work

(b) General nature of industry business, or establishment in which employed (or employer)

Housewife

9. BIRTHPLACE

(State or Country)

New York

10. NAME OF FATHER

David M. Carthy

11. BIRTHPLACE OF FATHER

(State or Country)

Ireland

12. MAIDEN NAME OF MOTHER

Mary Barry

13. BIRTHPLACE OF MOTHER

(State or Country)

Ireland

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

(Address)

E. Carithers
Moscow

15.

Filed Jan. 9 1913

D. M. Discher
(Deputy) Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

Jan 8 1913
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from

Jan 1910, to Jan 8 1913,

that I last saw her alive on Jan 7 1912,

and that death occurred on the date stated above, at 6 AM.

The CAUSE OF DEATH was as follows:

4th degree Burns Disease.

(Duration) 2 yrs. mos. ds.

Contributory

(Secondary)

(Duration) yrs. mos. ds.

(Signed) W. H. Carithers M. D.

19 (Address) Moscow,

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death yrs. 2 mos. days. In the State yrs. mos. days.

Where was disease contracted if not at place of death?

Former or usual residence.

19. PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

Moscow, Idaho. Jan. 10 1913

20. UNDERTAKER

ADDRESS

Geo. M. Kelly Moscow

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Form V. S. No. 5 20M.1-16-12

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH

Registration District No. 16

County of Booth

Primary Registration District No. 1078

City of Moscow

(No. _____, _____ St.)

File No. 3643

Registered No. 120137

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

Lucinda Beersley

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX

Female

4. COLOR OR RACE

White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED.

Widow
(Write the word.)

6. DATE OF BIRTH

January 15th 1825
(Month) (Day) (Year)

7. AGE

87 yrs. 11 mos. 24 ds.

IF LESS than 1 day
how many _____ hrs. or
_____ mins.?

8. OCCUPATION

(a) Trade, profession or particular kind of work
(b) General nature of industry, business, or establishment in which employed (or employer)

Housewife

9. BIRTHPLACE

(State or Country)

New York

10. NAME OF FATHER

Wm Jackson

11. BIRTHPLACE OF FATHER

(State or Country)

don't know

12. MAIDEN NAME OF MOTHER

Lucinda Jackson

13. BIRTHPLACE OF MOTHER

(State or Country)

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

H. L. Coats

(Address)

Moscow Idaho

15.

Filed Jan 9th 1913

D. M. Quishel
Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

Jan 8 1913
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from

Jan 1 1913, to Jan 8 1913,

that I last saw him alive on Jan 8 1913,

and that death occurred on the date stated above, at 7th St.

The CAUSE OF DEATH* was as follows:

Old age

(Duration) _____ yrs. _____ mos. 8 ds.

Contributory
(Secondary)

(Duration) _____ yrs. _____ mos. _____ ds.

(Signed)

J. N. Clarke M. D.

19 (Address) Moscow, Ida

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death _____ yrs. _____ mos. _____ days. In the State _____ yrs. _____ mos. _____ days.

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

Moscow, Idaho

Jan 10 1913

20. UNDERTAKER

ADDRESS

Soc. Health

Moscow

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Form V. S. No. 5. 10M. 6-20-11.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics
File No. 3766
Registered No. 1

1. PLACE OF DEATH

Registration District No. 20

County of Elmore

Primary Registration District No. 2020

City of Mountain Home

(No. Mercedes Anchustegui St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

Mercedes Anchustegui

If death occurred in a hospital, institution or camp give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX

Female

4. COLOR OR RACE

White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED.

(Write the word.)

6. DATE OF BIRTH

Nov (Month) 30 (Day) 1910 (Year)

7. AGE

2 yrs. 1 mos. 23 ds.

IF LESS than 1 day
how many.....hrs.or
.....min.)

8. OCCUPATION

- (a) Trade, profession or particular kind of work
(b) General nature of industry business or establishment in which employed (or employer)

9. BIRTHPLACE

(State or Country)

Mountain Home

10. NAME OF FATHER

Pedro Anchustegui

11. BIRTHPLACE OF FATHER

(State or Country)

Spain

12. MAIDEN NAME OF MOTHER

Gracia Anchustegui

13. BIRTHPLACE OF MOTHER

(State or Country)

Spain

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

Pedro Anchustegui

(Address)

Mountain Home

15.

Filed Jan. 24th 1913

B. W. Malher

Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

January (Month) 23rd (Day) 1913 (Year)

17. I HEREBY CERTIFY, That I attended deceased from

Jan. 23rd 1913, only 1913

that I last saw her alive on Jan. 23rd 1913

and that death occurred on the date stated above, at 3 A.M.

The CAUSE OF DEATH* was as follows:

Asphyxia during infantile convulsions - intestinal origin

(Duration) yrs. mos. 3 hrs.

Contributory (Secondary)

Intestinal auto-intoxication

(Duration) yrs. mos. 1 ds.

(Signed)

B. W. Malher M. D.

Jan. 23 1913. (Address) Mountain Home

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death.....yrs.....mos.....ds. State.....yrs.....mos.....ds.

Where was disease contracted,

If not at place of death?

Former or

usual residence.

19. PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

Mountain Home

Jan. 25th 1913

20. UNDERTAKER

ADDRESS

J. M. Cowen

Mountain Home

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Form V. S. No. 5 20M.1-16-12

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics
File No. 13768
Registered No. 2

1. PLACE OF DEATH. Bannock
County of Pocatello
City of Pocatello
Registration District No. _____
Primary Registration District No. _____
(No. North Main St.)
If death occurs away from usual residence, give facts called for under special information. 2. FULL NAME Fred Mealy

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX Male 4. COLOR OR RACE White 5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.)

6. DATE OF BIRTH 1 (Month) 1 (Day) 1913 (Year)

7. AGE 1 yrs. 1 mos. 1 ds. IF LESS than 1 day how many 1 hrs. or 1 mins.?

8. OCCUPATION Machinist
(a) Trade, profession or particular kind of work
(b) General nature of industry business, or establishment in which employed (or employer)

9. BIRTHPLACE Germany
(State or Country)

10. NAME OF FATHER ✓

11. BIRTHPLACE OF FATHER ✓
(State or Country)

12. MAIDEN NAME OF MOTHER ✓

13. BIRTHPLACE OF MOTHER ✓
(State or Country)

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Rapier, Found an
(Address) deceased

15. Filed Jan 3rd 1913 J. B. Sturly
Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH Jan 2 1913
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from Dec. 31 1912, to 191,
that I last saw him alive on Dec. 31 1912,
and that death occurred on the date stated above, at — M.

The CAUSE OF DEATH* was as follows:
Acute military tuberculosis
of lung
found dead

(Duration) — yrs. — mos. — ds.

Contributory (Secondary) —

(Duration) — yrs. — mos. — ds.

(Signed) E. Roberts M. D.

Jan 3 1913 (Address) Pocatello Ida.

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death — yrs. — mos. — days. In the State — yrs. — mos. — days.

Where was disease contracted if not at place of death? —

Former or usual residence —

19. PLACE OF BURIAL OR REMOVAL W. H. H. H. DATE OF BURIAL Jan 10 1913

20. UNDERTAKER W. H. H. H. ADDRESS Pocatello

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Form V. S. No. 5 20M.1-16-12

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH.

Registration District No.

County of *Damocle*

Primary Registration District No.

City of *Procatello*(No. *230*, *Do. Wayer*. St.)

File No.

Registered No.

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

Lydia Gardner Carter

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX

4. COLOR OR RACE

5. SINGLE, MARRIED, WIDOWED OR DIVORCED.

*Female. Female.**Married*

6. DATE OF BIRTH

October 16 1856

(Month)

(Day)

(Year)

7. AGE

56 yrs. 2 mos. 20 ds.

IF LESS than 1 day
how many hrs. or
..... mins.?

8. OCCUPATION

(a) Trade, profession or particular kind of work

(b) General nature of industry business, or establishment in which employed (or employer)

Housewife

9. BIRTHPLACE

(State or Country)

Ogden Utah

10. NAME OF FATHER

James N. Gardner

11. BIRTHPLACE OF FATHER

(State or Country)

New York

12. MAIDEN NAME OF MOTHER

Mary Carter

13. BIRTHPLACE OF MOTHER

(State or Country)

Michigan

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

Eliza Newett

(Address)

241 N. 3rd Ave.

15.

Filed

*Jan 7th 1913**S B**Sturley*

Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH

Jan 5th

(Month)

(Day)

1913

17. I HEREBY CERTIFY, That, I attended deceased from

*Nov 20th 1913, to Jan 5th 1913*that I last saw her alive on *Jan 5th 1913*and that death occurred on the date stated above, at *5:20 P.M.*

The CAUSE OF DEATH* was as follows:

Nephritis (Chronic)(Duration) *One* yrs. *—* mos. *✓* ds.

Contributory (Secondary)

Genl Anasarca(Duration) *about 6* yrs. *—* mos. *—* ds.

(Signed)

W. A. Wright

M. D.

19. (Address) *Procatello, Idaho*

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death yrs. mos. days. In the State yrs. mos. days.

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

*Sturley**Jan 7th 1913*

20. UNDERTAKER

ADDRESS

*W. A. Wright**Procatello Idaho*

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. FIRST-CLASS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Form V. S. No. 5 20M.1-16-12

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH.

Registration District No. 19

County of Bannock

Primary Registration District No. 1002

City of Pocatello

(No. Ranch St.)

File No. 13770

Registered No. 4

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

Joseph Farrell

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX

Male

4. COLOR OR RACE

White

5. SINGLE, MARRIED, WID-
OWED OR DIVORCED

Married
(Write the words)

6. DATE OF BIRTH

Oct-

3

1859

(Month)

(Day)

(Year)

7. AGE

54

3

3

yrs.

mos.

ds.

IF LESS than _____ day
how many _____ hrs. or
_____ mins.

8. OCCUPATION

(a) Trade, profession or particular kind of work

Rancher.

(b) General nature of industry business, or establishment in which employed (or employer)

9. BIRTHPLACE

(State or Country)

Troy N. Y.

10. NAME OF FATHER

George Farrell.

11. BIRTHPLACE OF FATHER

(State or Country)

12. MAIDEN NAME OF MOTHER

13. BIRTHPLACE OF MOTHER

(State or Country)

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

Henry J. Farrell

(Address)

Pocatello

15.

Filed

Jan 8th

1913

O.B. Stealy

Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH

Oct

6

1913

(Month)

(Day)

(Year)

17. I HEREBY CERTIFY, That I attended deceased from

191, to

191,

that I last saw h. alive on

191,

and that death occurred on the date stated above, at _____ M.

The CAUSE OF DEATH* was as follows:

Rheumatism & heart disease
(Nitroglycerin)
(found dead)

(Duration) _____ yrs. _____ mos. _____ ds.

Contributory

(Secondary)

(Duration) _____ yrs. _____ mos. _____ ds.

(Signed)

Jan 6, 1913 (Address) Pocatello Idaho

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death _____ yrs. _____ mos. _____ days. In the State _____ yrs. _____ mos. _____ days.

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL DATE OF BURIAL

New Cemetery Jan 9 1913

20. UNDERTAKER

ADDRESS

Pocatello

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Form V. S. No. 5 20M.1-16-12

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH.

Registration District No.

County of

Primary Registration District No.

City of

(No. 1220, N. Harrison St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

File No.

Registered No.

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX

4. COLOR OR RACE

5. SINGLE, MARRIED, WIDOWED OR DIVORCED.

Female

White

Married (Write the word.)

6. DATE OF BIRTH

March

14

1880

(Month)

(Day)

(Year)

7. AGE

32

10

26

ds.

IF LESS than 1 day
how many hrs. or
..... mins.?

8. OCCUPATION

(a) Trade, profession or particular kind of work

(b) General nature of industry business, or establishment in which employed (or employer)

Housewife

9. BIRTHPLACE

(State or Country)

Sweden

10. NAME OF FATHER

Gustave Olson

11. BIRTHPLACE OF FATHER

(State or Country)

Sweden

12. MAIDEN NAME OF MOTHER

Gustava Johanson

13. BIRTHPLACE OF MOTHER

(State or Country)

Sweden

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

David Niltbrand

(Address)

1220 St. Harrison

15.

Filed

Jan 11th

1913

J.B. Sterley

Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH

Jan 9

(Month)

(Day)

1913

17. I HEREBY CERTIFY, That I attended deceased from

Jan 7th

1913

to

Jan 9th

1913

that I last saw her alive on Jan 9th 1913and that death occurred on the date stated above, at 4¹⁵ AM.

The CAUSE OF DEATH was as follows:

Pneumonia Septic Infection

(Duration)

yrs.

mos.

ds.

Contributory
(Secondary)

(Duration)

yrs.

mos.

ds.

(Signed)

H. A. Castle

M. D.

Jan 10th 1913

(Address)

Pocatello Idaho

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place

of death

yrs.

mos.

days.

In the

State

yrs.

mos.

days.

Where was disease contracted
if not at place of death?

Former or
usual residence

19. PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

St. Paul

Jan 12th 1913

20. UNDERTAKER

ADDRESS

J.B. Sterley Pocatello Id.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Form V. S. No. 5 20M.1-16-12

CERTIFICATE OF DEATH

1. PLACE OF DEATH

County of *Bannock*

City of *Pocatello*

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

Registration District No.

Primary Registration District No.

(No. *839 N. Harrison* St.)

Carl Nelson

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

File No. *3777*

Registered No. *8*

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX

Male

4. COLOR OR RACE

White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED.

(Write the word.)

6. DATE OF BIRTH

(Month) (Day) (Year)

7. AGE

about 30 yrs.

IF LESS than 1 day
how many hrs. or
mins.?

8. OCCUPATION

(a) Trade, profession or particular kind of work

carpenter

(b) General nature of industry business, or establishment in which employed (or employer)

9. BIRTHPLACE

(State or Country)

Sweden

10. NAME OF FATHER

11. BIRTHPLACE OF FATHER

(State or Country)

12. MAIDEN NAME OF MOTHER

13. BIRTHPLACE OF MOTHER

(State or Country)

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

(Address)

*M. Maeser
Pocatello Idaho*

15.

Filed

Jan 25 1913

O. B. Straly

Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

Jan 22 1913
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from

191... to 191...
that I last saw him alive on 191...

and that death occurred on the date stated above, at M.

The CAUSE OF DEATH* was as follows:

*Severe Radial Artery
Thrombosis*

(Duration) yrs. mos. ds.

Contributory
(Secondary)

(Duration) yrs. mos. ds.

(Signed)

O. B. Straly M. D.
Jan 29 1913 (Address) *Pocatello Idaho*

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death... yrs... mos... days. In the State... yrs... mos... days.

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

M. Maeser *Jan 29 1913*

20. UNDERTAKER

ADDRESS

M. Maeser *Pocatello*

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

County of <u>Lamar</u> City of <u>Pocatello</u>		Registration Primary Reg. <u>1002</u> (No. <u>Paul A. Baird</u> St.)	of Idaho DEPARTMENT OF HEALTH Bureau of Vital Statistics File No. <u>3776</u> Registered No. <u>10</u>
If death occurs away from usual residence, give facts called for under special information. 2. FULL NAME <u>Paul A. Baird</u> If death occurred in a hospital, institution or camp, give its NAME instead of street and number.			
PERSONAL AND STATISTICAL PARTICULARS			
3. SEX <u>Male</u>	4. COLOR OR RACE <u>White</u>	5. SINGLE, MARRIED, WIDOWED OR DIVORCED. <u>Married</u>	
6. DATE OF BIRTH <u>March 1 1888</u> (Month) (Day) (Year)			
7. AGE <u>24</u> yrs. <u>10</u> mos. <u>—</u> ds.		IF LESS than 1 day how many hrs. or mins.?	
8. OCCUPATION <u>Railroading</u> (a) Trade, profession or particular kind of work (b) General nature of industry, business, or establishment in which employed (or employer)			
9. BIRTHPLACE <u>Justin Iowa</u> (State or Country)			
10. NAME OF FATHER <u>J. D. Baird</u>			
11. BIRTHPLACE OF FATHER <u>Iowa</u> (State or Country)			
12. MAIDEN NAME OF MOTHER <u>Olive M. Newhouse</u>			
13. BIRTHPLACE OF MOTHER <u>Ohio</u> (State or Country)			
14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE (Informant) <u>J. D. Baird</u> (Address) <u>San Diego Cal</u>			
15. Filed <u>Jan 28 1913</u> <u>O. B. Strley</u> Local Registrar			
MEDICAL CERTIFICATE OF DEATH.			
16. DATE OF DEATH <u>Jan 26 1913</u> (Month) (Day) (Year)			
17. I HEREBY CERTIFY, That I attended deceased from <u>Jan 24 1913</u> , to <u>Jan 26 1913</u> , that I last saw him alive on <u>Jan 26 1913</u> , and that death occurred on the date stated above, at <u>2:45</u> P. M.			
The CAUSE OF DEATH* was as follows: <u>Pulmonary Tuberculosis</u> (Duration) <u>2</u> yrs. <u>about</u> mos. ds. Contributory <u>morphine</u> (Secondary) (Duration) <u>3</u> yrs. <u>about</u> mos. ds. (Signed) <u>W. A. Smith</u> M. D. (Address) <u>Pocatello, Idaho</u>			
*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.			
18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.) At place of death yrs. mos. <u>2</u> days. In the State yrs. mos. days. Where was disease contracted if not at place of death? <u>✓</u> Former or usual residence <u>✓</u>			
19. PLACE OF BURIAL OR REMOVAL <u>St. Lawrence's</u>		DATE OF BURIAL <u>Jan 28 1913</u>	
20. UNDERTAKER <u>M. M. Walker</u>		ADDRESS <u>Pocatello</u>	

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
 N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

NO. 96.

Form V. S. No. 5 20M.1-16-12

CERTIFICATE OF DEATH

 State of Idaho
 BOARD OF HEALTH
 Bureau of Vital Statistics

1. PLACE OF DEATH.

Registration District No. 8County of BonnerPrimary Registration District No. 2033City of Sandpoint

(No. _____, _____ St.)

File No. 3807Registered No. 160

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

Mrs. Mary Ashley.

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX

Female

4. COLOR OR RACE

White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED.

Widowed
(Write the word.)

6. DATE OF BIRTH

August81839

(Month)

(Day)

(Year)

7. AGE

73 yrs. 5 mos. 19 ds.
 IF LESS than 1 day
 how many _____ hrs. or
 _____ mins.

8. OCCUPATION

(a) Trade, profession or particular kind of work

Housewife

(b) General nature of industry business, or establishment in which employed (or employer)

9. BIRTHPLACE

(State or Country) Ohio.

10. NAME OF FATHER

Anex Stein

11. BIRTHPLACE OF FATHER

(State or Country) Ohio

12. MAIDEN NAME OF MOTHER

13. BIRTHPLACE OF MOTHER

(State or Country) Ohio

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Ethel Ashley.(Address) Sandpoint, Idaho.

15.

Filed Jan. 28, 1913M. McKinnon

Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH

January271913

(Month)

(Day)

(Year)

17. I HEREBY CERTIFY, That I attended deceased from

Jan 20 1913, to Jan 26 1913,that I last saw her alive on Jan 26 1913,and that death occurred on the date stated above, at 6 A.M.

The CAUSE OF DEATH* was as follows:

Cerebral Haemorrhage(Duration) _____ yrs. _____ mos. 7 ds.Contributory Arteriosclerosis
(Secondary)(Duration) 2 yrs. _____ mos. _____ ds.(Signed) M. McKinnon M. D.Jan 28, 1913 (Address) Sandpoint

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death _____ yrs. _____ mos. _____ days. In the State _____ yrs. _____ mos. _____ days.

Where was disease contracted if not at place of death?

Former or usual residence _____

19. PLACE OF BURIAL OR REMOVAL

Sandpoint, Idaho.

DATE OF BURIAL

Jan. 29, 1913

20. UNDERTAKER

E. M. Brower

ADDRESS

S

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Form V. S. No. 5 20M.1-16-12

No. 97.

CERTIFICATE OF DEATH

 State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH.

Registration District No.

County of Bonner

Primary Registration District No.

City of Sandpoint.

(No. , St.)

File No.

Registered No. 159

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Johnn Kujawski.

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX

Male

4. COLOR OR RACE

White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED.

Married (the word.)

6. DATE OF BIRTH

April.

25

1848

(Month)

(Day)

(Year)

7. AGE

64 yrs. 9 mos. 4 ds.

 IF LESS than 1 day
how many hrs. or
mins.?

8. OCCUPATION

(a) Trade, profession or particular kind of work

Retired Farmer.

(b) General nature of industry business, or establishment in which employed (or employer)

9. BIRTHPLACE

(State or Country)

Turin, Germany.

10. NAME OF FATHER

11. BIRTHPLACE OF FATHER

(State or Country)

12. MAIDEN NAME OF MOTHER

13. BIRTHPLACE OF MOTHER

(State or Country)

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Phillip Willi,

(Address) Sandpoint, Idaho

15.

Filed Jan. 30, 1913

M. McKinnon.

Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH

January.

29.

1913

(Month)

(Day)

(Year)

17. I HEREBY CERTIFY, That I attended deceased from

Oct 1912, to Jan 15 1913.

that I last saw him alive on Jan 15 1913.

and that death occurred on the date stated above, at 4 AM.

The CAUSE OF DEATH* was as follows:

Bronchitis - with Pleurisy

(Duration)

yrs.

6 mos.

ds.

Contributory (Secondary)

Chronic Bronchitis

(Duration)

yrs.

6 mos.

ds.

(Signed)

M. D.

(Address)

Sandpoint

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place

of death. yrs. mos. days.

In the

State. yrs. mos. days.

Where was disease contracted if not at place of death?

Former or

usual residence.

19. PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

Sandpoint, Idaho.

Jan. 31 1913

20. UNDERTAKER

ADDRESS

E. M. Brower.

Sandpoint, Idaho

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Form V. S. No. 5 20M.1-16-12

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH.

County of Bonner
City of Kootenai

Registration District No. 8

Primary Registration District No. 2033

(No. _____ St.)

File No. 3810

Registered No. 166

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Walter R. Towle

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX 4. COLOR OR RACE 5. SINGLE, MARRIED, WIDOWED OR DIVORCED.

Male White Married

6. DATE OF BIRTH

Feb. 23 1832
(Month) (Day) (Year)

7. AGE

80 yrs. 11 mos. 17 ds.

IF LESS than 1 day
how many hrs. or
..... mins.?

8. OCCUPATION

(a) Trade, profession or particular kind of work

(b) General nature of industry business, or establishment in which employed (or employer)

Retired Farmer

9. BIRTHPLACE

(State or Country)

Vermont

10. NAME OF FATHER

Samuel Towle

11. BIRTHPLACE OF FATHER

(State or Country)

12. MAIDEN NAME OF MOTHER

Lucinda Woolburn

13. BIRTHPLACE OF MOTHER

(State or Country)

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

Will H. Patten

(Address)

Kootenai

15.

Filed Jan. 11th. 1913

M. McKinnon.

Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH

Jan 10 1913
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from

July 1912 to Jan 1913,
that I last saw him alive on Jan 10 1913,

and that death occurred on the date stated above, at 4⁴⁵ P.M.

The CAUSE OF DEATH* was as follows:

Cardiac Dilatation

(Duration) 3 yrs. _____ mos. _____ ds.

Contributory Old age and
(Secondary) malnutrition

(Duration) _____ yrs. _____ mos. _____ ds.

(Signed) Will H. Patten M. D.

Jan 13 1913 (Address) Kootenai

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death yrs. mos. days. In the State yrs. mos. days.

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL

Sandpoint, Idaho.

DATE OF BURIAL

Jan. 13, 1913

20. UNDERTAKER

E. M. Brower.

ADDRESS

Sandpoint, Idaho

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Form V. S. No. 5 20M.1-16-12

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH.

Registration District No. 8County of BonnerPrimary Registration District No. 2033File No. 3811City of Sandpoint

(No. _____, _____ St.)

Registered No. 160

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Alonza Judd Williams,

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX

4. COLOR OR RACE

5. SINGLE, MARRIED, WID-
OWED OR DIVORCED.

Male

White

Married.
(Write the word.)

6. DATE OF BIRTH

September

5

1860

(Month)

(Day)

(Year)

7. AGE

52

yrs.

4

mos.

7

ds.

IF LESS than 1 day
how many _____ hrs. or
_____ mins.?

8. OCCUPATION

(a) Trade, profession or
particular kind of work

Common Laborer.

(b) General nature of industry
business, or establishment in
which employed (or employer)

9. BIRTHPLACE

(State or Country)

Wisconsin

10. NAME OF
FATHER

Marcus Williams.

11. BIRTHPLACE
OF FATHER

(State or Country)

Unknown

12. MAIDEN NAME
OF MOTHER13. BIRTHPLACE
OF MOTHER

(State or Country)

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Mrs. A. J. Williams.(Address) 53 Mill Town, Sandpoint, Idaho.

15.

Filed Jan. 13, 1913 M. McKinnon.

Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH

January

12

1913

(Month)

(Day)

(Year)

17. I HEREBY CERTIFY, That I attended deceased from

Jan 1 1913, to Jan 12 1913,

that I last saw him alive on Jan 11 1913,

and that death occurred on the date stated above, at 7 A.M.

The CAUSE OF DEATH* was as follows:

Pneumonia - following Haemorrhage
of lung

(Duration)

yrs.

mos.

1 ds.

Contributory

(Secondary)

(Duration)

yrs.

mos.

2 ds.

(Signed)

Jan 13 1913

(Address)

Sandpoint

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place

of death _____ yrs. _____ mos. _____ days.

In the

State _____ yrs. _____ mos. _____ days.

Where was disease contracted
if not at place of death?Former or
usual residence

19. PLACE OF BURIAL OR REMOVAL

Sandpoint, Idaho.

DATE OF BURIAL

1-14-13 191

20. UNDERTAKER

E. M. Brower.

ADDRESS

SP. Idaho.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

No. 95.

Form V. S. No. 5 20M.1-16-12

CERTIFICATE OF DEATH

 State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH.

Registration District No.

County of BonnerPrimary Registration District No. 2033City of Sandpoint

(No., St.)

File No. 3812Registered No. 164

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Oscar Fredstrom

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX

Male

4. COLOR OR RACE

White5. SINGLE, MARRIED, WID-
OWED OR DIVORCED.Single
(Write the word.)

6. DATE OF BIRTH

1
(Month) (Day) (Year)

7. AGE

30 yrs. mos. ds.
 IF LESS than 1 day
how many hrs. or
..... mins.?

8. OCCUPATION

(a) Trade, profession or
particular kind of workLumber-jack(b) General nature of industry
business, or establishment in
which employed (or employer)Work in woods

9. BIRTHPLACE

(State or Country)

Sweden10. NAME OF
FATHER11. BIRTHPLACE
OF FATHER

(State or Country)

12. MAIDEN NAME
OF MOTHER13. BIRTHPLACE
OF MOTHER

(State or Country)

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) E. M. Brower.(Address) Sandpoint, Idaho.

15.

Filed Jan. 22 1913 M. McKinnon

Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH

January 20 1913
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from

191., to 191.,
that I last saw h. alive on 191.,
and that death occurred on the date stated above, at M.

The CAUSE OF DEATH* was as follows:

thick R.P. Train
Should Fractured

(Duration) yrs. mos. ds.

Contributory
(Secondary)

(Duration) yrs. mos. ds.

(Signed) M. Knapp M. D.19. (Address) Idaho
 *State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1)
MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.
18. LENGTH OF RESIDENCE (For Hospitals, Institutions,
Transients or Recent Residents.)

At place of death yrs. mos. days. In the State yrs. mos. days.

Where was disease contracted
if not at place of death?Former or
usual residence

19. PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

Sandpoint, IdahoJan 23 1913

20. UNDERTAKER

ADDRESS

E. M. BrowerSandpoint, Ida

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Form V. S. No. 5 20M.1-16-12

No. 99

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH.

Registration District No. 8

County of Bonner

Primary Registration District No. 2033

City of Sandpoint

(No. , St.)

File No. 3813

Registered No. 158

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Frank Lee

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX

Male

4. COLOR OR RACE

White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED.

Widowed
(Write the word.)

6. DATE OF BIRTH

(Month) (Day) (Year)

7. AGE

76 yrs. mos. ds.

IF LESS than 1 day
how many hrs. or mins.?

8. OCCUPATION

(a) Trade, profession or particular kind of work

Retired Farmer

(b) General nature of industry business, or establishment in which employed (or employer)

9. BIRTHPLACE

(State or Country)

Ky

10. NAME OF FATHER

11. BIRTHPLACE OF FATHER

(State or Country)

12. MAIDEN NAME OF MOTHER

13. BIRTHPLACE OF MOTHER

(State or Country)

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

M. Mc Kinnon,

(Address)

Sandpoint, Idaho.

15.

Filed Feb. 1 1913

M. Mc Kinnon

Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH

Jan. 31 1913
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from

Dec 10 1912, to Jan 31 1913,

that I last saw him alive on Jan 30 1913,

and that death occurred on the date stated above, at 5 A.M.

The CAUSE OF DEATH* was as follows:

Cancer of Stomach

(Duration) yrs. 6 mos. ds.

Contributory (Secondary) Had gastric trouble for 10 yrs

(Duration) yrs. mos. ds.

(Signed) M. Mc Kinnon M. D.

Feb. 1913 (Address) Sandpoint

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death yrs. mos. days. In the State yrs. mos. days.

Where was disease contracted if not at place of death?

Former or usual residence.

19. PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

Priest River, Idaho

Feb 2 1913

20. UNDERTAKER

ADDRESS

E. M. Brower,

Sandpoint, Ida.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Form V. S. No. 5. 12½M.7-24-11

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics
File No. 3811
Registered No. 157

1. PLACE OF DEATH. Registration District No. 8
County of Bonner Primary Registration District No. 2033
City of Granite (No. _____, _____ St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

George Rudolph

If death occurred in a hospital, institution or camp give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX male 4. COLOR OR RACE wh. 5. SINGLE, MARRIED, WIDOWED OR DIVORCED.
(Write the word.)

6. DATE OF BIRTH Apr. 25 1865
(Month) (Day) (Year)

7. AGE 47 yrs. 8 mos. 10 ds. IF LESS than 1 day
how many _____ hrs. or _____ min?

8. OCCUPATION

- (a) Trade, profession or particular kind of work.
(b) General nature of industry business or establishment in which employed (or employer)

Real Estate Agent

9. BIRTHPLACE
(State or Country)

Ill.

10. NAME OF FATHER

11. BIRTHPLACE OF FATHER
(State or Country)

12. MAIDEN NAME OF MOTHER

13. BIRTHPLACE OF MOTHER
(State or Country)

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

(Address)

15.

Filed June 6 1913

M. McFadden
Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH

January 5 1913
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from Jan 5 1913, to Jan 5 1913
that I last saw him alive on Jan 5 1913
and that death occurred on the date stated above, at 4 P. M.

The CAUSE OF DEATH* was as follows:

Acute Alcoholism

(Duration) _____ yrs. _____ mos. 10 ds.

Contributory
(Secondary)

(Duration) _____ yrs. _____ mos. _____ ds.

(Signed) Frank W. King M. D.

116 1913 (Address) Rathdrum, Pa.

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place _____ In the _____
of death _____ yrs. _____ mos. _____ ds. State _____ yrs. _____ mos. _____ ds.

Where was disease contracted,

If not at place of death?

Former or
usual residence.

19. PLACE OF BURIAL OR REMOVAL DATE OF BURIAL

Newport, Wash. 1/7 1913

20. UNDERTAKER

ADDRESS

G. R. Koppf Rathdrum

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Form V. S. No. 5. 10M. 6-20-11.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics
File No. 3816

1. PLACE OF DEATH. Registration District No. 8
County of Bonner Primary Registration District No. 2036
City of Prust River (No. _____, St.)

Registered No. 163

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Riva May Robinson

If death occurred in a hospital, institution or camp give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX 4. COLOR OR RACE 5. SINGLE, MARRIED, WID-
OWED OR DIVORCED.

Female white single
(Write the word.)

6. DATE OF BIRTH

Jan-16-1913
(Month) (Day) (Year)

7. AGE

— yrs. — mos. 5 ds. IF LESS than 1 day
how many hrs. or
..... min.?

8. OCCUPATION

(a) Trade, profession, or
particular kind of work none
(b) General nature of industry
business, or establishment in
which employed (or employer)

9. BIRTHPLACE

(State or Country)

Idaho10. NAME OF
FATHERRay W. Robinson11. BIRTHPLACE
OF FATHER

(State or Country)

Miss12. MAIDEN NAME
OF MOTHERMary E. Carr13. BIRTHPLACE
OF MOTHER

(State or Country)

Miss

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

(Address)

Ray W. Robinson
Prust River

15.

Filed

Feb 1 1913 M. McKinnis

Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

Jan-21-1913
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from

191, to 191

that I last saw her alive on Jan. 18 1913

and that death occurred on the date stated above, at unknown M.

The CAUSE OF DEATH* was as follows:

Accidental asphyxia

(Duration) yrs. mos. ds.

Contributory
(Secondary)

(Duration) yrs. mos. ds.

(Signed) Robinson M. D.

Jan. 21 1913 (Address) Prust River

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL,

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place In the
of death yrs. mos. ds. State yrs. mos. ds.

Where was Disease contracted,

If not at place of death?

Former or

usual residence.

19. PLACE OF BURIAL OR REMOVAL DATE OF BURIAL

Prust River Jan. 22 1913

20. UNDERTAKER

ADDRESS

none

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFAADING INK—THIS IS A PERMANENT RECORD.
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Form V. S. No. 5 20M.1-16-12

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics
File No. 3817

1. PLACE OF DEATH.

Registration District No. 1

County of Ada

Primary Registration District No. 2004

City of South Boise

(No. 3rd & Harvard St.)

Registered No. 10

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Mrs. Frances A. Sackett

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX

Female

4. COLOR OR RACE

White American

5. SINGLE, MARRIED, WIDOWED OR DIVORCED.

Married (Write the word)

6. DATE OF BIRTH

July 14 1842
(Month) (Day) (Year)

7. AGE

70 yrs. 3 mos. 26 ds.

IF LESS than 1 day
how many hrs. or mins.

8. OCCUPATION

(a) Trade, profession or particular kind of work

Housewife

(b) General nature of industry, business, or establishment in which employed (or employer)

9. BIRTHPLACE

(State or Country)

Illinois

10. NAME OF FATHER

Walsham Ruston

11. BIRTHPLACE OF FATHER

(State or Country)

Illinois

12. MAIDEN NAME OF MOTHER

Carmie Hochsuey

13. BIRTHPLACE OF MOTHER

(State or Country)

Illinois

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

St. Wagner

(Address)

Gen. Delivery

15.

Filed

June 11th 1913

1913

J. M. Taylor

Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH

January 10 1913
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from

Dec 20 1912 to June 10 1913

that I last saw her alive on June 9 1913

and that death occurred on the date stated above, at 8 a.m.

The CAUSE OF DEATH* was as follows:

Murdering Poison

(Duration) yrs. mos. ds.

Contributory (Secondary)

(Duration) yrs. mos. ds.

(Signed)

June 10 1913 (Address) Borah

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death yrs. mos. days. In the State yrs. mos. days.

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

Morris Hill

Jan 2 1913

20. UNDERTAKER

ADDRESS

Try & Sumner

Boise

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH.

Registration District No. 1County of AdaPrimary Registration District No. 2004City of So. Boise(No. South end of Broadway St.)File No. 3821Registered No. 15

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

Baby Allera

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX

Female

4. COLOR OR RACE

White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED.

Single
(Write the word.)

6. DATE OF BIRTH

Jan 2nd 1913
(Month) (Day) (Year)

7. AGE

— yrs. — mos. 4 ds.IF LESS than 1 day
how many — hrs. or
— mins.?

8. OCCUPATION

(a) Trade, profession or particular kind of work

none

(b) General nature of industry business, or establishment in which employed (or employer)

9. BIRTHPLACE

(State or Country)

So Boise Idaho

10. NAME OF FATHER

F. W. Allen

11. BIRTHPLACE OF FATHER

(State or Country)

Kansas

12. MAIDEN NAME OF MOTHER

Florence Lemon

13. BIRTHPLACE OF MOTHER

(State or Country)

Ills.

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

F. W. Allen

(Address)

South Boise

15.

Filed

Feb. 10-1913 J. M. Taylor
J. M. Taylor

1913

Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH

Jan 6th 1913
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from

Jan. 2nd 1913, to Jan. 6th 1913that I last saw him alive on Jan. 5th 1913and that death occurred on the date stated above, at 5 P. M.

The CAUSE OF DEATH* was as follows:

Convulsion following abnormal birth.(Duration) — yrs. — mos. — ds.Contributory
(Secondary)(Duration) — yrs. — mos. — ds.(Signed) J. M. Taylor M. D.Jan. 7th 1913 (Address) Boise Ida

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death — yrs. — mos. — days. In the State — yrs. — mos. — days.

Where was disease contracted if not at place of death?

Former or usual residence —

19. PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

Harris Hill Cemetery 1/7 1913

20. UNDERTAKER

ADDRESS

Schreiber & Videnfaden Boise, Ida.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Form V. S. No. 5 20M.1-16-12

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH.

Registration District No. 1

County of

Ada

Primary Registration District No. 2004

City of

near Boise

(No. County Park Farm St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

J. C. Benson

File No.

3822

Registered No.

16

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX

Male

4. COLOR OR RACE

White

5. SINGLE, MARRIED, WID-
OWED OR DIVORCED.Married
(Write the word.)

6. DATE OF BIRTH

not obtainable

(Month)

(Day)

(Year)

7. AGE

48

yrs.

mos.

ds.

IF LESS than 1 day
how many hrs. or
mins.?

8. OCCUPATION

(a) Trade, profession or
particular kind of work

none

(b) General nature of industry
business, or establishment in
which employed (or employer)Inmate County
Park Farm

9. BIRTHPLACE

(State or Country)

England

10. NAME OF
FATHER

not obtainable

11. BIRTHPLACE
OF FATHER

(State or Country)

" "

12. MAIDEN NAME
OF MOTHER

" "

13. BIRTHPLACE
OF MOTHER

(State or Country)

" "

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

E. J. S. S. S.

(Address)

County Park Farm

15.

Feb. 10 - 1913

J. M. Taylor

Filed

1-17-13

191

J. C. Benson

Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH

Jan

12

1913

(Month)

(Day)

(Year)

17. I HEREBY CERTIFY, That I attended deceased from

Oct 28

1912, to

Jan 12

1913,

that I last saw him alive on

Jan 2

1913,

and that death occurred on the date stated above, at 7 P. M.

The CAUSE OF DEATH* was as follows:

Apoplexy - arteriosclerosis

(Duration)

?

yrs.

mos.

ds.

Contributory
(Secondary)

Chronic interstitial nephritis

(Duration)

?

yrs.

mos.

ds.

(Signed)

W. H. S. S. S. M. D.

1-17-1913 (Address) Boise, Idaho

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place

of death.....yrs.....mos.....days.

In the

State.....yrs.....mos.....days.

Where was disease contracted
if not at place of death?Former or
usual residence.

Ada Co. Farm

19. PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

Marion Hill Co. Plot

Jan 17 1913

20. UNDERTAKER

ADDRESS

Schreibers & Sidenfaden

Boise

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
N. B.—Every item of information should be carefully supplied. AGE should be state EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Form V. S. No. 5. 10M. 6-20-11.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics
File No. 3821

1. PLACE OF DEATH.

Registration District No. 3

County of Canyon
City of near Caldwell

Primary Registration District No. 2005

(No. Rural No. 3 St.)

Registered No. 2

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

Mary Elizabeth Lohlein

If death occurred in a hospital, institution or camp give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX

F

4. COLOR OR RACE

W

5. SINGLE, MARRIED, WIDOWED OR DIVORCED.

Married
(Write the word.)

6. DATE OF BIRTH

August 23 1885
(Month) (Day) (Year)

7. AGE

57 yrs. 4 mos. 9 ds.

IF LESS than 1 day
how many hrs. or min.?

8. OCCUPATION

(a) Trade, profession, or particular kind of work

House Keeping

(b) General nature of industry business, or establishment in which employed (or employer)

X

9. BIRTHPLACE

(State or Country)

Baltimore Md

10. NAME OF FATHER

Fredrick Mayer

11. BIRTHPLACE OF FATHER

(State or Country)

Germany

12. MAIDEN NAME OF MOTHER

don't know

13. BIRTHPLACE OF MOTHER

(State or Country)

Germany

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

(Address)

Joseph Lohlein
Caldwell Idaho

15.

Filed Jan. 4 1913

Johd. Meyer
Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

1 1913
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from 12/31/12 1912, to 1/2 1913

that I last saw h.w alive on 1/2/13 1913

and that death occurred on the date stated above, at 5:15 P.M.

The CAUSE OF DEATH* was as follows:

Ruptured Gall Bladder

(Duration) yrs. mos. ds. 7

Contributory (Secondary)

arthritis deformans

(Duration) 30 yrs. mos. ds.

(Signed)

1/4/13 1913 (Address) Caldwell Idaho

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place In the
of death yrs. mos. ds. State yrs. mos. ds.

Where was Disease contracted,

If not at place of death?

Former or

usual residence

19. PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

Canyon Hill

1/5 1913

20. UNDERTAKER

ADDRESS

W. DyerCaldwell

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Form V. S. No. 5. 12½ M. 7-24-11

CERTIFICATE OF DEATH

State of Idaho

1. PLACE OF DEATH.

Registration District No.

County of CanyonPrimary Registration District No. 1005City of Caldwell(No. Arthur St.)Bureau of Vital Statistics
File No. 3835Registered No. 3

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Samuel D. Harthoff

If death occurred in a hospital, institution or camp give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX

Male

4. COLOR OR RACE

White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED.

married
(Write the word.)

6. DATE OF BIRTH

Dec. 5th 1847
(Month) (Day) (Year)

7. AGE

67 yrs. 28 mos. 18 ds.IF LESS than 1 day
how many hrs. or
..... min?

8. OCCUPATION

- (a) Trade, profession or particular kind of work.....
(b) General nature of industry business or establishment in which employed (or employer)

Zin Smith

9. BIRTHPLACE

(State or Country)

Ohio

10. NAME OF FATHER

Daniel Harthoff

11. BIRTHPLACE OF FATHER

(State or Country)

Germany

12. MAIDEN NAME OF MOTHER

Christena Pretzinger

13. BIRTHPLACE OF MOTHER

(State or Country)

Germany

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Mrs. Lena Harthoff(Address) Caldwell, Idaho

15.

Filed Jan. 2nd 1913John D. Meyer
Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH

Jan. 2nd 1913
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from

Jan. 2nd 1913, to Jan. 2nd 1913that I last saw him alive on Jan. 2nd 1913and that death occurred on the date stated above, at 1:30 P.M.

The CAUSE OF DEATH* was as follows:

Apoplexy (Cerebral)

(Duration) yrs. mos. ds.

Contributory Arteriosclerosis
(Secondary)

(Duration) yrs. mos. ds.

(Signed) John D. Meyer M. D.Jan. 2nd 1913 (Address) Caldwell, Idaho

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place In the
of death yrs. mos. ds. State yrs. mos. ds.

Where was disease contracted,

If not at place of death?

Former or

usual residence.

19. PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

Canyon HillJan. 4th 1913

20. UNDERTAKER

ADDRESS

M. C. DyerCaldwell

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
N. B.—Every item of information should be carefully supplied. AGE should be state EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Form V. S. No. 5. 10M. 6-20-11.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH.

Registration District No. 3

County of Canyon

Primary Registration District No. 2005

City of Middleton

(No. _____, _____ St.)

File No. 3827

Registered No. 5

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

Delilah E. Charney

If death occurred in a hospital, institution or camp give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

MEDICAL CERTIFICATE OF DEATH

3. SEX

F.

4. COLOR OR RACE

W.

5. SINGLE, MARRIED, WIDOWED OR DIVORCED.

Married
(Write the word.)

6. DATE OF BIRTH

Aug. 9 1855
(Month) (Day) (Year)

7. AGE

57 yrs. 5 mos. 1 ds.

IF LESS than 1 day
how many hrs. or
..... min.?

8. OCCUPATION

(a) Trade, profession, or particular kind of work
(b) General nature of industry business, or establishment in which employed (or employer)

Housekeeping

9. BIRTHPLACE

(State or Country) Holt Co. Mo.

10. NAME OF FATHER

G. F. Langdon

11. BIRTHPLACE OF FATHER

(State or Country) Iowa

12. MAIDEN NAME OF MOTHER

Annie J. J. J. J.

13. BIRTHPLACE OF MOTHER

(State or Country) Mo.

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) S. F. Charney

(Address) Middleton Idaho

15.

Filed Jan. 15 1913

J. S. Meyer
Local Registrar

16. DATE OF DEATH

Jan 10 1913
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from

12-1 1912, to 1-9 1913

that I last saw her alive on Jan 9th 1913

and that death occurred on the date stated above, at 9:40 A. M.

The CAUSE OF DEATH* was as follows:

uraemic Poisoning

(Duration) yrs. 1 mos. 9 ds.

Contributory (Secondary)

Complications of lung standing

(Duration) yrs. _____ mos. _____ ds.

(Signed) J. W. Hamer M. D.

1-11-1913 (Address) Middleton

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place _____ In the _____
of death yrs. mos. ds. State yrs. mos. ds.

Where was Disease contracted,

If not at place of death?

Former or

usual residence.

19. PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

Middleton Cemetery

Jan 12 1913

20. UNDERTAKER

ADDRESS

W. C. Dyer

Cablewell
Idaho

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
N. B.—Every item of information should be carefully supplied. AGE should be state EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Form V. S. No. 5. 10M. 6-20-11.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH.

Registration District No. 3

County of Canyon

Primary Registration District No. 2005

City of Caldwell

(No. , St.)

File No. 3828

Registered No. 6

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME William E Warner

If death occurred in a hospital, institution or camp give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX

4. COLOR OR RACE

5. SINGLE, MARRIED, WIDOWED, OR DIVORCED.

M

W

Single
(Write the word.)

6. DATE OF BIRTH

July

21

1840

(Month)

(Day)

(Year)

7. AGE

72 yrs.

6 mos.

ds.

IF LESS than 1 day
how many hrs. or
min.?

8. OCCUPATION

(a) Trade, profession, or particular kind of work

Farmer

(b) General nature of industry business, or establishment in which employed (or employer)

9. BIRTHPLACE

(State or Country)

Germany

10. NAME OF FATHER

Don't know

11. BIRTHPLACE OF FATHER

(State or Country)

Don't know

12. MAIDEN NAME OF MOTHER

Don't know

13. BIRTHPLACE OF MOTHER

(State or Country)

Don't know

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Fred Mitchell

(Address) Caldwell, Idaho

15.

Filed Jan. 15 1913

J. S. Meyer

Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

Jan

11

1913

(Month)

(Day)

(Year)

17. I HEREBY CERTIFY, That I attended deceased from

Jan 1

1913

to Jan 11

1913

that I last saw him alive on Jan 9 1913

and that death occurred on the date stated above, at 10 P.M.

The CAUSE OF DEATH* was as follows:

Tuberculosis of spine & abscess

(Duration) about 3 years mos. ds.

Contributory (Secondary)

(Duration) yrs. mos. ds.

(Signed) J. S. Meyer M. D.

1/13 1913 (Address) Caldwell, Idaho

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place In the of death yrs. mos. ds. State yrs. mos. ds.

Where was Disease contracted, If not at place of death?

Former or usual residence.

19. PLACE OF BURIAL OR REMOVAL DATE OF BURIAL

Canyon Hill

Jan 13 1913

20. UNDERTAKER

ADDRESS

W. B. Dyer

Caldwell

1. PLACE OF DEATH. Registration District No. 8
 County of Canyon Primary Registration District No. 2005
 City of Middleton (No. _____ St.)
 If death occurs away from usual residence, give facts called for under special information. 2. FULL NAME John Barton Smith
 Bureau of Vital Statistics
 File No. 3824
 Registered No. 7
 If death occurred in a hospital, institution or camp give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX Male 4. COLOR OR RACE American 5. SINGLE, MARRIED, WIDOWED OR DIVORCED. Widowed
 (Write the word.)

6. DATE OF BIRTH April 22 1941
 (Month) (Day) (Year)

7. AGE 71 yrs. 8 mos. 24 ds. IF LESS than 1 day how many _____ hrs. or _____ min.?

8. OCCUPATION Farmer Retired
 (a) Trade, profession, or particular kind of work
 (b) General nature of industry business, or establishment in which employed (or employer)

9. BIRTHPLACE (State or Country) Davis Co. Iowa.

10. NAME OF FATHER

11. BIRTHPLACE OF FATHER (State or Country)

12. MAIDEN NAME OF MOTHER

13. BIRTHPLACE OF MOTHER (State or Country)

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) E. L. Smith
 (Address) Boise Idaho.

15. Filed Jan 16 1913 John D. Meyer
 Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH Jan 16 1913
 (Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from Oct. 20 1912, to Jan 15th 1913
 that I last saw him alive on Jan 15th 1913, and that death occurred on the date stated above, at 12:30 A. M.
 The CAUSE OF DEATH* was as follows: Sclerosis of Liver

(Duration) 2 yrs. — mos. — ds.
 Contributory (Secondary) General anasarca

(Duration) 1 yr. — mos. — ds.
 (Signed) J. W. Thomas M. D.
1-16-1913 (Address) Middleton, Idaho

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place In the
 of death _____ yrs. _____ mos. _____ ds. State _____ yrs. _____ mos. _____ ds.
 Where was Disease contracted,
 If not at place of death? _____
 Former or
 usual residence _____

19. PLACE OF BURIAL OR REMOVAL Middleton Cemetery DATE OF BURIAL 1/17 1913
 20. UNDERTAKER W. F. Dyer ADDRESS Calhoun Idaho

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
 N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

MARGIN RESERVED FOR BINDING

1. PLACE OF DEATH.

Registration District No. 3County of CanyonPrimary Registration District No. 1005City of Caldwell(No. Main - St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

Levin H. MorState of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics
File No. 3834Registered No. 8

If death occurred in a hospital, institution or camp give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX

Male

4. COLOR OR RACE

white

5. SINGLE, MARRIED, WIDOWED OR DIVORCED.

Married
(Write the word.)

6. DATE OF BIRTH

January 18th 1913
(Month) (Day) (Year)

7. AGE

53 yrs. 5 mos. 27 ds.IF LESS than 1 day
how many hrs. or
..... min.?

8. OCCUPATION

(a) Trade, profession, or particular kind of work
(b) General nature of industry business, or establishment in which employed (or employer)Jeweler9. BIRTHPLACE
(State or Country)Trondhjem, Norway

10. NAME OF FATHER

Georgy Mor11. BIRTHPLACE OF FATHER
(State or Country)Trondhjem, Norway

12. MAIDEN NAME OF MOTHER

Martha Berger13. BIRTHPLACE OF MOTHER
(State or Country)Trondhjem, Norway

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Mrs. S. H. Mor(Address) Caldwell, Idaho

15.

Filed Jan. 20 1913J. H. Meyer
Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

June 18 1913
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from

1/16/13 1913, to 1/18/13 1913that I last saw him alive on 1/18/13 1913and that death occurred on the date stated above, at 4.0 M.

The CAUSE OF DEATH* was as follows:

Dissection HeartDissection Heart(Duration) yrs. mos. 7 ds.Contributory
(Secondary)Bronch. Pneumonia(Duration) yrs. mos. 14 ds.

(Signed)

W. H. Johnson M. D.

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL,

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place yrs. mos. ds. State yrs. mos. ds.

Where was Disease contracted,

If not at place of death?

Former or usual residence.

19. PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

Caldwell1/20 1913

20. UNDERTAKER

ADDRESS

W. H. JohnsonCaldwellDr. Johnson

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. N. B.—Every item of information should be carefully supplied. AGE should be state EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Registered No. 9

If death occurred in a hospital, institution or camp give its NAME instead of street and number.

1. PLACE OF DEATH. Registration District No. 3
County of Canyon Primary Registration District No. 1005
City of Caldwell (No. St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Jacob J. Billingsley

PERSONAL AND STATISTICAL PARTICULARS

3. SEX M. 4. COLOR OR RACE W. 5. SINGLE, MARRIED, WIDOWED OR DIVORCED. Widowed
(Write the word.)6. DATE OF BIRTH Feb 1867
(Month) (Day) (Year)

7. AGE 44 yrs. mos. ds. IF LESS than 1 day how many hrs. or min.?

8. OCCUPATION

(a) Trade, profession, or particular kind of work Labor.
(b) General nature of industry business, or establishment in which employed (or employer)

9. BIRTHPLACE

(State or Country) Indiana

10. NAME OF FATHER Jas. Billingsley

11. BIRTHPLACE OF FATHER

(State or Country) Do not know

12. MAIDEN NAME OF MOTHER Elizabeth Carson

13. BIRTHPLACE OF MOTHER

(State or Country) Do not know

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) James K. Billingsley

(Address) Caldwell, Id.

15.

Filed Jan. 24 1913

Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH Jan 22 1913
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from Oct 1 1913, to Jan 22 1913

that I last saw him alive on Jan 22 1913, and that death occurred on the date stated above, at 11 P. M.

The CAUSE OF DEATH* was as follows:

Cancer of Throat.

(Duration) yrs. mos. ds.

Contributory (Secondary) Hemorrhage

(Duration) yrs. mos. ds.

(Signed) S. D. Miller M. D.

Jan 24 1913 (Address) Caldwell

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place In the of death yrs. mos. ds. State yrs. mos. ds.

Where was Disease contracted, If not at place of death?

Former or usual residence.

19. PLACE OF BURIAL REMOVAL

DATE OF BURIAL

Coeys Hill

1/24 1913

20. UNDERTAKER

ADDRESS

W. C. Dyer

Caldwell

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. N. B.—Every item of information should be carefully supplied. AGE should be state EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Form V. S. No. 5. 10M. 6-20-11.

CERTIFICATE OF DEATH

1. PLACE OF DEATH.

County of Canyon
City of Parma

Registration District No. 3Primary Registration District No. 2007

(No. _____, _____ St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

George Bale

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics
File No. 3832

Registered No. 10

If death occurred in a hospital, institution or camp give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX

Male

4. COLOR OR RACE

W

5. SINGLE, MARRIED, WIDOWED OR DIVORCED.

(Write the word.) S

6. DATE OF BIRTH

Nov111912

(Month)

(Day)

(Year)

7. AGE

2 yrs.12 mos.12 ds.

If LESS than 1 day
how many hrs. or
..... min.?

8. OCCUPATION

- (a) Trade, profession or particular kind of work
(b) General nature of industry business or establishment in which employed (or employer)

9. BIRTHPLACE

(State or Country)

Canyon Co

10. NAME OF FATHER

Roy Bales

11. BIRTHPLACE OF FATHER

(State or Country)

Mich

12. MAIDEN NAME OF MOTHER

Alice Downing

13. BIRTHPLACE OF MOTHER

(State or Country)

Mich

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

(Address)

D. J. Downing

15.

Filed

Jan 24 1913Allen

Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

Jan.231913

(Month)

(Day)

(Year)

17. I HEREBY CERTIFY, That I attended deceased from

Jan 23 1913 to Jan 23 1913that I last saw him alive on Jan 23 1913and that death occurred on the date stated above, at 9 P M.

The CAUSE OF DEATH* was as follows:

Malnutrition

(Duration)

yrs.

2

mos.

ds.

Contributory
(Secondary)Capillary Bronchitis

(Duration)

yrs.

3

ds.

(Signed)

Jan 24 1913

(Address)

Crutley M. D.
Caldwell

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and 2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place

In the

of death

yrs.

mos.

ds.

State

yrs.

mos.

ds.

Where was disease contracted.

If not at place of death?

Former or

usual residence

19. PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

Parma1/24 1913

20. UNDERTAKER

ADDRESS

Ed Replem CoParma

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Form V. S. No. 5. 10M. 6-20-11.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics
File No. 3833
Registered No. 11

1. PLACE OF DEATH.

Registration District No. 3

County of Canyon

Primary Registration District No. 1006

City ofampa

(No. , St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

A. S. Welch

If death occurred in a hospital, institution or camp give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX

Male

4. COLOR OR RACE

White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED.

Married
(Write the word.)

6. DATE OF BIRTH

March

10

1854

(Month)

(Day)

(Year)

7. AGE

38

yrs. 10

mos.

ds.

IF LESS than 1 day

how many hrs. or min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work

Farmer

(b) General nature of industry business or establishment in which employed (or employer)

9. BIRTHPLACE

(State or Country)

Vermont

10. NAME OF FATHER

George Welch

11. BIRTHPLACE OF FATHER

(State or Country)

Vermont

12. MAIDEN NAME OF MOTHER

Electa Camp

13. BIRTHPLACE OF MOTHER

(State or Country)

Vermont

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

Mrs. Silas Wilson

(Address)

ampa Idaho

15.

Filed

1-5-1913

O. B. Beller M.D.

Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

July
(Month)2
(Day)1913
(Year)

17. I HEREBY CERTIFY, That I attended deceased from

July 2 1913, to 191
that I last saw him alive on 191
and that death occurred on the date stated above, at 9 P. M.

The CAUSE OF DEATH* was as follows:

Heart failure

(Duration) yrs. mos. ds.

Contributory
(Secondary)Some heart affection
of several years duration

(Duration) yrs. mos. ds.

(Signed)

J. H. Murray

M. D.

July 6 1913 (Address)ampa Idaho

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place ☒ In the
of death. yrs. mos. ds. State. yrs. mos. ds.

Where was disease contracted.

If not at place of death?

Former or

usual residence.

19. PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

F. K. Robinson

1-8 1913

20. UNDERTAKER

ADDRESS

F. K. Robinson

ampa Ida

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Form V. S. No. 5. 10M. 6-20-11.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics
File No. 3531

1. PLACE OF DEATH.
County of Canyon
City of Hampton

Registration District No. 3
Primary Registration District No. 1006
(No. _____, St.)

Registered No. 12

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Lula Ruth Rohrer

If death occurred in a hospital, institution or camp give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX Female 4. COLOR OR RACE White 5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.) Single
6. DATE OF BIRTH Dec 27 1912
(Month) (Day) (Year)
7. AGE _____ yrs. _____ mos. 9 ds. IF LESS than 1 day how many _____ hrs. or _____ min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work Infant
(b) General nature of industry business or establishment in which employed (or employer)

9. BIRTHPLACE
(State or Country) Hampton Canyon & Idaho

10. NAME OF FATHER C. W. Rohrer

11. BIRTHPLACE OF FATHER Wisconsin
(State or Country)

12. MAIDEN NAME OF MOTHER Lucy Tombridge

13. BIRTHPLACE OF MOTHER Wisconsin
(State or Country)

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) C. W. Rohrer

(Address) Hampton Idaho

15. Filed 1-7-1913 O. B. Beller M.D.
Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH Jan 5 1913
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from Dec 27 1912, to Jan 5 1913, that I last saw her alive on Jan 5 1913, and that death occurred on the date stated above, at 6 a. M.

The CAUSE OF DEATH* was as follows:
Umbilical Hemorrhage - External + internal - Blood non Coagulable vessels patulous. Blood in urine
(Duration) _____ yrs. _____ mos. 5 ds.

Contributory (Secondary) Harmophilic Family History
(Duration) _____ yrs. _____ mos. _____ ds.

(Signed) J. H. Murray M. D.
Jan 6 1913 (Address) Hampton Idaho

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death. _____ yrs. _____ mos. _____ ds. State. _____ yrs. _____ mos. _____ ds.
Where was disease contracted, _____
If not at place of death? _____
Former or usual residence. _____

19. PLACE OF BURIAL OR REMOVAL Kohlerdawn Cem DATE OF BURIAL 1-7-1913

20. UNDERTAKER F. S. Robinson ADDRESS Hampton Ida

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Form V. S. No. 5. 10M. 6-20-11.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics1. PLACE OF DEATH.
County of Canyon
City of NampaRegistration District No. 3
Primary Registration District No. 1006
(No. _____, _____ St.)File No. 3835Registered No. 13

If death occurred in a hospital, institution or camp give its NAME instead of street and number.

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

Isaac Harvey Hatfield

PERSONAL AND STATISTICAL PARTICULARS

3. SEX Male 4. COLOR OR RACE White 5. SINGLE, MARRIED, WIDOWED OR DIVORCED.
Married
(Write the word.)6. DATE OF BIRTH
September 12 1911
(Month) (Day) (Year)7. AGE 61 yrs. 3 mos. 28 ds. IF LESS than 1 day
how many _____ hrs. or
_____ min.?8. OCCUPATION
(a) Trade, profession, or particular kind of work harness maker
(b) General nature of industry business, or establishment in which employed (or employer) _____9. BIRTHPLACE
(State or Country) Vinton County Ohio10. NAME OF FATHER Jonas S. Hatfield11. BIRTHPLACE OF FATHER
(State or Country) Ohio12. MAIDEN NAME OF MOTHER Mary Ann Keeton13. BIRTHPLACE OF MOTHER
(State or Country) Ohio

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) J. H. Grosholz
(Address) Nampa Idaho15. Filed Jan 13 1913 O. B. Beller Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH
Jan 11th 1913
(Month) (Day) (Year)17. I HEREBY CERTIFY, That I attended deceased from
Jan 5 1913, to Jan 11 1913
that I last saw him alive on Jan 11th 1913
and that death occurred on the date stated above, at 12.30 A.M.

The CAUSE OF DEATH* was as follows:

myocarditis(Duration) 0 yrs. 0 mos. 6 ds.

Contributory (Secondary) _____

(Duration) _____ yrs. _____ mos. _____ ds.

(Signed) H. P. Ross M. D.
Jan 14 1913 (Address) Nampa, Ida

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place _____ In the _____
of death _____ yrs. _____ mos. _____ ds. State _____ yrs. _____ mos. _____ ds.Where was Disease contracted, Nampa
If not at place of death?
Former or Nampa
usual residence.19. PLACE OF BURIAL OR REMOVAL Kohlerlawn, Nampa DATE OF BURIAL Jan 13 191320. UNDERTAKER J. B. Schellabarger ADDRESS Nampa Ida

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Form V. S. No. 5. 10M. 6-20-11.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics
File No. 3836

1. PLACE OF DEATH.

Registration District No. 3County of CanyonPrimary Registration District No. 1006City of Naupau

(No. _____, _____ St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

Hugh Robert RossRegistered No. 14

If death occurred in a hospital, institution or camp give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX

Male

4. COLOR OR RACE

White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED.

Single
(Write the word.)

6. DATE OF BIRTH

Aug221913

(Month)

(Day)

(Year)

7. AGE

0 yrs.4 mos.22 ds.

IF LESS than 1 day
how many hrs. or
..... min.?

8. OCCUPATION

(a) Trade, profession, or particular kind of work

None

(b) General nature of industry business, or establishment in which employed (or employer)

9. BIRTHPLACE

(State or Country)

Naupau Ida

10. NAME OF FATHER

H. P. Ross

11. BIRTHPLACE OF FATHER

(State or Country)

Canada

12. MAIDEN NAME OF MOTHER

Claudia Cross

13. BIRTHPLACE OF MOTHER

(State or Country)

Wisconsin

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

H. P. Ross

(Address)

Naupau Ida

15.

Filed 1-15-1913O. B. Beller

Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

Jan131913

(Month)

(Day)

(Year)

17. I HEREBY CERTIFY, That I attended deceased from

Aug 22 1913 to Jan 13 1913that I last saw him alive on Jan 13 1913,and that death occurred on the date stated above, at 11 A. M.

The CAUSE OF DEATH* was as follows:

Atelectasis & pneumonia(Duration) yrs. 4 mos. 22 ds.Contributory
(Secondary)

(Duration) yrs. mos. ds.

(Signed)

H. P. Ross

M. D.

Jan 13, 1913 (Address) Naupau Ida

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place

In the

of death yrs. mos. ds. State yrs. mos. ds.

Where was Disease contracted,

If not at place of death?

Former or

usual residence.

19. PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

Kohlerlawn Naupau Jan 15 1913

20. UNDERTAKER

ADDRESS

F. H. Robinson Naupau Ida

MARGIN RESERVED FOR BINDING
WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Form V. S. No. 5. 10M. 6-20-11.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics
File No. 3837

Registered No. 15

If death occurred in a hospital, institution or camp give its NAME instead of street and number.

1. PLACE OF DEATH.

Registration District No. 3

County of Canyon

Primary Registration District No. 7006

City ofampa

(No. 1 St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

Lizzie J. Hoffmann

PERSONAL AND STATISTICAL PARTICULARS

3. SEX

Female

White

4. COLOR OR RACE

5. SINGLE, MARRIED, WIDOWED OR DIVORCED.
Married
(Write the word.)

6. DATE OF BIRTH

Sep

—

1862

(Month)

(Day)

(Year)

7. AGE

50 yrs. — mos. — ds.

IF LESS than 1 day
how many hrs. or min.?

8. OCCUPATION

(a) Trade, profession, or particular kind of work
(b) General nature of industry, business, or establishment in which employed (or employer)

House wife

9. BIRTHPLACE

(State or Country)

Ill

10. NAME OF FATHER

J. V. Hollinger

11. BIRTHPLACE OF FATHER

(State or Country)

Dont know

12. MAIDEN NAME OF MOTHER

Dont know

13. BIRTHPLACE OF MOTHER

(State or Country)

" "

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

Harry Hoffmann
ampa Ida

(Address)

15.

Filed 1-15-1913

O. B. Beller
Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

July

14

1913

(Month)

(Day)

(Year)

17. I HEREBY CERTIFY, That I attended deceased from

2:30 P. M. July 13, 1913, to 3:30 A. M. July 14, 1913.

that I last saw him alive on July 14, 1913,

and that death occurred on the date stated above, at 3:30 A. M.

The CAUSE OF DEATH* was as follows:

Paralysis from cerebral hemorrhage

(Duration) yrs. mos. ds.

Contributory (Secondary)

Hereditary

(Duration) yrs. mos. ds.

(Signed)

J. H. Murray

M. D.

July 14, 1913 (Address)ampa Ida

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place

In the

of death. yrs. mos. ds. State. yrs. mos. ds.

Where was Disease contracted,

If not at place of death?

Former or

usual residence.

19. PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

Ms Carroll Ill

191

20. UNDERTAKER

ADDRESS

J. H. Robinson

ampa Ida

Form V. S. No. 5. 10M. 6-20-11.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH.

Registration District No. 3County of CanyonPrimary Registration District No. 1006City of Nampa

(No. _____, _____ St.)

File No. 3838Registered No. 16

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

Jesus Anacabe

If death occurred in a hospital, institution or camp give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX

Male

4. COLOR OR RACE

White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED.

Single
(Write the word.)

6. DATE OF BIRTH

Aug 25 1912
(Month) (Day) (Year)

7. AGE

4 yrs. 27 mos. 27 ds.IF LESS than 1 day
how many hrs. or
..... min.?

8. OCCUPATION

(a) Trade, profession, or particular kind of work
(b) General nature of industry, business, or establishment in which employed (or employer)None

9. BIRTHPLACE

(State or Country)

Idaho

10. NAME OF FATHER

Jos. Anacabe

11. BIRTHPLACE OF FATHER

(State or Country)

Spain

12. MAIDEN NAME OF MOTHER

Angelica Luciraca

13. BIRTHPLACE OF MOTHER

(State or Country)

Spain

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

Jos. Anacabe
(Address) Nampa Ida

15.

Filed

1-17-1913 O.B. Beller MD.
Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

Jan. 16th 1913
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from

Jan. 14, 1913, to Jan. 16, 1913.that I last saw him alive on Jan. 16, 1913,and that death occurred on the date stated above, at 8:40 P. M.

The CAUSE OF DEATH* was as follows:

Broncho-pneumonia(Duration) _____ yrs. _____ mos. 2 ds.Contributory
(Secondary)None

(Duration) _____ yrs. _____ mos. _____ ds.

(Signed) H. L. Beller MD. M. D.1/17/1913 (Address) Nampa Ida

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL,

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place _____ In the _____
of death _____ yrs. _____ mos. _____ ds. State _____ yrs. _____ mos. _____ ds.Where was Disease contracted,
If not at place of death? _____Former or
usual residence _____

19. PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

St. John's Church 1/19 1913

20. UNDERTAKER

ADDRESS

F. K. Robinson Nampa Ida

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Form V. S. No. 5. 10M. 6-20-11.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics
File No. **3839**
Registered No. **17**

1. PLACE OF DEATH.

Registration District No. **3**County of **Canyon**Primary Registration District No. **1006**City of **ampa**

(No. _____, _____ St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

John Hickey

If death occurred in a hospital, institution or camp give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX

Male

4. COLOR OR RACE

White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED.

Married
(Write the word.)

6. DATE OF BIRTH

April

(Month)

8

(Day)

1845

(Year)

7. AGE

47

yrs.

9

mos.

11

ds.

IF LESS than 1 day

how many _____ hrs. or _____ min.?

8. OCCUPATION

- (a) Trade, profession or particular kind of work
(b) General nature of industry business or establishment in which employed (or employer)

Retired

9. BIRTHPLACE

(State or Country)

Parkville N. Mo.

10. NAME OF FATHER

John Hickey

11. BIRTHPLACE OF FATHER

(State or Country)

Ireland

12. MAIDEN NAME OF MOTHER

Ann Duvick

13. BIRTHPLACE OF MOTHER

(State or Country)

Ireland

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

J. P. Hickey

(Address)

ampa, Ida

15.

Filed

1-21-1913**J. B. Beller MD.**

Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

1 - **19** - **1913**
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from

Jan. 12, 1913, to Jan. 14, 1913that I last saw him alive on **Jan. 14, 1913**and that death occurred on the date stated above, at **9:30 P. M.**

The CAUSE OF DEATH* was as follows:

**Septic pericarditis
Primary**(Duration) **0** yrs. **0** mos. **8** ds.

Contributory (Secondary)

None(Duration) **0** yrs. **0** mos. **0** ds.

(Signed)

Geo. D. A. Kellogg, M. D.**1/20/1913** (Address) **ampa, Ida**

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death _____ yrs. _____ mos. _____ ds. State _____ yrs. _____ mos. _____ ds.

Where was disease contracted.

If not at place of death? _____

Former or

usual residence _____

19. PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

Kohler Lawnampa, Ida**1-21-1913**

20. UNDERTAKER

ADDRESS

J. B. Shellabarger**ampa, Ida**

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Form V. S. No. 5. 10M. 6-20-11.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH. Registration District No. 1003
County of Ada Canyon Primary Registration District No. 1006
City of Nampa (No. _____ St.)

File No. 3411Registered No. 18

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

Delia Boltz

If death occurred in a hospital, institution or camp give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX Female 4. COLOR OR RACE White 5. SINGLE, MARRIED, WIDOWED OR DIVORCED. Married

(Write the word)

6. DATE OF BIRTH

Dec 31 1912
(Month) (Day) (Year)

7. AGE

— yrs. — mos. 24 ds. IF LESS than 1 day how many hrs. or min.

8. OCCUPATION

- (a) Trade, profession or particular kind of work
(b) General nature of industry business or establishment in which employed (or employer)

9. BIRTHPLACE

(State or Country)

Ada County

10. NAME OF FATHER

Henry J Boltz

11. BIRTHPLACE OF FATHER

(State or Country)

Wisconsin

12. MAIDEN NAME OF MOTHER

Elizabeth Eckel

13. BIRTHPLACE OF MOTHER

(State or Country)

Wisconsin

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

Henry J Boltz
Nampa Idaho

(Address)

15.

Filed

1-24-1913 O.B. Belles M.D.

Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

Jan 24 1913
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from Dec 31 1912 to Jan 24 1913

that I last saw her alive on Jan 10 1912, and that death occurred on the date stated above, at _____ M.

The CAUSE OF DEATH* was as follows:

a case of Spina Bifida with large tumor on back
Death from Cerebral Convulsions

(Duration) — yrs. 24 mos. — ds.

Contributory (Secondary)

Congenital Malformation(Duration) — yrs. 24 mos. — ds.

(Signed)

S. D. Calver M. D.
1-25-1913 (Address) Nampa, Ida.

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and 2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death _____ yrs. _____ mos. _____ ds. State _____ yrs. _____ mos. _____ ds.

Where was disease contracted,

If not at place of death?

Former or

usual residence

19. PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

Catholic Bur Nampa Ida 1-26-1913

20. UNDERTAKER

ADDRESS

S. B. Shellebarger Nampa Ida

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Form V. S. No. 5. 10M. 6-20-11.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics
File No. 3841

1. PLACE OF DEATH.

Registration District No. 1003

County of Canyon

Primary Registration District No. 1006

City ofampa, Id. (No. _____ St.)

Registered No. 19

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Florence Hamilton

If death occurred in a hospital, institution or camp give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX

Female

4. COLOR OR RACE

White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED.

Married
(Write the word.)

6. DATE OF BIRTH

Sept 1 1882
(Month) (Day) (Year)

7. AGE

37 yrs. 3 mos. 28 ds.

IF LESS than 1 day
how many hrs. or min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work

(b) General nature of industry business or establishment in which employed (or employer)

Housekeeping

9. BIRTHPLACE

(State or Country)

Iowa

10. NAME OF FATHER

Louis Parratt

11. BIRTHPLACE OF FATHER

(State or Country)

France

12. MAIDEN NAME OF MOTHER

Engel Dugan

13. BIRTHPLACE OF MOTHER

(State or Country)

Iowa

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

(Address)

L. B. Parratt

ampa Idaho

15.

Filed 1-31-1913

O. B. Beller

Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

1 28 1913
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from

Jan 26 1913, to Jan 28 1913

that I last saw her alive on Jan 28 1913

and that death occurred on the date stated above, at 5 P. M.

The CAUSE OF DEATH* was as follows:

Septicemia

(Duration) yrs. 8 mos. ds.

Contributory (Secondary)

(Duration) yrs. mos. ds.

(Signed) O. B. Beller M. D.

Jan 31 1913 (Address)ampa Idaho

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death yrs. mos. ds. State yrs. mos. ds.

Where was disease contracted.

If not at place of death?

Former or

usual residence.

19. PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

Kohler Lawn aampa Id.

2-1-1913

20. UNDERTAKER

ADDRESS

B. Shellabarger

ampa Id.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics
File No. 3866
Registered No. 1

1. PLACE OF DEATH
County of Bingham
City of Blackfoot
Registration District No. 13
Primary Registration District No. 1007
(No. 550, East Idaho St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

John Alley Quillin

If death occurred in a hospital, institution or camp give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX Male 4. COLOR OR RACE White 5. SINGLE, MARRIED, WIDOWED OR DIVORCED. Married
(Write the word.)

6. DATE OF BIRTH April 1st 1868
(Month) (Day) (Year)

7. AGE 49 yrs. 9 mos. 0 ds. IF LESS than 1 day how many hrs. or min?

8. OCCUPATION

(a) Trade, profession or particular kind of work.
(b) General nature of industry business or establishment in which employed (or employer)

Contractor & Carpenter

9. BIRTHPLACE

(State or Country)

Va

10. NAME OF FATHER

John Quillin

11. BIRTHPLACE OF FATHER

(State or Country)

Va

12. MAIDEN NAME OF MOTHER

Malinda Addington

13. BIRTHPLACE OF MOTHER

(State or Country)

Va

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

Jacob J. Quillin
(Address) Blackfoot Idaho

15.

Filed Jan 2 1913 W. E. Patric
Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH

Jan 1st 1913
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from Sept 4th 1912 to Jan 1st 1913

that I last saw him alive on Jan 1st 1913 and that death occurred on the date stated above, at 1 P.M.

The CAUSE OF DEATH* was as follows:

Hemorrhage of lungs

(Duration) yrs. mos. 3 ds.
Contributory (Secondary) Pulmonary Tuberculosis

(Duration) yrs. mos. 5 ds.
(Signed) W. E. Patric M. D.
Jan 2 1913 (Address) Blackfoot Idaho

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place In the
of death yrs. mos. ds. State yrs. mos. ds.
Where was disease contracted,
If not at place of death?
Former or
usual residence.

19. PLACE OF BURIAL OR REMOVAL DATE OF BURIAL

Port City Cem.
Blackfoot Idaho Jan 3 1913
20. UNDERTAKER ADDRESS
E. J. Peck Blackfoot

MAINTAINED FOR BINDING

WRITE PLAINLY, WITH REDDING INK—THIS IS A PERMANENT RECORD. N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Form V. S. No. 5. 12½ M. 7-24-11

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics
File No. 3867
Registered No. 2

1. PLACE OF DEATH. Registration District No. 13
County of Bingham Primary Registration District No. 2053
City of Pocatello (No. St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Clarence M. Sorensen

If death occurred in a hospital, institution or camp give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX M 4. COLOR OR RACE W 5. SINGLE, MARRIED, WIDOWED OR DIVORCED. Single
(Write the word.)

6. DATE OF BIRTH Aug 24 1908
(Month) (Day) (Year)

7. AGE 4 yrs. 5 mos. 8 1/2 ds. IF LESS than 1 day how many hrs. or min?

8. OCCUPATION
(a) Trade, profession or particular kind of work.
(b) General nature of industry business or establishment in which employed (or employer).

9. BIRTHPLACE Idaho
(State or Country)

10. NAME OF FATHER Jens Sorensen

11. BIRTHPLACE OF FATHER Denmark
(State or Country)

12. MAIDEN NAME OF MOTHER Malene Hegland

13. BIRTHPLACE OF MOTHER Norway
(State or Country)

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) J. B. Davis, M.D.
(Address)

15. Jan 2nd 1913 M. E. Pattee
Filed Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH Jan 2 1913
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from Jan 2 1913, to Jan 2 1913, that I last saw him alive on Jan 2 1912 and that death occurred on the date stated above, at 1 P. M.

THE CAUSE OF DEATH* was as follows:
Capillary Bronchitis

(Duration) — yrs. — mos. 2 ds.

Contributory (Secondary)

(Duration) — yrs. — mos. — ds.

(Signed) J. B. Davis M. D.
1-2 1913 (Address) Pocatello, Idaho

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place In the
of death — yrs. — mos. — ds. State — yrs. — mos. — ds.
Where was disease contracted,
If not at place of death?
Former or usual residence.

19. PLACE OF BURIAL OR REMOVAL DATE OF BURIAL
Pocatello, Idaho Jan 4 1913

20. UNDERTAKER ADDRESS
J. B. Sorensen

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Form V. S. No. 5. 12½ M. 7-24-11

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics
File No. 3868
Registered No. 3

1. PLACE OF DEATH. Registration District No. 13
County of Bingham Primary Registration District No. 2053
City of Blackfoot (No. Idaho Insane Asylum St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Lloyd Bledsoe

If death occurred in a hospital, institution or camp give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX male 4. COLOR OR RACE white 5. SINGLE, MARRIED, WIDOWED OR DIVORCED. Single
(Write the word.)

6. DATE OF BIRTH
(Month) (Day) (Year)

7. AGE 29 yrs. mos. ds. IF LESS than 1 day how many hrs. or min?

8. OCCUPATION
(a) Trade, profession or particular kind of work. Machining
(b) General nature of industry business or establishment in which employed (or employer)

9. BIRTHPLACE (State or Country) Idaho

10. NAME OF FATHER

11. BIRTHPLACE OF FATHER (State or Country)

12. MAIDEN NAME OF MOTHER

13. BIRTHPLACE OF MOTHER (State or Country)

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) H. J. Simmons M.D.
(Address) Blackfoot Idaho

15. Filed Jan 9 1913 W. E. Patric Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH Jan 7 1913
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from Nov 12 1912, to Jan 7 1913 that I last saw him alive on Jan 7 1913 and that death occurred on the date stated above, at 10 A.M. The CAUSE OF DEATH* was as follows:

Respiratory & Cardiac failure - Idementia (chronic)

(Duration) yrs. mos. ds. Contributory (Secondary) Idementia Acute Dilatation

(Duration) yrs. mos. ds. (Signed) H. J. Simmons M. D. Jan 7 1913 (Address) Blackfoot Idaho

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place In the of death 2 yrs. 8 mos. ds. State yrs. mos. ds. Where was disease contracted, If not at place of death? Former or usual residence Boise Idaho

19. PLACE OF BURIAL OR REMOVAL DATE OF BURIAL Idaho Insane Asylum Jan 8 1913
20. UNDERTAKER ADDRESS H. J. Simmons, Blackfoot

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Form V. S. No. 5. 10M. 6-20-11.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics
File No. 3869

1. PLACE OF DEATH.
County of Bingham
City of Blackfoot

Registration District No. 13
Primary Registration District No. 2053
(No. Idaho Brown Argonne St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Seth Schanewaldt

Registered No. 44
If death occurred in a hospital, institution or camp give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX Male 4. COLOR OR RACE White 5. SINGLE, MARRIED, WIDOWED OR DIVORCED. Single
(Write the word.)

6. DATE OF BIRTH Mar 14 1872
(Month) (Day) (Year)

7. AGE 48 yrs. — mos. — ds. IF LESS than 1 day how many hrs. or min.?

8. OCCUPATION
(a) Trade, profession, or particular kind of work Laborer
(b) General nature of industry, business, or establishment in which employed (or employer)

9. BIRTHPLACE (State or Country) Idaho

10. NAME OF FATHER Don't know

11. BIRTHPLACE OF FATHER (State or Country) Minnesota

12. MAIDEN NAME OF MOTHER " "

13. BIRTHPLACE OF MOTHER (State or Country) Sweden

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) H. J. Simmons
(Address) Blackfoot Idaho

15. Filed Jan 9 1913 M. E. Pattee
Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH Jan 7 1913
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from Nov 12 1912 to Jan 7 1913, that I last saw him alive on Jan 7 1913, and that death occurred on the date stated above, at 10⁰⁰ A.M.

The CAUSE OF DEATH* was as follows:
Syphilis. paresis

(Duration) yrs. mos. ds.
Contributory (Secondary) Hypertrophy + Dilatation

(Duration) yrs. mos. ds.
(Signed) H. J. Simmons M. D.
Jan 7 1913 (Address) Blackfoot Ida.

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death yrs. 3 mos. ds. State yrs. mos. ds.
Where was Disease contracted, If not at place of death?
Former or usual residence. Malad Idaho

19. PLACE OF BURIAL OR REMOVAL Forest Hill DATE OF BURIAL Jan 10 1913

20. UNDERTAKER E. J. Puck ADDRESS Blackfoot

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Form V. S. No. 5. 10M. 6-20-11.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

File No. 3870

Registered No. 5

If death occurred in a hospital, institution or camp give its NAME instead of street and number.

1. PLACE OF DEATH.

Registration District No. 13

County of Bingham

Primary Registration District No. 2033

City of Thomas ward

(No. , St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

Fanny Mc Bride

PERSONAL AND STATISTICAL PARTICULARS

3. SEX

female

4. COLOR OR RACE

white

5. SINGLE, MARRIED, WIDOWED OR DIVORCED.

(Write the word.)

6. DATE OF BIRTH

Jan 9 1913
(Month) (Day) (Year)

7. AGE

yrs. mos. ds.

IF LESS than 1 day
how many . 2 . hrs. or
min.?

8. OCCUPATION

- (a) Trade, profession, or particular kind of work
(b) General nature of industry, business, or establishment in which employed (or employer)

9. BIRTHPLACE

(State or Country)

Thomas Ward Bingham Co

10. NAME OF FATHER

John Henry McBride

11. BIRTHPLACE OF FATHER

(State or Country)

Utah

12. MAIDEN NAME OF MOTHER

Elizabeth Ann Hall

13. BIRTHPLACE OF MOTHER

(State or Country)

Utah

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

Marion Crawford

(Address)

Blackfoot R.T.D. #2

15.

Filed

Jan 10 1913

M.E. Patrick

Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

Jan 9 1913
(Month) (Day) (Year)

17. I HEREBY CERTIFY That I attended deceased from 1913, to 1913

that I last saw her alive on Jan 9 1913, and that death occurred on the date stated above, at 11:30 P.M.

The CAUSE OF DEATH* was as follows:

Injury.
Premature
(7 mo in utero)

(Duration) yrs. mos. ds.

Contributory
(Secondary)

(Duration) yrs. mos. ds.

(Signed) M.E. Patrick
1-10-1913 (Address) Blackfoot

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place In the
of death. yrs. mos. ds. State. yrs. mos. ds.
Where was Disease contracted,
If not at place of death?
Former or
usual residence.

19. PLACE OF BURIAL OR REMOVAL DATE OF BURIAL

Thomas Riverside Cemetery 11 days 1913

20. UNDERTAKER

ADDRESS

Marion Crawford Blackfoot #2

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Form V. S. No. 5. 12½M. 7-24-11

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH. Registration District No. 13
County of Bingham Primary Registration District No. 2053
City of 2 1/2 E. Blackfoot (No. _____, _____ St.)

File No. 3871
Registered No. 6

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

Norman Everett Hofer

If death occurred in a hospital, institution or camp give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX 4. COLOR OR RACE 5. SINGLE, MARRIED, WIDOWED OR DIVORCED.

Male

White

5

(Write the word.)

6. DATE OF BIRTH

Dec

4

1913

(Month)

(Day)

(Year)

7. AGE

1 yrs. 9 mos. 9 ds.

IF LESS than 1 day
how many hrs. or
min?

8. OCCUPATION

(a) Trade, profession or particular kind of work.
(b) General nature of industry business or establishment in which employed (or employer)

None

9. BIRTHPLACE

(State or Country)

Idaho

10. NAME OF FATHER

August Hofer

11. BIRTHPLACE OF FATHER

(State or Country)

Switzerland

12. MAIDEN NAME OF MOTHER

Louise Burnard

13. BIRTHPLACE OF MOTHER

(State or Country)

Utah

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

August Hofer

(Address)

Blackfoot Route 3

15.

Filed June 14 1913

M. E. Patrice

Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH

Jan

13

1913

(Month)

(Day)

(Year)

17. I HEREBY CERTIFY, That I attended deceased from

Investigation

to

1913

that I last saw him alive on 1913

and that death occurred on the date stated above, at 6:30 M.

The CAUSE OF DEATH* was as follows:

Broncho-pneumonia

(Duration) yrs. mos. 3 ds.

Contributory
(Secondary)

(Duration) yrs. mos. ds.

(Signed)

M. E. Patrice M. D.

June 14 1913 (Address) Blackfoot

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place yrs. mos. ds. In the

of death yrs. mos. ds. State yrs. mos. ds.

Where was disease contracted,
If not at place of death?

Former or
usual residence

19. PLACE OF BURIAL OR REMOVAL DATE OF BURIAL

Pross City Cem. June 15 1913

20. UNDERTAKER ADDRESS

August Hofer Blackfoot

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Form V. S. No. 5. 12½M.7-24-11

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics
File No. 3872
Registered No. 7

1. PLACE OF DEATH. Registration District No. 13
County of Bingham Primary Registration District No. 2029
City of Aberdeen (No. _____, St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Elizabeth Storner

If death occurred in a hospital, institution or camp give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX Female 4. COLOR OR RACE White 5. SINGLE, MARRIED, WIDOWED OR DIVORCED. Single
(Write the word.)

6. DATE OF BIRTH June 23 1910
(Month) (Day) (Year)

7. AGE 2 yrs. 6 mos. 2 ds. IF LESS than 1 day
how many _____ hrs. or _____ min?

8. OCCUPATION

(a) Trade, profession or particular kind of work. _____
(b) General nature of industry business or establishment in which employed (or employer) _____

9. BIRTHPLACE

(State or Country) Idaho

10. NAME OF FATHER

George J. Storner

11. BIRTHPLACE OF FATHER

(State or Country) Germany

12. MAIDEN NAME OF MOTHER

Marie Horsch

13. BIRTHPLACE OF MOTHER

(State or Country) Germany

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Geo. J. Storner

(Address) Aberdeen Idaho

15.

Filed Jan 15 1913 M. C. Martin
Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH

Jan 13 1913
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from Dec 15 1912, to Jan 13 1913
that I last saw her alive on Jan 13 1913
and that death occurred on the date stated above, at 2:40 P.M.
The CAUSE OF DEATH* was as follows:
Adenoids

(Duration) _____ yrs. 2 mos. _____ ds.
Contributory Inanition - due to increasing
(Secondary) size of adenoids
(Duration) _____ yrs. _____ mos. _____ ds.
(Signed) M. C. Martin M. D.
Jan 15 1913 (Address) Aberdeen, Ida.

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place _____ In the _____
of death _____ yrs. _____ mos. _____ ds. State _____ yrs. _____ mos. _____ ds.
Where was disease contracted, _____
If not at place of death? _____
Former or _____
usual residence _____

19. PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

Memorial Cemetery Jan 16 1913
Aberdeen

20. UNDERTAKER

ADDRESS

Will. Bartel Aberdeen, Ida.

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Form V. S. No. 5. 12½ M. 7-24-11

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics
File No. 3873
Registered No. 8

1. PLACE OF DEATH.
County of Bingham
City of Blackfoot
Registration District No. 13
Primary Registration District No. 1007
(No. Journie Addition St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Julia E. Weiland

If death occurred in a hospital, institution or camp give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX Female 4. COLOR OR RACE white 5. SINGLE, MARRIED, WIDOWED OR DIVORCED. married
(Write the word.)

6. DATE OF BIRTH Jan 20 1913
(Month) (Day) (Year)

7. AGE 17 yrs. 10 mos. 26 ds.
IF LESS than 1 day how many... hrs. or min?

8. OCCUPATION
(a) Trade, profession or particular kind of work. Housewife
(b) General nature of industry business or establishment in which employed (or employer)

9. BIRTHPLACE (State or Country) Idaho

10. NAME OF FATHER W. D. Brugler

11. BIRTHPLACE OF FATHER (State or Country) Mo.

12. MAIDEN NAME OF MOTHER Lydie J. Hoffman

13. BIRTHPLACE OF MOTHER (State or Country) Mo.

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) William C. Weiland
(Address) Blackfoot Idaho

15. Filed Jan 23 1913 W. E. Patie
Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH Jan 20 1913
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from Jan 18 1913, to Jan 20 1913 that I last saw her alive on Jan 20 1913 and that death occurred on the date stated above, at 2 P. M.
The CAUSE OF DEATH* was as follows:
Pneumonia

(Duration) ~ yrs. mos. 3 ds.
Contributory (Secondary)

(Duration) yrs. mos. 2 ds.
(Signed) F. W. Mitchell M. D.
Jan 20 1913 (Address) Blackfoot Idaho

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death... yrs... mos... ds. In the State... yrs... mos... ds.
Where was disease contracted, If not at place of death?
Former or usual residence.

19. PLACE OF BURIAL OR REMOVAL DATE OF BURIAL
Brown City Cemetery Blackfoot 1/24 1913

20. UNDERTAKER ADDRESS
S. H. Dietrich Blackfoot

Given birth to child Jan 3-1913.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Form V. S. No. 5 20M.1-16-12

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH.

Registration District No. 13County of BinghamPrimary Registration District No. 1007City of Blackfoot(No. 16 So. Fisher St.)File No. 381Registered No. 9

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

Margaret Anderson

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX

Female

4. COLOR OR RACE

White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED.

Single
(Write the word.)

6. DATE OF BIRTH

Nov 10 1911
(Month) (Day) (Year)

7. AGE

1 yrs. 2 mos. 12 ds.

IF LESS than 1 day
how many hrs. or
..... mins.?

8. OCCUPATION

(a) Trade, profession or particular kind of work
(b) General nature of industry, business, or establishment in which employed (or employer)

None

9. BIRTHPLACE

(State or Country)

Blackfoot Idaho

10. NAME OF FATHER

James Henry Anderson

11. BIRTHPLACE OF FATHER

(State or Country)

Utah

12. MAIDEN NAME OF MOTHER

Verna Cull

13. BIRTHPLACE OF MOTHER

(State or Country)

Utah

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

(Address)

Blackfoot Idaho

15.

Filed

Jan 23 1913M.E. Patric

Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH

Jan 22nd 1913
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from

Jan 14 1913, to Jan 22 1913,

that I last saw her alive on Jan 22 1913

and that death occurred on the date stated above, at 7:30 P.

The CAUSE OF DEATH* was as follows:

Broncho-Pneumonia
followed by
scarlet fever

(Duration) yrs. mos. 9 ds.

Contributory (Secondary)

Scarlet fever(Duration) yrs. mos. 2 ds.

(Signed)

M.E. Patric M. D.1-23-1913(Address) Blackfoot

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death yrs. mos. days. In the State yrs. mos. days.

Where was disease contracted if not at place of death?

Former or usual residence.....

19. PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

Blackfoot IdaJan 23 1913

20. UNDERTAKER

ADDRESS

M.E. PatricBlackfoot

1. PLACE OF DEATH.		Registration District No. <u>13</u>		BOARD OF HEALTH Bureau of Vital Statistics	
County of <u>Bingham</u>		Primary Registration District No. <u>1007</u>		File No. <u>3875</u>	
City of <u>Blackfoot</u>		(No. <u>915 Shelling Avenue St.</u>)		Registered No. <u>10</u>	
If death occurs away from usual residence, give facts called for under special information.					
2. FULL NAME <u>Donald N. Davis</u>					
PERSONAL AND STATISTICAL PARTICULARS					
3. SEX <u>Male</u>		4. COLOR OR RACE <u>white</u>		5. SINGLE, MARRIED, WIDOWED OR DIVORCED. <u>single</u> (Write the word.)	
6. DATE OF BIRTH <u>March 6 1895</u> (Month) (Day) (Year)					
7. AGE <u>17 yrs. 10 mos. 21 ds.</u>		IF LESS than 1 day how many.....hrs. or.....min?			
8. OCCUPATION (a) Trade, profession or particular kind of work <u>Student</u> (b) General nature of industry business or establishment in which employed (or employer)					
9. BIRTHPLACE (State or Country) <u>Arizona</u>					
10. NAME OF FATHER <u>Nolan Davis</u>					
11. BIRTHPLACE OF FATHER (State or Country) <u>Montpelier Idaho</u>					
12. MAIDEN NAME OF MOTHER <u>Signe Arora Jacobson</u>					
13. BIRTHPLACE OF MOTHER (State or Country) <u>Heber Utah</u>					
14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE (Informant) <u>Nolan Davis</u> (Address) <u>Blackfoot Id.</u>					
15. <u>Jan 28 1913</u> <u>W. E. Patric</u> Filed Local Registrar					
MEDICAL CERTIFICATE OF DEATH.					
16. DATE OF DEATH <u>Jan 27 1913</u> (Month) (Day) (Year)					
17. I HEREBY CERTIFY, That I attended deceased from <u>Jan 10 1913</u> , to <u>Jan 24 1913</u> , that I last saw him alive on <u>Jan 24 1913</u> and that death occurred on the date stated above, at.....M. The CAUSE OF DEATH* was as follows: <u>Tuberculosis lungs</u> <u>and Brights Diseases</u>					
(Duration) <u>one</u> yrs. — mos. — ds.					
Contributory (Secondary)					
(Duration) yrs. mos. ds.					
(Signed) <u>John B. Cupper</u> M. D. <u>1-28-13</u> (Address) <u>Blackfoot</u>					
*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.					
18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.) At place yrs. mos. ds. In the yrs. mos. ds. of death yrs. mos. ds. State yrs. mos. ds. Where was disease contracted, If not at place of death? Former or usual residence.					
19. PLACE OF BURIAL OR REMOVAL DATE OF BURIAL <u>Grave City Cem. Blackfoot</u> <u>Jan 28 1913</u>					
20. UNDERTAKER ADDRESS <u>E. J. Beck</u> <u>Blackfoot</u>					

1. PLACE OF DEATH.
County of Bingham
City of Blackfoot

Registration District No. 13
Primary Registration District No. 2053
(No. Idaho Bureau of Vital Statistics)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

John T. Payne

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics
File No. 3876
Registered No. 11

If death occurred in a hospital, institution or camp give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX 4. COLOR OR RACE 5. SINGLE, MARRIED, WIDOWED OR DIVORCED.

Male

White

(Write the word.) ?

6. DATE OF BIRTH

1876
(Month) (Day) (Year)

7. AGE

36 yrs. ? mos. ? ds.

IF LESS than 1 day
how many.....hrs. or
.....min?

8. OCCUPATION

(a) Trade, profession or particular kind of work
(b) General nature of industry business or establishment in which employed (or employer)

Farmer

9. BIRTHPLACE

(State or Country)

Idaho

10. NAME OF FATHER

?

11. BIRTHPLACE OF FATHER

(State or Country)

?

12. MAIDEN NAME OF MOTHER

?

13. BIRTHPLACE OF MOTHER

(State or Country)

?

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

(Address)

Francis H. Poole
Blackfoot, Idaho

15.

Filed

Feb 3 1913

M. E. Patric
Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH

January 31 1913
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from

Nov 15 1911, to Jan 31 1913

that I last saw him alive on Jan 31 1913

and that death occurred on the date stated above, at 11:30 A. M.

The CAUSE OF DEATH* was as follows:

Exhaustion due to tubercular infection of bones & joints

(Duration) 3 yrs. ? mos. ? ds.

Contributory (Secondary)

(Duration) ? yrs. ? mos. ? ds.

(Signed) Francis H. Poole M. D.

Feb 2 1913 (Address) Blackfoot, Idaho

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place 13 4 In the
of death..... yrs. mos. ds. State..... yrs. mos. ds.

Where was disease contracted,

If not at place of death?

Former or

usual residence.

Middleton Idaho

19. PLACE OF BURIAL OR REMOVAL DATE OF BURIAL

Middleton Idaho 1913

20. UNDERTAKER

ADDRESS

E. J. Peck

Blackfoot

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
N. B.—Every item of information should be carefully supplied. AGE should be state EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Form V. S. No. 5. 10M. 6-20-11.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics
File No. 3847

1. PLACE OF DEATH.

Registration District No. 29

County of Lincoln

Primary Registration District No. 2015

City of Rupert

(No. , St.)

Registered No. 4

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

Cléo Johnson

If death occurred in a hospital, institution or camp give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX

Male

4. COLOR OR RACE 5. SINGLE, MARRIED, WIDOWED OR DIVORCED.

White

(Write the word.)

6. DATE OF BIRTH

11 (Month) 4 (Day) 1913 (Year)

7. AGE

2 yrs. 2 mos. 20 ds.

IF LESS than 1 day
how many.....hrs.or
min.?

8. OCCUPATION

- (a) Trade, profession or particular kind of work
(b) General nature of industry business or establishment in which employed (or employer)

9. BIRTHPLACE

(State or Country)

Rupert-Ida

10. NAME OF FATHER

Herman A Johnson

11. BIRTHPLACE OF FATHER

(State or Country)

Ida.

12. MAIDEN NAME OF MOTHER

Mac Martindale

13. BIRTHPLACE OF MOTHER

(State or Country)

Ida

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

Catmull

(Address)

Rupert-Ida

15.

Filed Feb. 16 1913

J. P. Killen

Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

1 (Month) 24 (Day) 1913 (Year)

17. I HEREBY CERTIFY, That I attended deceased from

Jan. 11, 1913, to Jan. 24 1913

that I last saw him alive on Jan. 24, 1913,

and that death occurred on the date stated above, at 9 A. M.

The CAUSE OF DEATH* was as follows:

Scarlet Fever

(Duration) yrs. mos. 13 ds.

Contributory (Secondary) Nephritis

(Duration) yrs. mos. 2 ds.

(Signed) J. B. Kenney M. D.

Jan. 24 1913 (Address) Rupert.

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death.....yrs.....mos.....ds. State.....yrs.....mos.....ds.
Where was disease contracted,
If not at place of death?
Former or usual residence.

19. PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

Rupert.

Jan. 24 1913

20. UNDERTAKER

ADDRESS

W. A. Goodman

Rupert.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Form V. S. No. 5. 10M. 6-20-11.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics
File No. 3878
Registered No. B

1. PLACE OF DEATH.

Registration District No. 29

County of Lincoln

Primary Registration District No. 2015

City of Rupert

(No. , St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

Hannah Rood

If death occurred in a hospital, institution or camp give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX

4. COLOR OR RACE 5. SINGLE, MARRIED, WIDOWED OR DIVORCED.

Female White married (Write the word.)

6. DATE OF BIRTH

Sept. 27 1867 (Month) (Day) (Year)

7. AGE

45 yrs. 9 mos. 19 ds.

IF LESS than 1 day
how many hrs. or min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work

(b) General nature of industry business or establishment in which employed (or employer)

Housewife

9. BIRTHPLACE

(State or Country)

Maine

10. NAME OF FATHER

Alfred Davison

11. BIRTHPLACE OF FATHER

(State or Country)

Nova Scotia

12. MAIDEN NAME OF MOTHER

13. BIRTHPLACE OF MOTHER

(State or Country)

N.Y.

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) M. G. Rood

(Address) Rupert

15.

Filed Feb. 10 1913

H. P. Keller

Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

Jan. 16 1913 (Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from

Jan. 1 1913, to Jan. 16 1913

that I last saw her alive on Jan. 16 1913,

and that death occurred on the date stated above, at 9 A. M.

The CAUSE OF DEATH* was as follows:

Pneumonia Lobar

(Duration) yrs. mos. 16 ds.

Contributory (Secondary)

Cardiac dil.

(Duration) yrs. mos. ds.

(Signed)

Jan. 16 1913 (Address) Rupert

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death yrs. mos. ds. State yrs. mos. ds.

Where was disease contracted.

If not at place of death?

Former or usual residence.

19. PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

Rupert

Jan. 18 1913

20. UNDERTAKER

ADDRESS

H. A. Goodman

Rupert

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Form V. S. No. 5 20M.1-16-12

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics
File No. 3879

1. PLACE OF DEATH.

Registration District No. 29

County of Lincoln

Primary Registration District No. 2102

City of Hayden

(No. _____ St.)

Registered No. 1

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Robert Zichalka

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX

4. COLOR OR RACE

5. SINGLE, MARRIED, WIDOWED OR DIVORCED.

Male

White

Married

6. DATE OF BIRTH

Sept 1 1863
(Month) (Day) (Year)

7. AGE

50 yrs. 4 mos. 6 ds.

IF LESS than 1 day
how many _____ hrs. or
_____ mins.?

8. OCCUPATION

(a) Trade, profession or particular kind of work
(b) General nature of industry business, or establishment in which employed (or employer)

Barker

9. BIRTHPLACE

(State or Country)

Ritisti Romania

10. NAME OF FATHER

Wilhelm Zichalka

11. BIRTHPLACE OF FATHER

(State or Country)

Saxony Germany

12. MAIDEN NAME OF MOTHER

X

13. BIRTHPLACE OF MOTHER

(State or Country)

X

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

Geo. Slater

(Address)

Hayden

15.

Filed

Feb 10 1913

V. P. Miller

Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH

Jan 6 1913
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from

Dec 22 1912 to Jan 5 1913

that I last saw him alive on Jan 5 1913

and that death occurred on the date stated above, at 8 P. M.

The CAUSE OF DEATH* was as follows:

Cardiac Asthma and
Arteriosclerotic

(Duration) 3 yrs. _____ mos. _____ ds.

Contributory

(Secondary)

(Duration) _____ yrs. _____ mos. _____ ds.

(Signed)

V. P. Miller M. D.
Jan 15 1913 (Address) Hayden

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death _____ yrs. _____ mos. _____ days. In the State _____ yrs. _____ mos. _____ days.

Where was disease contracted if not at place of death?

Former or usual residence.

19. PLACE OF BURIAL OR REMOVAL DATE OF BURIAL

Rupert Cemetery Jan 8 1913

20. UNDERTAKER

ADDRESS

W. A. Goodman Rupert

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Form V. S. No. 5 20M.1-16-12

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics
File No. 3880

1. PLACE OF DEATH

Registration District No. 29County of LincolnPrimary Registration District No. 2015City of Rupert

(No. _____, _____ St.)

Registered No. 2

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

Unnamed

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX

4. COLOR OR RACE

5. SINGLE, MARRIED, WIDOWED OR DIVORCED.

GirlWhiteInfant
(Write the word.)

6. DATE OF BIRTH

Jan
(Month)7
(Day)1913
(Year)

7. AGE

3 yrs. 0 mos. 0 ds.IF LESS than 1 day
how many _____ hrs. or
_____ mins.

8. OCCUPATION

- (a) Trade, profession or particular kind of work
(b) General nature of industry, business, or establishment in which employed (or employer)

9. BIRTHPLACE

(State or Country)

Rupert

10. NAME OF FATHER

L. H. Baxter

11. BIRTHPLACE OF FATHER

(State or Country)

Not known

12. MAIDEN NAME OF MOTHER

13. BIRTHPLACE OF MOTHER

(State or Country)

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

H. B. Woffenden

(Address)

Rupert

15.

Filed

Feb. 10 1913J. P. Killam

Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH

Jan
(Month)10
(Day)1913
(Year)

17. I HEREBY CERTIFY, That I attended deceased from

1913, to1913,that I last saw h. _____ alive on _____ 1913,

and that death occurred on the date stated above, at _____ M.

The CAUSE OF DEATH* was as follows:

Did not attend deceased after birth

(Duration) _____ yrs. _____ mos. _____ ds.

Contributory

(Secondary)

(Duration) _____ yrs. _____ mos. _____ ds.

(Signed)

J. P. Killam M. D.
Jan 16 1913 (Address) Rupert, Idaho

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place

of death _____ yrs. _____ mos. _____ days.

In the

State _____ yrs. _____ mos. _____ days.

Where was disease contracted if not at place of death?

Former or usual residence.

19. PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

Rupert CemeteryJan 12 1913

20. UNDERTAKER

ADDRESS

W. C. GormanRupert

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Form V. S. N. M. 1-16-12

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH.

Registration District No. 22

County of Blaine

Primary Registration District No. 2008

City of Payette

(No. , St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

Margaret S Dougherty

File No. 3882

Registered No. 635

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX

Female

4. COLOR OR RACE

White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED.

Married
(Write the word.)

6. DATE OF BIRTH

May 2 1832
(Month) (Day) (Year)

7. AGE

80 yrs. 11 mos. 25 ds.

IF LESS than 1 day
how many hrs. or
mins.?

8. OCCUPATION

(a) Trade, profession or particular kind of work

House wife

(b) General nature of industry business, or establishment in which employed (or employer)

9. BIRTHPLACE

(State or Country)

New Brunswick

10. NAME OF FATHER

John Dyer

11. BIRTHPLACE OF FATHER

(State or Country)

United States
Maine

12. MAIDEN NAME OF MOTHER

Jane Mitchell

13. BIRTHPLACE OF MOTHER

(State or Country)

New Brunswick

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Mrs. E. A. Anson

(Address) Payette Ida.

15.

Filed Jan 27 1913

Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH

Jan 27 1913
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from

Jan 14 1913, to Jan 27 1913,

that I last saw her alive on Jan 27 1913,

and that death occurred on the date stated above, at 8:45 A.M.

The CAUSE OF DEATH* was as follows:

Simultaneous

(Duration) 2 weeks yrs. mos. ds.

Contributory
(Secondary)

(Duration) yrs. mos. ds.

(Signed)

J. H. Barton M. D.

(Address) Payette Ida.

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death yrs. mos. days. In the State yrs. mos. days.

Where was disease contracted if not at place of death?

Former or usual residence.

19. PLACE OF BURIAL OR REMOVAL DATE OF BURIAL

Payette Ida Jan 28 1913

20. UNDERTAKER

ADDRESS

J. H. Adair Payette Ida

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Form V. S. 2 1/2 M. 7-24-11

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics
File No. 3883
Registered No. 64

1. PLACE OF DEATH.
County of Canyon
City of Payette

Registration District No. 2-
Primary Registration District No. 2557
(No. , St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

Frank Emil Dean

If death occurred in a hospital, institution or camp give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX male 4. COLOR OR RACE white 5. SINGLE, MARRIED, WIDOWED OR DIVORCED.
(Write the word.)

6. DATE OF BIRTH Dec 26 1912
(Month) (Day) (Year)

7. AGE yrs. 18 mos. ds. IF LESS than 1 day how many hrs. or min?

8. OCCUPATION
(a) Trade, profession or particular kind of work Infant
(b) General nature of industry business or establishment in which employed (or employer)

9. BIRTHPLACE
(State or Country) Payette Canyon Idaho

10. NAME OF FATHER Emil Dean

11. BIRTHPLACE OF FATHER
(State or Country) Iowa

12. MAIDEN NAME OF MOTHER Mathie Pedersen

13. BIRTHPLACE OF MOTHER
(State or Country) Weber

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) J. E. Croucher
(Address) Payette Idaho

15. Filed Jan 14 1913

Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH Jan 14 1913
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from 191 to 191 that I last saw him alive on 191 and that death occurred on the date stated above, at 5 A-M.

The CAUSE OF DEATH* was as follows:

Asphyxia - Death accidental no physician in attendance before death
(Duration) yrs. mos. ds.

Contributory (Secondary)
(Duration) yrs. mos. ds.
(Signed) J. E. Croucher M. D.
1-14-1913 (Address) Payette Idaho

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place In the of death yrs. mos. ds. State yrs. mos. ds.
Where was disease contracted,
If not at place of death?
Former or usual residence.

19. PLACE OF BURIAL OR REMOVAL DATE OF BURIAL
Payette Idaho Jan 15 1913

20. UNDERTAKER ADDRESS
Payette Idaho

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Form V. S. No. 5 20M.1-16-12

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH.

Registration District No. 22

County of Canyon

Primary Registration District No. 2005

City of Payette (No.) St.)

File No. 3884

Registered No. 63

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

Carl Oscar Johnson

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX

Male

4. COLOR OR RACE

White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED.

Single (Write the word.)

6. DATE OF BIRTH

Jan 3 1894
(Month) (Day) (Year)

7. AGE

19 yrs. — mos. 3 ds.

IF LESS than 1 day
how many hrs. or
..... mins.?

8. OCCUPATION

(a) Trade, profession or particular kind of work

Farmer

(b) General nature of industry business, or establishment in which employed (or employer)

9. BIRTHPLACE

(State or Country)

Idaho

10. NAME OF FATHER

Axel Johnson

11. BIRTHPLACE OF FATHER

(State or Country)

Sweden

12. MAIDEN NAME OF MOTHER

Mary A Bjorkman

13. BIRTHPLACE OF MOTHER

(State or Country)

Sweden

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

Axel Johnson

(Address)

Payette

15.

Filed

Jan 6 1913 J. B. Woodward
Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH

Jan 6 1913
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from

Jan 2nd 1913, to Jan 5th 1913
that I last saw him alive on Jan 5th 1913

and that death occurred on the date stated above, at 3 A.M.

The CAUSE OF DEATH* was as follows:

Pneumonic phthisis

(Duration) yrs 1 mos 21 ds,

Contributory ~~phthisis~~ pneumonia
(Secondary)

(Duration) yrs 1 mos 15 ds.

(Signed) Thomas A. Druff, M. D.

1913 (Address) Payette, Ida

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death yrs mos days. In the State yrs mos days.

Where was disease contracted if not at place of death?

Former or usual residence.

19. PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

Payette, Ida Jan 7 1913

20. UNDERTAKER

ADDRESS

W. H. Davis Payette, Ida

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Form V. S. No. 5. 10M. 6-20-11.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics
File No. 3886

1. PLACE OF DEATH.

Registration District No. 21

County of Blaine

Primary Registration District No. 2022

City of Hailey

(No. _____)

St. _____

Registered No. 2

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

Loak Mae Giffin Thompson
If death occurred in a hospital, institution or camp give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX

4. COLOR OR RACE 5. SINGLE, MARRIED, WID-
OWED OR DIVORCED

Female White married
(Write the word.)

6. DATE OF BIRTH

(Month) (Day) (Year)

7. AGE

32 yrs. 10 mos. 15 ds.

IF LESS than 1 day
how many hrs. or
..... min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work
(b) General nature of industry business or establishment in which employed (or employer)

Housewife

9. BIRTHPLACE
(State or Country)

Greenfield Ohio

10. NAME OF FATHER

J. W. Giffin

11. BIRTHPLACE OF FATHER
(State or Country)

12. MAIDEN NAME OF MOTHER

13. BIRTHPLACE OF MOTHER
(State or Country)

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

W. W. Thompson
Hailey Ida

(Address)

15.

Filed

Jan. 10 1913 R. H. Wright
Local Registrar
Per S. J.

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

Jan 8 1913
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from

Jan 8 1913, to Jan 8 1913

that I last saw him alive on Jan 8 1913

and that death occurred on the date stated above, at 5:30 P. M.

The CAUSE OF DEATH* was as follows:

Shock from Child Birth

(Duration) yrs. mos. ds.

Contributory
(Secondary)

(Duration) yrs. mos. ds.

(Signed) Robert H. Wright M. D.

Jan 10 1913 (Address) Hailey, Ida

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted,

If not at place of death?

Former or

usual residence.

19. PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

Hailey Ida Jan 10 1913

20. UNDERTAKER

ADDRESS

R. D. Harris Hailey Ida

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Form V. S. No. 5. 12½ M. 7-24-11

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics
File No. 3887
Registered No. 38

1. PLACE OF DEATH. Registration District No. 14
County of Custer Primary Registration District No. 2061
City of Challis (No. , St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

John Stas

If death occurred in a hospital, institution or camp give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX male 4. COLOR OR RACE white 5. SINGLE, MARRIED, WIDOWED OR DIVORCED. single
(Write the word.)

6. DATE OF BIRTH Don't know 1931
(Month) (Day) (Year)

7. AGE 87 yrs. mos. ds. IF LESS than 1 day how many hrs. or min?

8. OCCUPATION

(a) Trade, profession or particular kind of work. Rancher
(b) General nature of industry business or establishment in which employed (or employer)

9. BIRTHPLACE Germany
(State or Country)

10. NAME OF FATHER Don't know

11. BIRTHPLACE OF FATHER Germany
(State or Country)

12. MAIDEN NAME OF MOTHER Don't know

13. BIRTHPLACE OF MOTHER Germany
(State or Country)

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Jas Ebberts
(Address) Challis

15. Filed 1/24 1913 Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH Jan 22 1913
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from Jan 18 1913, to Jan 22 1913 that I last saw him alive on Jan 22 1913 and that death occurred on the date stated above, at 6 p. M.

The CAUSE OF DEATH* was as follows:
Myocarditis & valvular heart disease
Chronic nephritis
(Duration) yrs. mos. 30 ds.

Contributory Edema
(Secondary) (Duration) yrs. mos. 30 ds.
(Signed) W. Kelley M. D.
Jan 23 1913 (Address) Challis

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place In the
of death. yrs. mos. ds. State. yrs. mos. ds.
Where was disease contracted,
If not at place of death?
Former or
usual residence.

19. PLACE OF BURIAL OR REMOVAL DATE OF BURIAL
Challis, Ida 1/24 1913
20. UNDERTAKER ADDRESS
J. S. Ebberts.

MARGIN RESERVE

WRITE

N. B.—Every item of information should be carefully checked so that it may be properly classified. Exact state-
ments on back of certificate.

Form V. S. No. 5. 10M. 6-20-11.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics
File No. 3888
Registered No. 37
If death occurred in a hospital, institution or camp give its name instead of street and number.

1. PLACE OF DEATH.

Registration District

County of Butte

Primary Registrar

City of Mackay

(No.

St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

Barbara De Witt

PERSONAL AND STATISTICAL PARTICULARS

MEDICAL CERTIFICATE OF DEATH

3. SEX

4. COLOR OR RACE

5. SINGLE, MARRIED, WIDOWED OR DIVORCED

6. DATE OF DEATH

male white

single
(Write the word.)

6. DATE OF BIRTH

Jan 2 1913
(Month) (Day) (Year)

7. AGE

IF LESS than 1 day
how many hrs. or
..... min.)

6 yrs. 6 mos. 6 ds.

8. OCCUPATION

(a) Trade, profession or particular kind of work
(b) Nature of industry or establishment in which employed (or employer)

9. PLACE OF BIRTH

(State or Country)

Mackay Ida

10. NAME OF FATHER

Carl De Witt

11. BIRTHPLACE OF FATHER

(State or Country)

St Anthony Ida

12. MAIDEN NAME OF MOTHER

Barbara Ritsen

13. PLACE OF BIRTH OF MOTHER

(State or Country)

Afton Nyo.

14. ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

(Address)

15.

Filed 2/1 1913

Local

16. I HEREBY CERTIFY, That I attended deceased

that I last saw him alive on Jan 7,
and that death occurred on the date stated above, at 10

The CAUSE OF DEATH* was as follows:

Inanition

(Duration)

Contributory (Secondary)

(Duration)

(Signed)

1/8 1913 (Address) Mackay

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, MEANS OF INJURY; and 2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions or Recent Residents)

At place of death yrs. mos. d.
Where was disease contracted,
If not at place of death?
Former or usual residence.....

19. PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

Grace De Witt Jan 3 1913

20. UNDERTAKER

ADDRESS

Edna De Witt Mackay

WRITE PLAINLY, WITH UNFADEING INK—THIS IS A PERMANENT RECORD.
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Form V. S. No. 5. 12½ M. 7-24-11

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics
File No. 3884
Registered No. 8-7

1. PLACE OF DEATH.
County of Latah
City of Proy

Registration District No. 2065 15
Primary Registration District No. 45 2065
(No. _____, St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

Ruth Karolina Pearson

If death occurred in a hospital, institution or camp give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX Female 4. COLOR OR RACE White 5. SINGLE, MARRIED, WIDOWED OR DIVORCED. Single
(Write the word.)

6. DATE OF BIRTH Jan 9 1912
(Month) (Day) (Year)

7. AGE 11 mos. 26 ds. IF LESS than 1 day
how many _____ hrs. or _____ min?

8. OCCUPATION

(a) Trade, profession or particular kind of work. none
(b) General nature of industry business or establishment in which employed (or employer)

9. BIRTHPLACE Moulenceno Wash.
(State or Country)

10. NAME OF FATHER John Pearson

11. BIRTHPLACE OF FATHER Rhode Island
(State or Country)

12. MAIDEN NAME OF MOTHER Hilda Allen

13. BIRTHPLACE OF MOTHER Sweden
(State or Country)

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) John Pearson
(Address) Proy Idaho

15. Filed Jan 6 1913 J. W. Olson
Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH Jan 4 1913
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from Dec 30 1912 to Jan 4 1913
that I last saw him alive on Dec 30 1912
and that death occurred on the date stated above, at 2 9 M.

The CAUSE OF DEATH* was as follows:

Obstructive Jaundice
(Cataract)

(Duration) _____ yrs. _____ mos. 14 ds.
Contributory Purpura Haemorrhagica
(Secondary)

(Duration) _____ yrs. _____ mos. _____ ds.
(Signed) J. W. Olson M. D.
Jan 6 1913 (Address) Proy Idaho

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place _____ In the _____
of death _____ yrs. _____ mos. _____ ds. State _____ yrs. _____ mos. _____ ds.
Where was disease contracted,
If not at place of death? _____
Former or
usual residence. _____

19. PLACE OF BURIAL OR REMOVAL DATE OF BURIAL

Buried Ridge Cemetery Jan 6 1913

20. UNDERTAKER

ADDRESS

Pearson

Proy Idaho

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Form V. S. No. 5 20M.1-16-12

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics
3891

1. PLACE OF DEATH
County of Latah
City of Moscow
Registration District No. 15
Primary Registration District No. 1008
(No. _____ St.)
If death occurs away from usual residence, give facts called for under special information.

File No. _____
Registered No. 3
If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Joe A. Lauerer

PERSONAL AND STATISTICAL PARTICULARS

3. SEX male 4. COLOR OR RACE white 5. SINGLE, MARRIED, WIDOWED OR DIVORCED. single
(Write the word.)

6. DATE OF BIRTH March 9 1855
(Month) (Day) (Year)

7. AGE 56 yrs. 9 mos. 25 ds.
IF LESS than 1 day how many _____ hrs. or _____ mins.

8. OCCUPATION
(a) Trade, profession or particular kind of work Carpenter
(b) General nature of industry, business, or establishment in which employed (or employer) _____

9. BIRTHPLACE
(State or Country) Prague, Bohemia

10. NAME OF FATHER Anton Lauerer

11. BIRTHPLACE OF FATHER
(State or Country) Bohemia

12. MAIDEN NAME OF MOTHER Don't know

13. BIRTHPLACE OF MOTHER
(State or Country) Bohemia

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Mrs. Mary Hoke
(Address) Moscow, Ida

15. Filed Jan. 11 1913 J. M. Lusk
(Signature) Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH Jan 5th 1913
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from Jan 2 1913, to Jan 5 1913, that I last saw him alive on Jan 2nd 1913, and that death occurred on the date stated above, at 5:30 A.M.

The CAUSE OF DEATH* was as follows:
History would indicate
diabetes
not known
(Duration) _____ yrs. _____ mos. _____ ds.
Contributory (Secondary) _____
(Duration) _____ yrs. _____ mos. _____ ds.
(Signed) C. W. L. Williams M. D.
Jan 6, 1913 (Address) Moscow Idaho

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death _____ yrs. _____ mos. _____ days. In the State _____ yrs. _____ mos. _____ days.

Where was disease contracted if not at place of death?
Former or usual residence _____

19. PLACE OF BURIAL OR REMOVAL Moscow, Idaho DATE OF BURIAL Jan 7 1913

20. UNDERTAKER Geo. M. H. H. ADDRESS Moscow, Idaho

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Form V. S. No. 5 20M.1-16-12

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics
File No. 3892
Registered No. 2

1. PLACE OF DEATH.

Registration District No. 15

County of Seetch

Primary Registration District No. 1008

City of Moscow

(No. _____, _____ St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Eva Althea Hill

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX

4. COLOR OR RACE

5. SINGLE, MARRIED, WIDOWED OR DIVORCED.

Female White Married (Write the word.)

6. DATE OF BIRTH

June 22 1882
(Month) (Day) (Year)

7. AGE

30 yrs. 7 mos. 5 ds.

IF LESS than 1 day
how many hrs. or
..... mins.?

8. OCCUPATION

(a) Trade, profession or particular kind of work

(b) General nature of industry business, or establishment in which employed (or employer)

House wife

9. BIRTHPLACE

(State or Country)

Whitman Wn

10. NAME OF FATHER

Joseph P Ringo

11. BIRTHPLACE OF FATHER

(State or Country)

Missouri

12. MAIDEN NAME OF MOTHER

Emile Foster

13. BIRTHPLACE OF MOTHER

(State or Country)

Ill

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

Mrs Emma Williams

(Address)

601 Campus ave

15.

Filed Jan 11 1913

Pullman
McDonnell
(Seal) Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH

Jan 9 1913
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from

Jan 8 1913, to Jan 9 1913,

that I last saw her alive on Jan 8 1913,

and that death occurred on the date stated above, at 5:30 A.M.

The CAUSE OF DEATH* was as follows:

Sarcoma

(Duration) yrs. mos. ds.

Contributory Hemorrhage
(Secondary)

(Duration) yrs. mos. ds.

(Signed) Chas. L. Gutman M. D.

19 (Address) Moscow, Ida.

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death yrs. mos. days. In the State yrs. mos. days.

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

Viola

Jan 12 1913

20. UNDERTAKER

ADDRESS

Go Slett

Moscow

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Form V. S. No. 5 20M.1-16-12

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics
File No. 3893
Registered No. 1

1. PLACE OF DEATH

Registration District No. 14

County of Gatah

Primary Registration District No. 1008

City of Moscow

(No. , St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

A. Margaret Reeder

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX

4. COLOR OR RACE

5. SINGLE, MARRIED, WIDOWED OR DIVORCED.

F. M. White

Single
(Write the word.)

6. DATE OF BIRTH

Nov. 26 1895
(Month) (Day) (Year)

7. AGE

17 yrs. 1 mos. 16 ds.

IF LESS than 1 day
how many hrs. or
mins?

8. OCCUPATION

(a) Trade, profession or particular kind of work

(b) General nature of industry business, or establishment in which employed (or employer)

Student

9. BIRTHPLACE

(State or Country)

Denver, Colo.

10. NAME OF FATHER

R. R. Reeder

11. BIRTHPLACE OF FATHER

(State or Country)

Louisa Co. Iowa

12. MAIDEN NAME OF MOTHER

Anna M. Bemrod

13. BIRTHPLACE OF MOTHER

(State or Country)

Lorraine Germany

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

(Address)

15.

Filed Jan. 13 1917

D. M. Reisher
(Deputy) Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

Jan. 12 1917
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from

Jan. 11 1917, to Jan. 12 1917

that I last saw her alive on Jan. 12 1917

and that death occurred on the date stated above, at 11 A.M.

The CAUSE OF DEATH* was as follows:

Acute Ascending Paralysis
(Landry's Paralysis)

(Duration) yrs. mos. 2 ds.

Contributory Not Known
(Secondary)

(Duration) yrs. mos. ds.

(Signed) Joseph Aspray M. D.

Jan. 12 1917 (Address) Moscow, Ida.

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death. yrs. mos. days. In the State. yrs. mos. days.

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

Moscow

Jan. 14 1917

20. UNDERTAKER

ADDRESS

Geo. S. S. S.

Moscow

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Form V. S. No. 5. 12½ M. 7-24-11

CERTIFICATE OF DEATH

1. PLACE OF DEATH.

County of SalathCity of near TroyRegistration District No. 15Primary Registration District No. 2064

(No. _____, _____ St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

John N. Trout

State of Idaho

BOARD OF HEALTH
Bureau of Vital StatisticsFile No. 3894Registered No. 6

If death occurred in a hospital, institution or camp give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX

m

4. COLOR OR RACE

w

5. SINGLE, MARRIED, WIDOWED OR DIVORCED.

widower
(Write the word.)

6. DATE OF BIRTH

Dec
(Month)5
(Day)1863
(Year)

7. AGE

50 yrs. — 26 mos. 26 ds.IF LESS than 1 day
how many _____ hrs. or
_____ min?

8. OCCUPATION

(a) Trade, profession or particular kind of work.

farmer

(b) General nature of industry business or establishment in which employed (or employer)

9. BIRTHPLACE

(State or Country)

Indiana

10. NAME OF FATHER

John Trout

11. BIRTHPLACE OF FATHER

(State or Country)

Penn

12. MAIDEN NAME OF MOTHER

Don't Know

13. BIRTHPLACE OF MOTHER

(State or Country)

Penn.

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

J. W. Clemm

(Address)

Troy Idaho

15.

Filed Jan 3 1913J. E. Hoyt

Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH

Jan33

(Month)

(Day)

(Year)

17. I HEREBY CERTIFY, That I attended deceased from

191 , to191 that I last saw h. _____ alive on _____ 191 and that death occurred on the date stated above, at 9 A-M

The CAUSE OF DEATH* was as follows:

Killed by falling back while waiting a deep well

(Duration)

sudden yrs.

mos.

ds.

Contributory (Secondary)

(Duration)

yrs.

mos.

ds.

(Signed)

Jan 3 1913

(Address)

J. E. Hoyt
Kendrick

M. D.

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place

In the

of death _____ yrs. _____ mos. _____ ds. State _____ yrs. _____ mos. _____ ds.

Where was disease contracted,

If not at place of death?

Former or

usual residence.

19. PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

Bethel Cemetery Jan 5 1913

20. UNDERTAKER

ADDRESS

none—

Form V. S. No. 5. 12½ M. 7-24-11

CERTIFICATE OF DEATH

1. PLACE OF DEATH. Registration District No. 15
 County of Latah Primary Registration District No. 2064
 City of Kendrien (No. _____, _____ St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

Daniel Benjamin

State of Idaho
 BOARD OF HEALTH
 Bureau of Vital Statistics

File No. 3895Registered No. 5

If death occurred in a hospital, institution or camp give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX M 4. COLOR OR RACE W 5. SINGLE, MARRIED, WIDOWED OR DIVORCED.
Widower
 (Write the word.)

6. DATE OF BIRTH Oct 9 1832
 (Month) (Day) (Year)

7. AGE 80 yrs. 3 mos. 3 ds. IF LESS than 1 day how many _____ hrs. or _____ min?

8. OCCUPATION

(a) Trade, profession or particular kind of work. Farmer
 (b) General nature of industry business or establishment in which employed (or employer)

9. BIRTHPLACE

(State or Country)

Indiana

10. NAME OF FATHER

11. BIRTHPLACE OF FATHER

(State or Country)

12. MAIDEN NAME OF MOTHER

13. BIRTHPLACE OF MOTHER

(State or Country)

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

(Address)

J. H. Benjamin
Kendrien Ida.

15.

Filed Jan 13 1913Local Registrar J. E. Hoyt

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH

Jan 12 1913
 (Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from

Jan 1 1913, to Jan 12 1913

that I last saw him alive on Jan 1 1913

and that death occurred on the date stated above, at 10 M.

The CAUSE OF DEATH* was as follows:

Senile debility

(Duration) _____ yrs. _____ mos. 13 ds.

Contributory

(Secondary)

(Duration) _____ yrs. _____ mos. _____ ds.

(Signed)

W. B. Rothwell M. D.
Jan 13 1913 (Address) Kendrien

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place _____ In the _____
 of death _____ yrs. _____ mos. _____ ds. State _____ yrs. _____ mos. _____ ds.

Where was disease contracted,

If not at place of death?

Former or

usual residence.

19. PLACE OF BURIAL OR REMOVAL DATE OF BURIAL

Dunlap Iowa Jan 13 1913

20. UNDERTAKER

ADDRESS

J. C. Groce close Julia close

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Form V. S. No. 5. 12½ M. 7-24-11

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics
File No. 3896
Registered No. 8

1. PLACE OF DEATH. Registration District No. 16
County of Salath Primary Registration District No. 2066
City of Pottlatch (No. _____, St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

Meresa Ethel Sitts

If death occurred in a hospital, institution or camp give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX Female 4. COLOR OR RACE White 5. SINGLE, MARRIED, WIDOWED OR DIVORCED.
married
(Write the word.)

6. DATE OF BIRTH February 11th 1885
(Month) (Day) (Year)

7. AGE 27 11 29 IF LESS than 1 day
yrs. mos. ds. how many _____ hrs. or
_____ min?

8. OCCUPATION

(a) Trade, profession or particular kind of work.
(b) General nature of industry business or establishment in which employed (or employer)

House Wkr.

9. BIRTHPLACE
(State or Country)

Providence Wis
Marquette Co

10. NAME OF FATHER

Thomas Murphy

11. BIRTHPLACE OF FATHER
(State or Country)

Canada

12. MAIDEN NAME OF MOTHER

E. Lee Maddux

13. BIRTHPLACE OF MOTHER
(State or Country)

Canada

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

Fredrick E. Sitts
Pottlatch Idaho

(Address)

15.

Filed Jan 14 1913 D. M. Thompson
Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH

Jan 13 1913
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from

Jan 12 1913, to Jan 13 1913

that I last saw her alive on Jan 13 1913

and that death occurred on the date stated above, at 6 A M.

The CAUSE OF DEATH* was as follows:

Rupture of Uterus during
confinement

(Duration) yrs. mos. ds.

Contributory
(Secondary)

(Duration) yrs. mos. ds.

(Signed) J. M. Thompson M. D.
Jan 13 1913 (Address) Pottlatch Idaho

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death. yrs. mos. ds. State. yrs. mos. ds.

Where was disease contracted,

If not at place of death?

Former or

usual residence.

19. PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

Palouse Wash

Jan 14 1913

20. UNDERTAKER

ADDRESS

E. Anderson

Palouse Wash

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Form V. S. No. 5. 12½ M. 7-24-11

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics
File No. 3899
Registered No. 1

1. PLACE OF DEATH. Registration District No. 17
County of Carroll Primary Registration District No. 2078
City of Prosser (No. , St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

Stella Lindsey

If death occurred in a hospital, institution or camp give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX Female 4. COLOR OR RACE White 5. SINGLE, MARRIED, WIDOWED OR DIVORCED. Single
(Write the word.)
6. DATE OF BIRTH Jan. 2 1913
(Month) (Day) (Year)

7. AGE 21 yrs. 0 mos. 0 ds. IF LESS than 1 day how many hrs. or min?

8. OCCUPATION

(a) Trade, profession or particular kind of work.
(b) General nature of industry business or establishment in which employed (or employer)

Domestic

9. BIRTHPLACE

(State or Country)

America

10. NAME OF FATHER

G. O. Lindsey

11. BIRTHPLACE OF FATHER

(State or Country)

12. MAIDEN NAME OF MOTHER

13. BIRTHPLACE OF MOTHER

(State or Country)

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

(Address)

15.

Filed

Jan 3 1913

Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

January 2 1913
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from Aug 23 1910, to Jan. 2 1913
that I last saw her alive on Jan. 2 1913
and that death occurred on the date stated above, at 9 A. M.
The CAUSE OF DEATH* was as follows:

Epilepsy.

(Duration) yrs. mos. ds.

Contributory (Secondary)

Insanity

(Duration) yrs. mos. ds.

(Signed)

Dr. J. C. Givens M. D.
Jan 2 1913 (Address) Prosser, Ida

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death yrs. mos. ds. In the State yrs. mos. ds.
Where was disease contracted,
If not at place of death?
Former or usual residence.

19. PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

Asylum Cemetery Jan. 3 1913

20. UNDERTAKER

ADDRESS

George Shaw Prosser, Ida.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Form V. S. No. 5. 12½ M. 7-24-11

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics
File No. 3900
Registered No.

1. PLACE OF DEATH
County of Carver
City of Orfino
Registration District No. 17
Primary Registration District No. 2078
(No. , St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Wilson Mc Kee

If death occurred in a hospital, institution or camp give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX Male 4. COLOR OR RACE White 5. SINGLE, MARRIED, WIDOWED OR DIVORCED. Widower
(Write the word.)
6. DATE OF BIRTH 1848
(Month) (Day) (Year)

7. AGE 65 yrs. mos. ds. IF LESS than 1 day how many hrs. or min?

8. OCCUPATION Labour
(a) Trade, profession or particular kind of work
(b) General nature of industry business or establishment in which employed (or employer)

9. BIRTHPLACE America
(State or Country)

10. NAME OF FATHER ?

11. BIRTHPLACE OF FATHER ?
(State or Country)

12. MAIDEN NAME OF MOTHER ?

13. BIRTHPLACE OF MOTHER ?
(State or Country)

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) John Givens
(Address) Orfino Ida

15. Jan 30 1913
Filed Jan 30 1913
J. M. Smith
Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH January 9 1913
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from July 29 1912, to Jan. 9 1913
that I last saw him alive on Jan 8 1913
and that death occurred on the date stated above, at 10 A.M.
The CAUSE OF DEATH* was as follows:
Atherosclerosis.

(Duration) yrs. mos. ds.
Contributory (Secondary) Insanity
(Duration) 5 yrs. 11 mos. ds.
(Signed) John Givens M. D.
19 (Address)

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death yrs. mos. ds. In the State yrs. mos. ds.
Where was disease contracted,
If not at place of death?
Former or usual residence.

19. PLACE OF BURIAL OR REMOVAL DATE OF BURIAL

Orfino Cemetery Jan. 10 1913
20. UNDERTAKER ADDRESS

Geo H. Shreve Orfino Ida

MARGIN RESERVED FOR BINDING

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Form V. S. No. _____		CERTIFICATE OF DEATH		State of Idaho BOARD OF HEALTH Bureau of Vital Statistics	
1. PLACE OF DEATH County of <u>Cameron</u> City of <u>Dent, Ida</u>		Registration District No. <u>17</u> Primary Registration District No. <u>2078</u> (No. _____ St.)		File No. <u>3901</u> Registered No. <u>3</u>	
<p>If death occurs away from usual residence, give facts called for under special information.</p> <p>2. FULL NAME <u>August Charles Hartwig</u></p>					
PERSONAL AND STATISTICAL PARTICULARS			MEDICAL CERTIFICATE OF DEATH.		
3. SEX <u>Male</u>	4. COLOR OR RACE <u>White</u>	5. SINGLE, MARRIED, WIDOWED OR DIVORCED. <u>Married</u> (Write the word.)			
6. DATE OF BIRTH <u>Aug 30 1873</u> (Month) (Day) (Year)					
7. AGE <u>29 yrs. 5 mos. 22 ds.</u>		IF LESS than 1 day how many hrs. or mins.?			
8. OCCUPATION (a) Trade, profession or particular kind of work <u>Farmer</u> (b) General nature of industry business, or establishment in which employed (or employer) _____					
9. BIRTHPLACE (State or Country) <u>Germany</u>					
10. NAME OF FATHER <u>Carl Hartwig</u>					
11. BIRTHPLACE OF FATHER (State or Country) <u>Germany</u>					
12. MAIDEN NAME OF MOTHER <u>Unknown</u>					
13. BIRTHPLACE OF MOTHER (State or Country) <u>Unknown</u>					
14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE (Informant) <u>Mrs. August C. Hartwig</u> (Address) <u>Dent, Ida</u>					
15. Filed <u>Jan 14 1913</u> <u>Jo Hartwig</u> Local Registrar					
16. DATE OF DEATH <u>Jan 12 1913</u> (Month) (Day) (Year)					
17. I HEREBY CERTIFY, That I attended deceased from <u>1913</u> to <u>1913</u> , that I last saw h. alive on <u>1913</u> , and that death occurred on the date stated above, at <u>M.</u> The CAUSE OF DEATH* was as follows: <u>Unknown</u>					
(Duration) yrs. mos. ds. Contributory (Secondary) (Duration) yrs. mos. ds. (Signed) _____ M. D. 19..... (Address) _____					
*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL. 18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.) At place of death yrs. mos. days. In the State yrs. mos. days. Where was disease contracted if not at place of death? Former or usual residence					
19. PLACE OF BURIAL OR REMOVAL <u>Cameron, Ida</u>				DATE OF BURIAL <u>Jan 15 1913</u>	
20. UNDERTAKER <u>None</u>				ADDRESS _____	

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Form V. S. No. 5. 12½ M. 7-24

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics
File No. 3902
Registered No. 4

1. PLACE OF DEATH
County of Carver
City of Orofino
Registration District 17
Primary Registration No. 2
(No. _____ St.)

If death occurs away from usual residence, give facts called for under special information.

2. NAME John Henderson

If death occurred in a hospital, institution or camp give its NAME instead of street and number.

PERSONAL AND SOCIAL PARTICULARS

3. SEX Male 4. COLOR OR COMPLEXION White 5. SINGLE, MARRIED, WIDOWED OR DIVORCED. Single
(Write the word.)

6. DATE OF BIRTH Jan 22 1913
(Month) (Day) (Year)

7. AGE 72 yrs. 0 mos. 0 ds. IF LESS than 1 day how many hrs. or min?

8. OCCUPATION
(a) Trade, profession or particular kind of work. Miner
(b) General nature of industry business or establishment in which employed (or employer)

9. BIRTHPLACE Connecticut
(State or Country)

10. NAME OF FATHER 2

11. BIRTHPLACE OF FATHER 2
(State or Country)

12. MAIDEN NAME OF MOTHER 2

13. BIRTHPLACE OF MOTHER 2
(State or Country)

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) John H. Gorman
(Address) Orofino, Ida

15. Filed May 30 1913
J. M. Daily
Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH Jan 22 1913
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from Dec 29 1912 to Jan 22 1913
that I last saw him alive on Jan 22 1913
and that death occurred on the date stated above, at 9 P. M.

The CAUSE OF DEATH was as follows:
organic heart disease

Insanity
(Duration) yrs. mos. 24 ds.

Contributory (Secondary) Insanity
(Duration) yrs. mos. 24 ds.

(Signed) Dr. J. M. Gorman M. D.
Jan 24 1913 (Address) Orofino Idaho

State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place In the
of death yrs. mos. ds. State yrs. mos. ds.
Where was disease contracted,
If not at place of death?
Former or
usual residence

19. PLACE OF BURIAL OR REMOVAL Rayburn Cemetery DATE OF BURIAL May 23 1913

20. UNDERTAKER Geo. H. Shreve ADDRESS Orofino, Ida

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Form V. S. No. 5 20M.1-16-12

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics
File No. **3904**

1. PLACE OF DEATH. Registration District No. **17**
County of **Carroll** Primary Registration District No. **2078**
City of **Profino** (No. _____ St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME **Salomon Banner**

Registered No. **6**

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX **Male** 4. COLOR OR RACE **White** 5. SINGLE, MARRIED, WIDOWED OR DIVORCED. **Married**
(Write the word.)

6. DATE OF BIRTH **June 19 1859**
(Month) (Day) (Year)

7. AGE **53 yrs. 7 mos. 9 ds.** IF LESS than 1 day how many _____ hrs. or _____ mins.

8. OCCUPATION
(a) Trade, profession or particular kind of work **Farmer**
(b) General nature of industry business, or establishment in which employed (or employer)

9. BIRTHPLACE **N. Va.**
(State or Country)

10. NAME OF FATHER **Archibald Banner**

11. BIRTHPLACE OF FATHER **N. Va.**
(State or Country)

12. MAIDEN NAME OF MOTHER **Elizabeth Roy**

13. BIRTHPLACE OF MOTHER **N. Va.**
(State or Country)

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) **Douglas Banner**

(Address) **Profino, Ida**

15. Filed **Jan 30 1913** **J. M. King**
Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH **Jan 28 1913**
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from 1911, to **Jan 28 1913**, that I last saw him alive on **Jan 20 1913** and that death occurred on the date stated above, at **6 P. M.**
The CAUSE OF DEATH* was as follows:

Valvular Heart Disease

(Duration) **2** yrs. **7** mos. **1** ds.

Contributory **Bright's Disease**
(Secondary)

(Duration) **2** yrs. **7** mos. **1** ds.

(Signed) **J. M. King** M. D.

Jan 30 1913 (Address) **Profino, Ida**

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals; Institutions, Transients or Recent Residents.)

At place of death. _____ yrs. _____ mos. _____ days. In the State _____ yrs. _____ mos. _____ days.

Where was disease contracted if not at place of death? _____

Former or usual residence. _____

19. PLACE OF BURIAL OR REMOVAL DATE OF BURIAL

Profino Cemetery **Jan 30 1913**

20. UNDERTAKER ADDRESS

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Form V. S. No. 5 20M.1-16-12

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics
File No. 3905

1. PLACE OF DEATH.

Registration District No. 17

County of

Primary Registration District No. 2078

City of

(No. St.)

Registered No. 6

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

Mary Stiles

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX

Female

4. COLOR OR RACE

White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED.

Widowed
(Write the word.)

6. DATE OF BIRTH

April 1 1840
(Month) (Day) (Year)

7. AGE

72 yrs 9 mos 27 ds.

IF LESS than 1 day
how many hrs. or
mins.?

8. OCCUPATION

(a) Trade, profession or particular kind of work
(b) General nature of industry business, or establishment in which employed (or employer)

Housewife

9. BIRTHPLACE

(State or Country)

N.Y.

10. NAME OF FATHER

Cunningham

11. BIRTHPLACE OF FATHER

(State or Country)

N.Y.

12. MAIDEN NAME OF MOTHER

Unknown

13. BIRTHPLACE OF MOTHER

(State or Country)

Unknown

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

A. S. Stiles

(Address)

Griffin, Ida

15.

Filed

June 28 1913

Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH

January 28 1913
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from

January 23 1913, to January 28 1913,
that I last saw him alive on January 28 1913.

and that death occurred on the date stated above, at 8 P.M.
The CAUSE OF DEATH* was as follows:

La Grippe

(Duration) yrs. mos. 6 ds.

Contributory
(Secondary)

(Duration) yrs. mos. ds.

(Signed)

J. M. Fairly M. D.
January 13 1913 (Address) Griffin, Ida

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death yrs. mos. days. In the State yrs. mos. days.

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL

Griffin, Ida

DATE OF BURIAL

January 30 1913

20. UNDERTAKER

W. E. Shaddard

ADDRESS

Griffin, Ida

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics
File No. 3907
Registered No. 1

1. PLACE OF DEATH, Registration District No. 31
County of Cassia Primary Registration District No. 2124
City of Burley (No. St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

David C. Cluff Marchant

If death occurred in a hospital, institution or camp give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX 4. COLOR OR RACE 5. SINGLE, MARRIED, WIDOWED OR DIVORCED.

Male White Married

6. DATE OF BIRTH

Jan 25 1871
(Month) (Day) (Year)

7. AGE

72 yrs. 11 mos. 10 ds.

IF LESS than 1 day
how many hrs. or min?

8. OCCUPATION

- (a) Trade, profession or particular kind of work.
(b) General nature of industry business or establishment in which employed (or employer).

Miner & Farmer

9. BIRTHPLACE

(State or Country)

England

10. NAME OF FATHER

John Marchant

11. BIRTHPLACE OF FATHER

(State or Country)

England

12. MAIDEN NAME OF MOTHER

Cluff

13. BIRTHPLACE OF MOTHER

(State or Country)

Scotland

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

Stanley Marchant

(Address)

Burley Ida.

15.

Filed 2-8 1913

Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH

Jan 6 1913
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from

Jan 1 1913, to Jan 6 1913

that I last saw him alive on Jan 6 1913

and that death occurred on the date stated above, at 5 P.M.

The CAUSE OF DEATH* was as follows:

Pneumonia

(Duration) yrs. mos. 10 ds.

Contributory (Secondary)

(Duration) yrs. mos. ds.

(Signed) J. C. Patterson M. D.

Jan 7 1913 (Address) Burley Idaho

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place In the of death yrs. mos. ds. State yrs. mos. ds.

Where was disease contracted,

If not at place of death?

Former or

usual residence.

19. PLACE OF BURIAL OR REMOVAL DATE OF BURIAL

Burley Ida Jan 9 1913

20. UNDERTAKER

ADDRESS

L. B. Bailey Burley Ida

Ida

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Form V. S. No. 5. 12½ M. 7-24-11

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics
File No. 3908
Registered No. 2.

1. PLACE OF DEATH. Registration District No. 31
County of Cassia Primary Registration District No. 21st
City of Burley (No. , St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Daniel William Stephen

If death occurred in a hospital, institution or camp give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX Male 4. COLOR OR RACE White 5. SINGLE, MARRIED, WIDOWED OR DIVORCED. Single (Write the word.)

6. DATE OF BIRTH June 9 1859 (Month) (Day) (Year)

7. AGE 53 yrs. 2 mos. 22 ds. IF LESS than 1 day how many hrs. or min?

8. OCCUPATION (a) Trade, profession or particular kind of work. Farmer (b) General nature of industry business or establishment in which employed (or employer)

9. BIRTHPLACE (State or Country) Clark Co., Mo.

10. NAME OF FATHER Geo. Christian Stephen

11. BIRTHPLACE OF FATHER (State or Country) Germany

12. MAIDEN NAME OF MOTHER Elizabeth L. Wade

13. BIRTHPLACE OF MOTHER (State or Country) Medina Co. Ohio

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE (Informant) Elizabeth L. Stephen (Address) Burley, Ida.

15. Filed 3-8 1913 L. B. Gallogly Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH Jan. 31 1913 (Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from 191, to 191 that I last saw h alive on 191 and that death occurred on the date stated above, at M.

The CAUSE OF DEATH* was as follows:
Violent death
Struck by Railroad train
accident
(Duration) yrs. mos. ds.
Contributory (Secondary) L. B. Gallogly, Coroner
(Duration) yrs. mos. ds.
(Signed) M. D.
19 (Address)

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.) At place In the of death yrs. mos. ds. State yrs. mos. ds. Where was disease contracted, If not at place of death? Former or usual residence.

19. PLACE OF BURIAL OR REMOVAL DATE OF BURIAL Burley, Ida. Feb. 6 1913

20. UNDERTAKER ADDRESS L. B. Gallogly Burley, Ida.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Form V. S. No. 5. 12½ M. 7-24-11

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics
File No. 3909
Registered No. 3

1. PLACE OF DEATH. Registration District No. 31
County of Primary Registration District No. 2146
City of (No. St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

Ina Martindale

If death occurred in a hospital, institution or camp give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX Female 4. COLOR OR RACE White 5. SINGLE, MARRIED, WIDOWED OR DIVORCED Single
(Write the word.)

6. DATE OF BIRTH May 21 1913
(Month) (Day) (Year)

7. AGE 8 yrs. 8 mos. 2 ds. IF LESS than 1 day how many hrs. or min?

8. OCCUPATION

(a) Trade, profession or particular kind of work. Baker
(b) General nature of industry business or establishment in which employed (or employer)

9. BIRTHPLACE Oakley, Idaho.
(State or Country)

10. NAME OF FATHER Wm. A. Martindale

11. BIRTHPLACE OF FATHER Utah
(State or Country)

12. MAIDEN NAME OF MOTHER Minnie Gee

13. BIRTHPLACE OF MOTHER Utah
(State or Country)

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) W. A. Martindale
(Address) Oakley, Idaho

15. Filed Feb 1 1913 L. B. Storch Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH Jan 23 1913
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from Jan 13 1913, to Jan 23 1913, that I last saw her alive on Jan 23 1913, and that death occurred on the date stated above, at 12 M. The CAUSE OF DEATH* was as follows: Influenza

(Duration) yrs. 10 ds. Contributory (Secondary) Meningitis

(Duration) yrs. 12 ds. (Signed) E. P. O'Leary M. D. Jan 23 1913 (Address) Oakley, Ida.

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place In the of death yrs. mos. ds. State yrs. mos. ds. Where was disease contracted, If not at place of death? Former or usual residence.

19. PLACE OF BURIAL OR REMOVAL DATE OF BURIAL

20. UNDERTAKER F. H. O'Leary Resident. ADDRESS Oakley, Ida.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Form V. S. No. 5. 12½ M. 7-24-11

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics
File No. 3910
Registered No. 4

1. PLACE OF DEATH. Registration District No. 31
County of Cassia Primary Registration District No. 2126
City of Oakley (No. _____, _____ St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

Franklin Ray Warr

If death occurred in a hospital, institution or camp give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX Male 4. COLOR OR RACE white 5. SINGLE, MARRIED, WIDOWED OR DIVORCED Married
(Write the word.)

6. DATE OF BIRTH October 19, 1888
(Month) (Day) (Year)

7. AGE 14 yrs. 3 mos. 6 ds. IF LESS than 1 day how many hrs. or min?

8. OCCUPATION

(a) Trade, profession or particular kind of work.
(b) General nature of industry business or establishment in which employed (or employer)

Farmer

9. BIRTHPLACE

(State or Country)

Oakley Idaho

10. NAME OF FATHER

William Warr

11. BIRTHPLACE OF FATHER

(State or Country)

England.

12. MAIDEN NAME OF MOTHER

Gertrude Isabelle Smith

13. BIRTHPLACE OF MOTHER

(State or Country)

Tooele Utah

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

(Address)

Marion Idaho

15.

Filed Feb 1, 1913

Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH

January 25, 1913
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from Jan. 24, 1913, to Jan. 25, 1913.

that I last saw him alive on Jan. 25, 1913, and that death occurred on the date stated above, at 4:13 P. M.

The CAUSE OF DEATH* was as follows:

Crushing partial amputation of left leg, by plungers in hay bales.

(Duration) _____ yrs. _____ mos. 1 ds.

Contributory (Secondary) Myocarditis with excessive adiposity

(Duration) 9 mos. 1 ds.

(Signed) E. P. O'Leary M. D.
Jan. 25, 1913 (Address) Oakley Idaho

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place In the
of death _____ yrs. _____ mos. _____ ds. State _____ yrs. _____ mos. _____ ds.
Where was disease contracted,
If not at place of death?
Former or usual residence.

19. PLACE OF BURIAL OR REMOVAL DATE OF BURIAL

Marion Idaho Jan. 27, 1913

20. UNDERTAKER ADDRESS

Harold L. Lewis Marion Idaho

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Form V. S. No. 5. 12½ M. 7-24-11

1. PLACE OF DEATH.

County of CassiaCity of BasinRegistration District No. 21Primary Registration District No. 2176

(No. _____, _____ St.)

State of Idaho

BOARD OF HEALTH
Bureau of Vital StatisticsFile No. 3911Registered No. 5

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

Pearl Druechel

If death occurred in a hospital, institution or camp give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX

Female

4. COLOR OR RACE

White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED.

Single
(Write the word)

6. DATE OF BIRTH

Dec. 24, 1912
(Month) (Day) (Year)

7. AGE

7 yrs. 7 mos. 25 ds.IF LESS than 1 day
how many _____ hrs. or
_____ min?

8. OCCUPATION

(a) Trade, profession or particular kind of work.
(b) General nature of industry business or establishment in which employed (or employer)Nurse

9. BIRTHPLACE

(State or Country)

Idaho

10. NAME OF FATHER

Henry Druechel

11. BIRTHPLACE OF FATHER

(State or Country)

Utah

12. MAIDEN NAME OF MOTHER

Eleanor Francks

13. BIRTHPLACE OF MOTHER

(State or Country)

Utah

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) X(Address) X Basin Idaho.

15.

Filed

Jan 15 3 1913L B Stockslager
Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH

Jan. 15, 1913
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from

Jan. 14, 1913, to Jan. 17, 1913that I last saw her alive on Jan. 14, 1913and that death occurred on the date stated above, at 7 A. M.

The CAUSE OF DEATH* was as follows:

Influenza Pneumonia(Duration) _____ yrs. _____ mos. 6 ds.

Contributory (Secondary)

hepatitis

(Duration) _____ yrs. _____ mos. _____ ds.

(Signed) E. Polokum M. D.Jan. 8 1913 (Address) Oakley, Id.

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place _____ In the _____
of death _____ yrs. _____ mos. _____ ds. State _____ yrs. _____ mos. _____ ds.
Where was disease contracted,
If not at place of death?
Former or
usual residence.

19. PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

Basin Cassia Co. Idaho, Jan. 19, 1913

20. UNDERTAKER

ADDRESS

Basin Idaho

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Form V. S. No. 5. 12½ M. 7-24-11

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics
File No. 3912
Registered No. 6

1. PLACE OF DEATH. Registration District No. 31
County of Cassia Primary Registration District No. 2171
City of Albion (No. _____, _____ St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

Buell

If death occurred in a hospital, institution or camp give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX 4. COLOR OR RACE 5. SINGLE, MARRIED, WIDOWED OR DIVORCED.

Female white (Write the word.)

6. DATE OF BIRTH February 4 1913
(Month) (Day) (Year)

7. AGE IF LESS than 1 day
_____ yrs. _____ mos. _____ ds. how many _____ hrs. or _____ min.

8. OCCUPATION

(a) Trade, profession or particular kind of work. none
(b) General nature of industry business or establishment in which employed (or employer)

9. BIRTHPLACE

(State or Country) Albion Idaho

10. NAME OF FATHER

Elmer A Buell

11. BIRTHPLACE OF FATHER

(State or Country) Kansas

12. MAIDEN NAME OF MOTHER

Mary Amy Elder

13. BIRTHPLACE OF MOTHER

(State or Country) Kansas

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Elmer A Buell
(Address) Albion Idaho

15. Filed Feb 7 1913 L. B. Stodolger
Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH Feb 4 1913
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from Feb 4 1913, to Feb 4 1913, that I last saw her alive on Feb 4 1913 and that death occurred on the date stated above, at 6:30 PM. The CAUSE OF DEATH* was as follows: Pneumonia

(Duration) _____ yrs. _____ mos. _____ ds.
Contributory (Secondary)

(Duration) _____ yrs. _____ mos. _____ ds.
(Signed) L. B. Stodolger M. D.
Feb 4 1913 (Address) Albion Idaho

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place In the
of death _____ yrs. _____ mos. _____ ds. State _____ yrs. _____ mos. _____ ds.
Where was disease contracted,
If not at place of death?
Former or
usual residence.

19. PLACE OF BURIAL OR REMOVAL DATE OF BURIAL
Albion Ida Feb 4 1913

20. UNDERTAKER ADDRESS
Elmer A Buell Albion Idaho

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Form V. S. No. 5. 12½ M. 7-24-11

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics
File No. 3913
Registered No. 7

1. PLACE OF DEATH. Registration District No. 31
County of Blaine Primary Registration District No. 21501
City of Albion (No. _____, _____ St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

Bull

If death occurred in a hospital, institution or camp give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX 4. COLOR OR RACE 5. SINGLE, MARRIED, WIDOWED OR DIVORCED.

Female White (Write the word.)

6. DATE OF BIRTH February 4 1913
(Month) (Day) (Year)

7. AGE IF LESS than 1 day
how many 7 hrs. or min?
_____ yrs. _____ mos. _____ ds.

8. OCCUPATION

(a) Trade, profession or particular kind of work.

None

(b) General nature of industry business or establishment in which employed (or employer)

9. BIRTHPLACE

(State or Country)

Albion, Idaho

10. NAME OF FATHER

Elmer A Bull

11. BIRTHPLACE OF FATHER

(State or Country)

Kansas

12. MAIDEN NAME OF MOTHER

Mary Amy Elder

13. BIRTHPLACE OF MOTHER

(State or Country)

Kansas

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

Elmer A Bull

(Address)

Albion Idaho

15.

Filed Feb 7 1913 L. B. Stockbridge
Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH

Feb 4 1913
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from Feb 4 1913, to Feb 4 1913
that I last saw her alive on Feb 4 1913

and that death occurred on the date stated above, at 10:30 M.

The CAUSE OF DEATH* was as follows:

Premature Labor

_____ (Duration) _____ yrs. _____ mos. _____ ds.

Contributory
(Secondary)

_____ (Duration) _____ yrs. _____ mos. _____ ds.

(Signed)

L. B. Stockbridge M. D.
Feb 4 1913 (Address) Albion Idaho

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place _____ In the _____
of death _____ yrs. _____ mos. _____ ds. State _____ yrs. _____ mos. _____ ds.

Where was disease contracted,

If not at place of death?

Former or

usual residence.

19. PLACE OF BURIAL OR REMOVAL DATE OF BURIAL

Albion Idaho Feb 4 1913

20. UNDERTAKER

ADDRESS

Elmer A. Bull. Albion Idaho

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Form V. S. No. 5. 12½ M. 7-24-11

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics
File No. 3914
Registered No. 8

1. PLACE OF DEATH. Registration District No. 31
County of Cassia Primary Registration District No. 2190
City of Albion (No. , St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

Murle Cora Keelson

If death occurred in a hospital, institution or camp give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX 4. COLOR OR RACE 5. SINGLE, MARRIED, WIDOWED OR DIVORCED.

Female White Single (Write the word.)

6. DATE OF BIRTH May 16 1894
(Month) (Day) (Year)

7. AGE 18 yrs. 8 mos. ds. IF LESS than 1 day how many hrs. or min?

8. OCCUPATION
(a) Trade, profession or particular kind of work. at school
(b) General nature of industry business or establishment in which employed (or employer)

9. BIRTHPLACE
(State or Country) Emery, Emery Co., Utah

10. NAME OF FATHER Olof Keelson

11. BIRTHPLACE OF FATHER Utah
(State or Country)

12. MAIDEN NAME OF MOTHER Charlotte Roper

13. BIRTHPLACE OF MOTHER Utah
(State or Country)

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Thomas E. Harper
(Address) Albion Idaho

15. Filed Feb 10 1913 L. B. Stockbridge
Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH Jan 17 1913
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from Jan 12 1913, to Jan 17 1913 that I last saw h. alive on Jan 17 1913

and that death occurred on the date stated above, at 9:30 A.M.

The CAUSE OF DEATH* was as follows:
Typhoid Fever

(Duration) yrs. mos. ds. 19
Contributory (Secondary) Corruption of the liver

(Duration) yrs. mos. ds.
(Signed) L. B. Stockbridge M. D.
Jan 18 1913 (Address) Albion Idaho

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place In the
of death yrs. mos. ds. State yrs. mos. ds.
Where was disease contracted,
If not at place of death?
Former or
usual residence.

19. PLACE OF BURIAL OR REMOVAL DATE OF BURIAL
Albion Idaho Jan 19 1913

20. UNDERTAKER ADDRESS
Thomas E. Harper Albion Idaho

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. N. B.—Every item of information should be carefully supplied. AGE should be state EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Form V. S. No. 5. 10M. 6-20-11.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics
File No. 3916
Registered No. 2

1. PLACE OF DEATH.

Registration District No. 28County of ShoshonePrimary Registration District No. 1011City of Wallace(No. Hope Hospital St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

John Leroy Warren

If death occurred in a hospital, institution or camp give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX

male

4. COLOR OR RACE

white

5. SINGLE, MARRIED, WIDOWED OR DIVORCED.

single
(Write the word.)

6. DATE OF BIRTH

Aug 13

(Month)

(Day)

1888

(Year)

7. AGE

24

yrs.

— mos.

— ds.

IF LESS than 1 day
how many . . . hrs. or
. . . min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work
(b) General nature of industry business or establishment in which employed (or employer)

miner

9. BIRTHPLACE

(State or Country)

Idaho

10. NAME OF FATHER

Harry Warren

11. BIRTHPLACE OF FATHER

(State or Country)

Idaho

12. MAIDEN NAME OF MOTHER

Elizabeth Buchanan

13. BIRTHPLACE OF MOTHER

(State or Country)

Utah

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

Leroy Warren

(Address)

Manti, Idaho

15.

Filed

Jan 15 1913H. Leo Linsley

Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

Jan

(Month)

14

(Day)

1913

(Year)

17. I HEREBY CERTIFY, That I attended deceased from

Jan 10 1913 to Jan 14 1913that I last saw him alive on Jan 14 1913and that death occurred on the date stated above, at 10:45 M.

The CAUSE OF DEATH* was as follows:

Bilateral Lobar Pneumonia(Duration) — yrs. — mos. 5 ds.

Contributory (Secondary)

(Duration) — yrs. — mos. — ds.

(Signed)

Wm. J. Smith M. D.Jan 15 1913 (Address) Wallace, Ida

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and 2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death . . . yrs. . . mos. . . ds. State . . . yrs. . . mos. . . ds.

Where was disease contracted,

If not at place of death?

Former or

usual residence.

Burke, Idaho

19. PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

Manti, UtahJan 16 1913

20. UNDERTAKER

ADDRESS

H. P. Ward, U. GeoWallace, Ida

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Form V. S. No. 5. 12½ M. 7-24-11

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics
File No. **3917**
Registered No. **7**

1. PLACE OF DEATH. Registration District No. **28**
County of **Shoshone** Primary Registration District No. **1011-**
City of **Wallace** (No. _____, First Street _____ St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME **Juliet A. Mallory**

If death occurred in a hospital, institution or camp give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX **female** 4. COLOR OR RACE **white** 5. SINGLE, MARRIED, WIDOWED OR DIVORCED.
widowed
(Write the word.)

6. DATE OF BIRTH
4 **20** **1839**
(Month) (Day) (Year)

7. AGE **73** yrs **8** mos **28** ds. IF LESS than 1 day how many _____ hrs. or _____ min?

8. OCCUPATION

(a) Trade, profession or particular kind of work. **none**
(b) General nature of industry business or establishment in which employed (or employer)

9. BIRTHPLACE
(State or Country) **New York**

10. NAME OF FATHER **Gabriel Caldwell.**

11. BIRTHPLACE OF FATHER
(State or Country) **New York**

12. MAIDEN NAME OF MOTHER **Maria Anderson**

13. BIRTHPLACE OF MOTHER
(State or Country) **New York**

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) **Angus Sutherland**
(Address) **Wallace, Idaho.**

15. Filed **Jan 21** **1913** **G. Leo Quinley**
Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH
1 **18** **1913**
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from
191 to **191**

that I last saw h. _____ alive on **191**
and that death occurred on the date stated above, at _____ M.

The CAUSE OF DEATH was as follows:

General debility

(Duration) _____ yrs. _____ mos. _____ ds.

Contributory (Secondary)

(Duration) _____ yrs. _____ mos. _____ ds.

(Signed) **G. Leo Quinley** M. D.

Jan 21 **1913** (Address) **Wallace, Idaho**

State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place _____ In the _____
of death _____ yrs. _____ mos. _____ ds. State _____ yrs. _____ mos. _____ ds.

Where was disease contracted,
If not at place of death? _____
Former or
usual residence _____

19. PLACE OF BURIAL OR REMOVAL DATE OF BURIAL
Lewiston Idaho. **1/22** **1913**

20. UNDERTAKER ADDRESS
Bruce M. Maitland **Wallace**

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Form V. S. No. 5. 12½ M. 7-24-11

CERTIFICATE OF DEATH

1. PLACE OF DEATH.
County of Shoshone
City of Wallace

Registration District No. 28
Primary Registration District No. 1011
(No. Wallace Hospital St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

Edward Maloney

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics
File No. 3918
Registered No. 3

If death occurred in a hospital, institution or camp give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX 4. COLOR OR RACE 5. SINGLE, MARRIED, WIDOWED OR DIVORCED.

Male White (Write the word.)

6. DATE OF BIRTH

(Month) (Day) (Year)

7. AGE

57 yrs. — mos. — ds.

IF LESS than 1 day
how many.....hrs. or
.....min?

8. OCCUPATION

- (a) Trade, profession or particular kind of work
(b) General nature of industry business or establishment in which employed (or employer)

9. BIRTHPLACE

(State or Country)

10. NAME OF FATHER

not given

11. BIRTHPLACE OF FATHER

(State or Country)

not given

12. MAIDEN NAME OF MOTHER

not given

13. BIRTHPLACE OF MOTHER

(State or Country)

not given

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

(Address)

Wallace Hospital
Wallace Ida

15.

Filed

Jan 20 1913 H. Leodunsky
Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH

1 12 1913
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from

Nov 1912, to Jan 12 1913
that I last saw him alive on Jan 11 1913

and that death occurred on the date stated above, at 4:30

The CAUSE OF DEATH* was as follows:

Chronic Interstitial
Nephritis

(Duration) 2 yrs. mos. ds.

Contributory
(Secondary)

(Duration) mos. ds.

(Signed)

Chas. A. Fitzmaurice M. D.
Jan 20 1913 (Address) Burke Sta

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place Wallace Hospital in the
of death..... yrs. mos. ds. State..... yrs. mos. ds.

Where was disease contracted,

If not at place of death?

Former or

usual residence... Hurricane, Idaho

19. PLACE OF BURIAL OR REMOVAL DATE OF BURIAL

Wallace Idaho Jan 21 1913

20. UNDERTAKER

ADDRESS

E. J. Winters Wallace

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Form V. S. No. 5. 12½M.7-24-11

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics
File No. 3919
Registered No. 5

1. PLACE OF DEATH.
County of Shoshone
City of Wallace

Registration District No. 28
Primary Registration District No. 1011
(No. Hope Hospital St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Guy Blaine Potter

If death occurred in a hospital, institution or camp give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX male 4. COLOR OR RACE white 5. SINGLE, MARRIED, WIDOWED OR DIVORCED. single
(Write the word.)

6. DATE OF BIRTH May 8 1892
(Month) (Day) (Year)

7. AGE 19 yrs. 8 mos. 14 ds. IF LESS than 1 day
how many.....hrs. or
.....min?

8. OCCUPATION
(a) Trade, profession or particular kind of work laborer
(b) General nature of industry business or establishment in which employed (or employer) about railroad yards

9. BIRTHPLACE
(State or Country) Ogden, Utah.

10. NAME OF FATHER J. M. Potter

11. BIRTHPLACE OF FATHER Oregon
(State or Country)

12. MAIDEN NAME OF MOTHER Alice Brown

13. BIRTHPLACE OF MOTHER Maine
(State or Country)

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) J. M. Potter
(Address) Wallace, Idaho.

15. Filed Jan 23 1913 H. Leo Linsley
Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH 1 22 1913
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from Jan 22 1913, to Jan 22 1913
that I last saw him alive on Jan 22 1913
and that death occurred on the date stated above, at 4:45 P.M.

The CAUSE OF DEATH* was as follows:

Shock following
fracture of Skull
(Duration) yrs. mos. 5 hrs.
Contributory (Secondary) Wagon Crash
(Duration) yrs. mos. ds.

(Signed) Jan 23 1913 (Address) Wallace, Idaho M. D.

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place Hope Hospital In the
of death 0 yrs. 0 mos. 1 ds. State Idaho yrs. mos. ds.
Where was disease contracted,
If not at place of death?
Former or
usual residence.....

19. PLACE OF BURIAL OR REMOVAL Wallace, Idaho. DATE OF BURIAL 1 / 24 1913.

20. UNDERTAKER Bruce G. Norstee ADDRESS Wallace, Id.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Form V. S. No. 5. 12½M.7-24-11

CERTIFICATE OF DEATH

1. PLACE OF DEATH. Registration Dist. 28
County of Shoshone Primary Registrar [REDACTED] District No. 1011-
City of Wallace (No. Providence Hospital [REDACTED] St.)

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics
File No. 3920
Registered No. 6-

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Lila Zellars

If death occurred in a hospital, institution or camp give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX female 4. COLOR OR RACE white 5. SINGLE, MARRIED, WIDOWED OR DIVORCED. single
(Write the word.)

6. DATE OF BIRTH 1 22 1895
(Month) (Day) (Year)

7. AGE 18 yrs. 0 mos. 1 ds. IF LESS than 1 day how many.....hrs. or min?

8. OCCUPATION

(a) Trade, profession or particular kind of work..... none
(b) General nature of industry business or establishment in which employed (or employer)

9. BIRTHPLACE (State or Country) Joplin, Missouri,

10. NAME OF FATHER I. L. Zellars,

11. BIRTHPLACE OF FATHER (State or Country) Kansas

12. MAIDEN NAME OF MOTHER Rosa Stoltz,

13. BIRTHPLACE OF MOTHER (State or Country) Illinois,

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE (Informant) I. L. Zellars
(Address) Gem, Idaho.

15. Filed Jan 25 1913 H. Levensky
Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH

1 23 1913
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from Jan 23 1913, to Jan 23 1913
that I last saw h. alive on Jan 23 1913

and that death occurred on the date stated above, at 7/13 M.

The CAUSE OF DEATH* was as follows:

Purulentitis

(Duration) yrs. mos. ds.

Contributory (Secondary)

(Duration) yrs. mos. ds.

(Signed) Mrs. Mowery M. D.
Jan 25 1913 (Address) Wallace Ida

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place Providence Hospital
of death..... yrs. mos. ds. State..... yrs. mos. ds.

Where was disease contracted, If not at place of death?

Former or usual residence.....

19. PLACE OF BURIAL OR REMOVAL Wallace, Idaho. DATE OF BURIAL 1/25 1913

20. UNDERTAKER Bruce W. Wooten ADDRESS Wallace

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Form V. S. No. 5. 12½ M. 7-24-11

1. PLACE OF DEATH. Registration District No. 28
County of Shoshone Primary Registration District No. 1011
City of Wallace (No. Wallace Hospital St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

Isaac Peterson

State of Idaho

BOARD OF HEALTH
Bureau of Vital Statistics

File No. 3921Registered No. 7

If death occurred in a hospital, institution or camp give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX male 4. COLOR OR RACE White 5. SINGLE, MARRIED, WIDOWED OR DIVORCED. married
(Write the word.)

6. DATE OF BIRTH

1 (Month) 1 (Day) 1913 (Year)

7. AGE

42 yrs. 0 mos. 0 ds.

IF LESS than 1 day
how many.....hrs. or
.....min?

8. OCCUPATION

(a) Trade, profession or particular kind of work.....Miner
(b) General nature of industry business or establishment in which employed (or employer).....Quartz Mines

9. BIRTHPLACE

(State or Country)

10. NAME OF FATHER

not given

11. BIRTHPLACE OF FATHER

(State or Country)

12. MAIDEN NAME OF MOTHER

13. BIRTHPLACE OF MOTHER

(State or Country)

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

Wallace Hospital
(Address) Wallace, Idaho.

15.

Filed Jan. 26 1913

St. Leo Dingley
Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH

Jan 24 1913
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from

Jan 10 1913, to Jan 24 1913
that I last saw him alive on Jan 23 1913

and that death occurred on the date stated above, at 10 P. M.

The CAUSE OF DEATH* was as follows:

Gun shot wound of chest

..... (Duration) yrs. 3 mos. ds.

Contributory
(Secondary)

Pyemia + nephritis

..... (Duration) yrs. mos. ds.

(Signed)

Chas. H. Drithman M. D.

Jan 25 1913 (Address) Brake 9th

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place Wallace Hospital In the
of death..... yrs. mos. ds. State..... yrs. mos. ds.

Where was disease contracted,

If not at place of death?

Former or

usual residence.....

19. PLACE OF BURIAL OR REMOVAL DATE OF BURIAL

Kellogg, Idaho

1/26 1913

20. UNDERTAKER

ADDRESS

Brace & Masten Wallace, Ida.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Form V. S. No. 5 20M.1-16-12

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics
File No. **3922**

1. PLACE OF DEATH. Registration District No. **23**
County of **Turner** Primary Registration District No. **2087**
City of **Buhl** (No. _____, St.)

Registered No. _____

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME **Ben Yebisly**

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX **Male** 4. COLOR OR RACE **White** 5. SINGLE, MARRIED, WIDOWED OR DIVORCED. **Single**
(Write the word.)

6. DATE OF BIRTH **Dec 17 1873**
(Month) (Day) (Year)

7. AGE **40 yrs. 1 mos. 3 ds.** IF LESS than 1 day how many hrs. or mins.?

8. OCCUPATION
(a) Trade, profession or particular kind of work **Capitalist**
(b) General nature of industry business, or establishment in which employed (or employer)

9. BIRTHPLACE (State or Country) **Columbus Neb.**

10. NAME OF FATHER **John Yebisly**

11. BIRTHPLACE OF FATHER (State or Country) **Switzerland**

12. MAIDEN NAME OF MOTHER **Marie Pickley**

13. BIRTHPLACE OF MOTHER (State or Country) **Switzerland**

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) **Anna Sandmeyer**
(Address) **Buhl Idaho**

15. Filed **1-21** 191**3** **John H. Dwyer**
Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH **Jan 19 20 1913**
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from **Jan 19 1913**, to **Jan 20 1913**, that I last saw him alive on **Jan 19 1913**, and that death occurred on the date stated above, at **5 P.M.**
The CAUSE OF DEATH* was as follows:

Pneumonia

(Duration) yrs. mos. **5** ds.

Contributory (Secondary)

(Duration) yrs. mos. ds.

(Signed) **J. R. Morgan** M. D.

Jan 21 1913 (Address) **Turner Falls**

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death yrs. mos. days. In the State yrs. mos. days.

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL DATE OF BURIAL

Turner Idaho **Jan 21 1913**

20. UNDERTAKER ADDRESS

H. B. Evans **Buhl**

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Form V. S. No. 5. 12½M.7-24-11

CERTIFICATE OF DEATH

1. PLACE OF DEATH
County of *Idaho Falls*
City of *Deep Creek*

Registration District No. *2087*
Primary Registration District No. *23*
(No. _____, _____ St.)

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics
File No. *3923*
Registered No. _____

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

Delva Gladys Blystone

If death occurred in a hospital, institution or camp give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX 4. COLOR OR RACE 5. SINGLE, MARRIED, WIDOWED OR DIVORCED.

girl *White* *Single*
(Write the word.)

6. DATE OF BIRTH
Nov 13 1908
(Month) (Day) (Year)

7. AGE
4 yrs. *1* mos. *22* ds.
IF LESS than 1 day how many _____ hrs. or _____ min?

8. OCCUPATION
(a) Trade, profession or particular kind of work
(b) General nature of industry business or establishment in which employed (or employer)

9. BIRTHPLACE
(State or Country) *Colorado*

10. NAME OF FATHER
Orville L. Blystone

11. BIRTHPLACE OF FATHER
(State or Country) *Illinois*

12. MAIDEN NAME OF MOTHER
Bessie Price

13. BIRTHPLACE OF MOTHER
(State or Country) *Wisconsin*

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) *Orville L. Blystone*
(Address) *Deep Creek*

15. Filed *1-5* 1913. *J. W. Mungley*
Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH
Jan 4 1913
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from *Jan 4* 1913, to *Jan 4* 1913, that I last saw her alive on *Jan 4* 1913 and that death occurred on the date stated above, at *3 P. M.*

The CAUSE OF DEATH* was as follows:
Pneumonia

(Duration) _____ yrs. _____ mos. _____ ds.

Contributory (Secondary)

(Duration) _____ yrs. _____ mos. *4* ds.

(Signed) *J. W. Mungley* M. D.
Jan 4 1913 (Address) *Deep Creek*

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place _____ In the _____

of death _____ yrs. _____ mos. _____ ds. State _____ yrs. _____ mos. _____ ds.

Where was disease contracted, If not at place of death? _____

Former or usual residence _____

19. PLACE OF BURIAL OR REMOVAL DATE OF BURIAL
Files *1-6* 1913

20. UNDERTAKER ADDRESS
None

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Form V, S. No. 5. 12½ M. 7-24-11

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics
File No. 3921
Registered No. _____

1. PLACE OF DEATH.
County of Twin Falls
City of 4 W Buhl

Registration District No. 23
Primary Registration District No. 2087
(No. _____, St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

Louella Johnson

If death occurred in a hospital, institution or camp give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX F 4. COLOR OR RACE white 5. SINGLE, MARRIED, WIDOWED OR DIVORCED. single
(Write the word.)

6. DATE OF BIRTH Dec 20 1912
(Month) (Day) (Year)

7. AGE _____ yrs. _____ mos. 7 ds. IF LESS than 1 day, how many _____ hrs. or _____ min?

8. OCCUPATION

(a) Trade, profession or particular kind of work. None
(b) General nature of industry business or establishment in which employed (or employer) _____

9. BIRTHPLACE

(State or Country) 4 W Buhl

10. NAME OF FATHER

J. G. Johnson

11. BIRTHPLACE OF FATHER

(State or Country) Idaho Neb.

12. MAIDEN NAME OF MOTHER

Louise M. Young

13. BIRTHPLACE OF MOTHER

(State or Country) Mich.

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) J. H. Muzley

(Address) Buhl Ida

15.

Filed 1-27 1913

J. H. Muzley
Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH

Jan 26 1913
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from

Jan 20 1913, to Jan 25 1913

that I last saw her alive on Jan 25 1913

and that death occurred on the date stated above, at 1 A.M.

The CAUSE OF DEATH* was as follows:

Pneumonia

(Duration) _____ yrs. _____ mos. 3 ds.

Contributory (Secondary) Enterocolitis

(Duration) _____ yrs. _____ mos. 10 ds.

(Signed) J. H. Muzley M. D.

1-26 1913 (Address) Buhl Ida

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place _____ In the _____
of death _____ yrs. _____ mos. _____ ds. State _____ yrs. _____ mos. _____ ds.

Where was disease contracted,

If not at place of death?

Former or

usual residence _____

19. PLACE OF BURIAL OR REMOVAL DATE OF BURIAL

Giles

1-27 1913

20. UNDERTAKER

ADDRESS

H. B. Evans

Buhl Ida

Form V. S. No. 5 20M.1-16-12

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH.

Registration District No. *X 23*

County of *Lincoln*

Primary Registration District No. *File 2086*

File No. *3925*

City of *Filer*

(No. _____, St.)

Registered No. _____

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME *Edwin Thompson Winfrey*

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX

4. COLOR OR RACE

5. SINGLE, MARRIED, WIDOWED OR DIVORCED.

Man

White

Married
(Write the word.)

6. DATE OF BIRTH

May 2 1855
(Month) (Day) (Year)

7. AGE

57 yrs. 8 mos. 4 ds.

IF LESS than 1 day
how many _____ hrs. or
_____ mins.?

8. OCCUPATION

(a) Trade, profession or particular kind of work

Farmer

(b) General nature of industry business, or establishment in which employed (or employer)

9. BIRTHPLACE

(State or Country)

Missouri' Carroll

10. NAME OF FATHER

11. BIRTHPLACE OF FATHER

(State or Country)

12. MAIDEN NAME OF MOTHER

Chair

13. BIRTHPLACE OF MOTHER

(State or Country)

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

C. J. Crosby

(Address)

Carroll' Filer, Idaho

15.

Filed

1-9

1913

A. A. Newberry

Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH

Jan 8 1913
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from

191... to 191...

that I last saw him alive on 191...

and that death occurred on the date stated above, at M.

The CAUSE OF DEATH* was as follows:

(Sudden) Not known

(Duration) yrs. mos. ds.

Contributory (Secondary)

(Duration) yrs. mos. ds.

(Signed)

A. A. Newberry M. D.

19 (Address)

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death yrs. mos. days. In the State yrs. mos. days.

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

Turner Faces Ida

1-9 1913

20. UNDERTAKER

ADDRESS

Charles J. Crosby

Gurneall

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Form V. S. No. 5 20M.1-16-12

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics
File No. 3927

1. PLACE OF DEATH.

Registration District No. 23

County of Twin Falls

Primary Registration District No. 2085

City of

(No. St.)

Registered No.

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Franklin H. Baker

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX 4. COLOR OR RACE 5. SINGLE, MARRIED, WIDOWED OR DIVORCED.

Male

White

Married (the word.)

6. DATE OF BIRTH

Sept. 8th, 1856

(Month) (Day) (Year)

7. AGE

56 yrs. 4 mos. 3 ds.

IF LESS than 1 day
how many hrs. or mins.?

8. OCCUPATION

(a) Trade, profession or particular kind of work

Farmer

(b) General nature of industry business, or establishment in which employed (or employer)

9. BIRTHPLACE

(State or Country) Clayton, Mass.

10. NAME OF FATHER

Henry Baker

11. BIRTHPLACE OF FATHER

(State or Country) Anchron, N. Y.

12. MAIDEN NAME OF MOTHER

Sophia Giddings

13. BIRTHPLACE OF MOTHER

(State or Country) Clayton, Mass.

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Mrs Mary A. Baker

(Address) Twin Falls

15.

Filed 1-12 1913

Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH

Jan. 11 1913
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from Oct. 1912, to Jan 11 1913,

that I last saw him alive on Jan 10 1913,

and that death occurred on the date stated above, at 2:30 P. M.

The CAUSE OF DEATH* was as follows:

Abscess of Lung & Empyema

(Duration) yrs. 3 mos. ds.

Contributory Severe bronchitis & cancer on back (Secondary) of neck.

(Duration) yrs. mos. ds.

(Signed) J. R. Morgan M. D.

Jan 12 1913 (Address) Twin Falls

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death. yrs. mos. days. In the State. yrs. mos. days.

Where was disease contracted if not at place of death?

Former or usual residence.

19. PLACE OF BURIAL OR REMOVAL DATE OF BURIAL

Twin Falls Jan 13 1913

20. UNDERTAKER

ADDRESS

Charles J. Crosby Twin Falls

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Form V. S. No. 5 20M.1-16-12

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics
File No. **3928**

1. PLACE OF DEATH. Registration District No. **23**
County of **Lewis & Clark** Primary Registration District No. **2185**
City of _____ (No. _____ St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME **Mrs. Samantha Cleveland**

Registered No. _____
If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX **Female** 4. COLOR OR RACE **White** 5. SINGLE, MARRIED, WIDOWED OR DIVORCED. **Married**

6. DATE OF BIRTH **May 15 - 1859**
(Month) (Day) (Year)

7. AGE **53 yrs. 2 mos. 25 ds.**
IF LESS than 1 day how many hrs. or mins.?

8. OCCUPATION
(a) Trade, profession or particular kind of work **Housewife**
(b) General nature of industry, business, or establishment in which employed (or employer)

9. BIRTHPLACE (State or Country) **Georgia**

10. NAME OF FATHER **Houston Martin**

11. BIRTHPLACE OF FATHER (State or Country) **Georgia**

12. MAIDEN NAME OF MOTHER **Salla Huffaker**

13. BIRTHPLACE OF MOTHER (State or Country) **Texas**

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) **J. P. Cleveland**
(Address) **Lewis Falls**

15. Filed **1-11** 191**3** **John D. Hughes**
Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH **Jan 9 1913**
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from **Jan 8 - 1913**
Made on call on deceased **Jan 8 - 1913**, to **1913**,

that I last saw him alive on **Jan 8 1913**

and that death occurred on the date stated above, at **M.**

The CAUSE OF DEATH* was as follows:

Endocarditis & atheromatous condition of valves & blood vessels
(Duration) yrs. mos. ds.

Contributory (Secondary)

(Duration) yrs. mos. ds.

(Signed) **J. R. Morgan** M. D.

Jan 9 1913 (Address) **Lewis Falls**

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death yrs. mos. days. In the State yrs. mos. days.

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL **Lewis Falls** DATE OF BURIAL **1-10 1913**

20. UNDERTAKER **Charles J. Cross** ADDRESS **Lewis Falls**

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Form V. S. No. 5. 12½ M. 7-24-11

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics
File No. 3929
Registered No.

1. PLACE OF DEATH. Registration District No. 23
County of Twin Falls Primary Registration District No. 2084
City of Kimberly (No. St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

Frank Barnes Hardin

If death occurred in a hospital, institution or camp give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX male 4. COLOR OR RACE white 5. SINGLE, MARRIED, WIDOWED OR DIVORCED. married
(Write the word.)

6. DATE OF BIRTH Nov 8 1894
(Month) (Day) (Year)

7. AGE 58 yrs. 1 mos. 24 ds. IF LESS than 1 day how many hrs. or min?

8. OCCUPATION Minister
(a) Trade, profession or particular kind of work.
(b) General nature of industry business or establishment in which employed (or employer)

9. BIRTHPLACE Indiana
(State or Country)

10. NAME OF FATHER Frank A. Hardin

11. BIRTHPLACE OF FATHER Ohio
(State or Country)

12. MAIDEN NAME OF MOTHER Alice Barnes

13. BIRTHPLACE OF MOTHER New York
(State or Country)

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) John J. White, M.D.
(Address) Kimberly, Idaho

15. Filed 10 4 1913
Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH Jan 2 1913
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from September 1912, to Jan. 2 1913
that I last saw him alive on Jan. 2 1913
and that death occurred on the date stated above, at 5 P. M.
The CAUSE OF DEATH* was as follows:
Aortic Aneurism

(Duration) 5 yrs. mos. ds.
Contributory Aortic Stenosis
(Secondary)
(Duration) 2 yrs. mos. ds.
(Signed) John J. White M. D.
19 (Address) Kimberly

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place In the
of death yrs. mos. ds. State yrs. mos. ds.
Where was disease contracted,
If not at place of death?
Former or
usual residence.

19. PLACE OF BURIAL OR REMOVAL DATE OF BURIAL
Twin Falls Jan 4 1913

20. UNDERTAKER # 81 ADDRESS
C. J. Crooby Twin Falls

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Form V. S. No. 5. 12½ M. 7-24-11

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics
File No. 3937
Registered No. 1

1. PLACE OF DEATH. Registration District No. 32
County of Buena Primary Registration District No. 2127
City of Winchester (No. _____, _____ St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

Infant Bair

If death occurred in a hospital, institution or camp give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX 4. COLOR OR RACE 5. SINGLE, MARRIED, WIDOWED OR DIVORCED.

Female, whiteSingle
(Write the word.)

6. DATE OF BIRTH

January 12 1913
(Month) (Day) (Year)

7. AGE

— yrs. — mos. — ds.

IF LESS than 1 day
how many 8 hrs. or
— min?

8. OCCUPATION

- (a) Trade, profession or particular kind of work. II
(b) General nature of industry business or establishment in which employed (or employer)

9. BIRTHPLACE

(State or Country)

Winchester

10. NAME OF FATHER

John J. Bair

11. BIRTHPLACE OF FATHER

(State or Country)

Kentucky

12. MAIDEN NAME OF MOTHER

Blenche Lane

13. BIRTHPLACE OF MOTHER

(State or Country)

Mo

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

(Address)

John J. Bair
Winchester, Idaho

15.

Filed 1-14 1913Elton P. Rogers
Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH

January 12th 1913
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from

Jan 12 - 1913, to Jan 12 1913that I last saw her alive on Jan 12 1913and that death occurred on the date stated above, at 12 M

The CAUSE OF DEATH* was as follows:

Premature birth
(Six and 1/2 months gestation)

(Duration) _____ yrs. _____ mos. _____ ds.

Contributory
(Secondary)

(Duration) _____ yrs. _____ mos. _____ ds.

(Signed) Elton P. Rogers M. D.1-12 1913 (Address) Winchester

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place _____ In the _____

of death _____ yrs. _____ mos. _____ ds. State _____ yrs. _____ mos. _____ ds.

Where was disease contracted, _____

If not at place of death? _____

Former or _____

usual residence _____

19. PLACE OF BURIAL OR REMOVAL DATE OF BURIAL

Rollins Cemetery 1-12 1913

20. UNDERTAKER ADDRESS

none employed

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Form V. S. No. 5 20M.1-16-12

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH.

Registration District No.

County of

Primary Registration District No.

City of

(No.)

State

Registered No.

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX

4. COLOR OR RACE

5. SINGLE, MARRIED, WIDOWED OR DIVORCED.

Female

White

Widow

(Write the word.)

6. DATE OF BIRTH

Feb 7th

1893

(Month)

(Day)

(Year)

7. AGE

87 yrs. 11 mos. 1 ds.

IF LESS than 1 day
how many hrs. or
mins.?

8. OCCUPATION

(a) Trade, profession or particular kind of work

Retired

(b) General nature of industry business, or establishment in which employed (or employer)

9. BIRTHPLACE

(State or Country)

Ohio

10. NAME OF FATHER

Ebenzer Miles

11. BIRTHPLACE OF FATHER

(State or Country)

American

12. MAIDEN NAME OF MOTHER

Mrs Mathers

13. BIRTHPLACE OF MOTHER

(State or Country)

American

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

Mrs E. F. Conant

(Address)

Conant Idaho

15.

Filed

1-9

1913

L. M. McConnell

Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH

(Month)

(Day)

1913

17. I HEREBY CERTIFY, That I attended deceased from

1912, to 1913,

that I last saw him alive on 1913,

and that death occurred on the date stated above, at M.

The CAUSE OF DEATH* was as follows:

Roxley

(Duration) yrs. mos. ds.

Contributory
(Secondary)

(Duration) yrs. mos. ds.

(Signed) M. D.

19 (Address)

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death yrs. mos. days. In the State yrs. mos. days.

Where was disease contracted if not at place of death?

Former or usual residence.

19. PLACE OF BURIAL OR REMOVAL DATE OF BURIAL

Masonic Cemetery Jan. 10 1913

20. UNDERTAKER

ADDRESS

Schreiber & Sons Boise

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Form V. S. No. 5 20M.1-16-12

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH.

Registration District No.

County of Ada

Primary Registration District No.

City of Boise

(No. 410 State Idaho St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Clara M. Larson

File No. 3932

Registered No. 29

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX

female

4. COLOR OR RACE

White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED.

Married
(Write the word.)

6. DATE OF BIRTH

July 12 1885
(Month) (Day) (Year)

7. AGE

27 6 17
yrs. mos. ds.

IF LESS than 1 day
how many hrs. or
mins.?

8. OCCUPATION

(a) Trade, profession or particular kind of work

housewife

(b) General nature of industry, business, or establishment in which employed (or employer)

9. BIRTHPLACE

(State or Country)

Marshall Minn.

10. NAME OF FATHER

Charles Mellensthein

11. BIRTHPLACE OF FATHER

(State or Country)

Germany

12. MAIDEN NAME OF MOTHER

13. BIRTHPLACE OF MOTHER

(State or Country)

Germany

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

Jacob Larson

(Address)

515. 14ave No.ampa.cda

15.

Filed 1 30

1913

Ed M. Connel
Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH

Jan 29 1913
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from

Jan 28 1913, to Jan 29 1913,

that I last saw her alive on Jan 29 1913,

and that death occurred on the date stated above, at 9 A.M.

The CAUSE OF DEATH* was as follows:

Puerperal Septicaemia

(Duration) yrs. mos. 7 da.

Contributory
(Secondary)

(Duration) yrs. mos. ds.

(Signed) L. P. McCall M. D.

1/29/13 (Address) Boise Idaho

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death yrs. mos. days. In the State yrs. mos. days.

Where was disease contracted if not at place of death?

Former or usual residence Nampa

19. PLACE OF BURIAL OR REMOVAL DATE OF BURIAL

Marshall Minn. 1913

20. UNDERTAKER

Schreiber & Vidu

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Form V. S. No. 5 20M.1-16-12

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH.

Registration District No.

County of Ada

Primary Registration District No.

City of Boise

(No. 412, State Idaho St.)

File No. 3834

Registered No. 16

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Charles C. Stone

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX Male 4. COLOR OR RACE White 5. SINGLE, MARRIED, WIDOWED OR DIVORCED. Widower
(Write the word.)

6. DATE OF BIRTH Mar 9 1847
(Month) (Day) (Year)

7. AGE 65 yrs. 10 mos. 5 ds. IF LESS than 1 day how many hrs. or mins.?

8. OCCUPATION
(a) Trade, profession or particular kind of work Miner
(b) General nature of industry business, or establishment in which employed (or employer)

9. BIRTHPLACE Kentucky
(State or Country)

10. NAME OF FATHER Not Obtainable

11. BIRTHPLACE OF FATHER Not Obtainable
(State or Country)

12. MAIDEN NAME OF MOTHER Not Obtainable

13. BIRTHPLACE OF MOTHER Not Obtainable
(State or Country)

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Mrs Carrie Mandy

(Address) Boise, Idaho

15. Filed 1-14 1913 LS McCune

Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH Jan 14 1913
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from Jan 9 1913, to Jan 14 1913, that I last saw him alive on Jan 10 1913, and that death occurred on the date stated above, at 6 A. M.

The CAUSE OF DEATH* was as follows: acute peritonitis

(Duration) yrs. mos. ds.

Contributory (Secondary)

(Duration) yrs. mos. ds.

(Signed) Geo Calush M. D.

19..... (Address)

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death.....yrs.....mos.....days. In the St Alphonsus Hospital State.....yrs.....mos.....days.

Where was disease contracted if not at place of death?

Former or usual residence. Idaho

19. PLACE OF BURIAL OR REMOVAL Dry Creek Cemetery DATE OF BURIAL 1/15 1913

20. UNDERTAKER Schreiber & Gidenfaden ADDRESS Boise, Idaho

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH.

Registration District No.

County of Ada

Primary Registration District No.

City of Boise(No. St. Luke's Hospital St.)File No. 3935Registered No. 20

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME J. Frank Albert Evers

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX Male 4. COLOR OR RACE White 5. SINGLE, MARRIED, WIDOWED OR DIVORCED. married
(Write the word.)6. DATE OF BIRTH Nov. 30 1878
(Month) (Day) (Year)7. AGE 34 yrs. 1 mos. 19 ds.
IF LESS than 1 day how many hrs. or mins.?8. OCCUPATION
(a) Trade, profession or particular kind of work Railway Mail
(b) General nature of industry business, or establishment in which employed (or employer) Club9. BIRTHPLACE
(State or Country) Massachusetts10. NAME OF FATHER Charles Evers11. BIRTHPLACE OF FATHER England
(State or Country)12. MAIDEN NAME OF MOTHER Not obtainable13. BIRTHPLACE OF MOTHER Not obtainable
(State or Country)

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) W. S. Roberts
(Address) Boise Idaho15. Filed 191 68 M. Connel
Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH Jan 18 1913
(Month) (Day) (Year)17. I HEREBY CERTIFY, That I attended deceased from Jan 4 1913 to Jan 18 1913, that I last saw him alive on Jan 18 1913, and that death occurred on the date stated above, at 7 P. M.
The CAUSE OF DEATH* was as follows:Bright Disease(Duration) yrs. 2 mos. ds.
Contributory (Secondary) Uphritis(Duration) yrs. ds.
(Signed) W. S. Roberts M. D.
Jan 20 1913 (Address) Boise Idaho

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death yrs. 4 mos. 14 days. In the State yrs. 14 mos. 14 days.Where was disease contracted if not at place of death Portland OregonFormer or usual residence Portland Oregon

19. PLACE OF BURIAL OR REMOVAL DATE OF BURIAL

Morris Hill Burial Jan 20 1913

20. UNDERTAKER ADDRESS

Joy & Summers Boise Id.

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Form V. S. No. 5 20M.1-16-12

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics
File No. 3936

1. PLACE OF DEATH.

Registration District No.

County of Ada

Primary Registration District No.

City of Boise

(No. 1010, Franklin St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME James Lindley Loree

Registered No. 24

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX

Male

4. COLOR OR RACE

Caucasian

5. SINGLE, MARRIED, WIDOWED OR DIVORCED.

married
(Write the word.)

6. DATE OF BIRTH

October 31 1884
(Month) (Day) (Year)

7. AGE

28 yrs. 3 mos. 6 ds.

IF LESS than 1 day
how many hrs. or
..... mins.?

8. OCCUPATION

(a) Trade, profession or particular kind of work

Physician and

(b) General nature of industry business, or establishment in which employed (or employer)

Surgeon

9. BIRTHPLACE

(State or Country)

Lisco, Livingston Co Michigan

10. NAME OF FATHER

James H. Loree

11. BIRTHPLACE OF FATHER

(State or Country)

Lisco, Livingston Co Michigan

12. MAIDEN NAME OF MOTHER

Maria Lindley

13. BIRTHPLACE OF MOTHER

(State or Country)

Detroit, Wayne Co Mich

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

Belle H. Loree

(Address)

Boise, Idaho

15.

Filed 1-27 1913

CS M. Connel

Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH

January 27 1913
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from

191 , to 191 ,
that I last saw him alive on Jan 26 191 ,
and that death occurred on the date stated above, at 3:30 AM.

The CAUSE OF DEATH* was as follows:

Pulmonary Tuberculosis

(Duration) yrs. mos. ds.

Contributory
(Secondary)

(Duration) yrs. mos. ds.

(Signed)

J. O. Springer M. D.
Jan 27, 1913 (Address) Boise, Ida.

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death yrs. mos. days. In the State yrs. mos. days.

Where was disease contracted if not at place of death?

Former or usual residence. 1010 Franklin St Boise

19. PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

Morris Hill Cemetery

1/28 1913

20. UNDERTAKER

ADDRESS

Schreiber & Sidenfaden

Boise Idaho

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Form V. S. No. 5 20M.1-16-12

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH.

Registration District No.

County of Blaine

Primary Registration District No.

City of Blaine(No. 1110, Idaho St.)File No. 393Registered No. 21

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

James Henry Twogood

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX

Male

4. COLOR OR RACE

white

5. SINGLE, MARRIED, WIDOWED OR DIVORCED.

Widowed

6. DATE OF BIRTH

July121886

(Month)

(Day)

(Year)

7. AGE

86 yrs. 6 mos. 13 ds.IF LESS than 1 day
how many hrs. or
..... mins.?

8. OCCUPATION

(a) Trade, profession or particular kind of work

Retiree

(b) General nature of industry business, or establishment in which employed (or employer)

9. BIRTHPLACE

(State or Country)

Troy New York

10. NAME OF FATHER

11. BIRTHPLACE OF FATHER

(State or Country)

America

12. MAIDEN NAME OF MOTHER

Permelia Ann Custer

13. BIRTHPLACE OF MOTHER

(State or Country)

Laramie Perm.

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

Carrie Twogood Loring

(Address)

1110 Idaho Street

15.

Filed 1-25 1913C. M. Correll

Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH

Jan.251913

(Month)

(Day)

(Year)

17. I HEREBY CERTIFY, That I attended deceased from

Jan. 24 1913, to Jan. 25 1913,that I last saw him alive on Jan. 24 1913,and that death occurred on the date stated above, at M.

The CAUSE OF DEATH* was as follows:

Heart Failure

(Duration) yrs. mos. ds.

Contributory
(Secondary)

(Duration) yrs. mos. ds.

(Signed)

Geo. C. Custer M. D.

19. (Address)

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death yrs. mos. days. In the State yrs. mos. days.

Where was disease contracted if not at place of death?

Former or usual residence.

19. PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

Marion Hill Cemetery1/26 1913

20. UNDERTAKER

ADDRESS

Schubert & HidenfadenBlaine

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Form V. S. No. 5 20M.1-16-12

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH.

Registration District No.

County of Ada

Primary Registration District No.

City of Boise(No. St Luke's Hospital St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

Fredrick CampbellFile No. 39345Registered No. 15

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX

Male

4. COLOR OR RACE

White American

5. SINGLE, MARRIED, WIDOWED OR DIVORCED.

Single
(Write the word.)

6. DATE OF BIRTH

not obtainable

(Month)

(Day)

(Year)

7. AGE

82 yrs. — mos. — ds.

IF LESS than 1 day
how many hrs. or
..... mins.?

8. OCCUPATION

(a) Trade, profession or particular kind of work
(b) General nature of industry, business, or establishment in which employed (or employer)

Jeweler

9. BIRTHPLACE

(State or Country)

Ohio

10. NAME OF FATHER

not obtainable

11. BIRTHPLACE OF FATHER

(State or Country)

12. MAIDEN NAME OF MOTHER

13. BIRTHPLACE OF MOTHER

(State or Country)

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Donas W Brown(Address) 1120 Grove St

15.

Filed 1-14 1913 Les M Connel

Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH

Jan131913

(Month)

(Day)

(Year)

17. I HEREBY CERTIFY, That I attended deceased from

Nov 12 1912, to Jan 13 1913,that I last saw him alive on Jan 13 1913,

and that death occurred on the date stated above, at M.

The CAUSE OF DEATH* was as follows:

Senile gangrene

(Duration) yrs. mos. ds.

Contributory
(Secondary)

(Duration) yrs. mos. ds.

(Signed) Geo Calhoun M. D.

19 (Address)

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death yrs. mos. days. In the State yrs. mos. days.

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

Cleveland Ohionot known 1913

20. UNDERTAKER

ADDRESS

Fry & SummersBoise Idaho

1-16-12

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

File No.

3939

Registered No.

18

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

1. PLACE OF DEATH.

County of Ada

Registration District No.

City of Boise

Primary Registration District No.

(No. 1201, River St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME John Pilant

PERSONAL AND STATISTICAL PARTICULARS

3. SEX

Male

4. COLOR OR RACE

White American

5. SINGLE, MARRIED, WIDOWED OR DIVORCED.

Married
(Write the word.)

6. DATE OF BIRTH

June 13 - 1886
(Month) (Day) (Year)

7. AGE

86 yrs. 7 mos. - ds.IF LESS than 1 day
how many hrs. or
..... mins.?

8. OCCUPATION

(a) Trade, profession or particular kind of work

Farmer

(b) General nature of industry, business, or establishment in which employed (or employer)

9. BIRTHPLACE

(State or Country)

Idaho

10. NAME OF FATHER

Not Obtainable

11. BIRTHPLACE OF FATHER

(State or Country)

Not Obtainable

12. MAIDEN NAME OF MOTHER

Not Obtainable

13. BIRTHPLACE OF MOTHER

(State or Country)

Not Obtainable

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

Louise Pilant(Address) 1201 River St

15.

Filed

1 - 171913L. S. M. Council

Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH

1 - 15
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from

1/14 1913 to 1/14 1913
that I last saw him alive on 1/14 1913and that death occurred on the date stated above, at - M.

The CAUSE OF DEATH* was as follows:

Senility(Duration) 1 yrs. 0 mos. 0 ds.Contributory
(Secondary)(Duration) 1 yrs. 0 mos. 0 ds.(Signed) Prof. A. C. Douglas M. D.1/17 1913 (Address) Talk Bedg

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death yrs. mos. days. In the State yrs. mos. days.

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL DATE OF BURIAL

Morris Hill Road Jan 17 1913

20. UNDERTAKER

ADDRESS

Boise Id

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Form V. S. No. 5 20M.1-16-12

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH.

Registration District No.

County of

Primary Registration District No.

City of

(No.)

St.)

File No.

Registered No.

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX

4. COLOR OR RACE

5. SINGLE, MARRIED, WIDOWED OR DIVORCED

Male

White

Single
(Write the word.)

6. DATE OF BIRTH

(Month)

(Day)

(Year)

7. AGE

55 yrs.

mos.

ds.

IF LESS than 1 day
how many hrs. or
..... mins.?

8. OCCUPATION

(a) Trade, profession or particular kind of work

(b) General nature of industry business, or establishment in which employed (or employer)

Saloon keeper

9. BIRTHPLACE

(State or Country)

San Francisco Cal.

10. NAME OF FATHER

Abraham L. Levy

11. BIRTHPLACE OF FATHER

(State or Country)

Poland

12. MAIDEN NAME OF MOTHER

Anna Schemenok

13. BIRTHPLACE OF MOTHER

(State or Country)

Germany.

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

(Address)

O. H. Blatt

15.

Filed

1 - 4

191

3 C. M. Carmel

Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH

January

2

1913

(Month)

(Day)

(Year)

17. I HEREBY CERTIFY, That I attended deceased from

January 1, 1912, to January 1, 1912,

that I last saw him alive on January 1, 1912,

and that death occurred on the date stated above, at 9 A.M.

The CAUSE OF DEATH* was as follows:

Acute Infectious

(Duration) yrs. mos.

Contributory
(Secondary)

(Duration) yrs. mos. ds.

(Signed)

J. M. D.

January 19, 1912 (Address) Boise

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death yrs. mos. days. In the State yrs. mos. days.

Where was disease contracted if not at place of death?

Former or usual residence.

19. PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

Jewins Cemetery

Jan. 5, 1913

20. UNDERTAKER

ADDRESS

Schreibers & Hidenfaden

Boise

Form V. S. No. 5 20M.1-16-12

CERTIFICATE OF DEATH

State of Idaho
 BOARD OF HEALTH
 Bureau of Vital Statistics
 File No. **3941**

1. PLACE OF DEATH. Registration District No. _____
 County of Ada Primary Registration District No. _____
 City of Boise (No. 410 State St.)

Registered No. 25
 If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Harry Flood

PERSONAL AND STATISTICAL PARTICULARS

3. SEX Male 4. COLOR OR RACE White 5. SINGLE, MARRIED, WIDOWED OR DIVORCED. Single
 (Write the word.)

6. DATE OF BIRTH Not Obtainable
 (Month) (Day) (Year)

7. AGE about 20 yrs. — mos. — ds.
 IF LESS than 1 day how many hrs. or mins.?

8. OCCUPATION
 (a) Trade, profession or particular kind of work Bar tender
 (b) General nature of industry, business, or establishment in which employed (or employer) Owyhee Buffet

9. BIRTHPLACE Athol, Mass
 (State or Country)

10. NAME OF FATHER not obtainable

11. BIRTHPLACE OF FATHER not obtainable
 (State or Country)

12. MAIDEN NAME OF MOTHER not obtainable

13. BIRTHPLACE OF MOTHER not obtainable
 (State or Country)

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Sister M. Finton

(Address) St. Alphonsus Hospital

15. _____

Filed 1-27 1913 CS McGinnel
 Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH Jan 25 1913
 (Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from Jan 20 1913, to Jan 26 1913
 that I last saw him alive on Jan 25 1913
 and that death occurred on the date stated above, at 4 P.M.
 The CAUSE OF DEATH* was as follows:
Pneumonia

(Duration) yrs. mos. ds.
 Contributory (Secondary)
 (Duration) yrs. mos. ds.
 (Signed) Chas V. Gernon M. D.
 19 (Address) The Mills

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.) St. Alphonsus Hospital

At place of death yrs. mos. days. In the State yrs. mos. days.

Where was disease contracted if not at place of death?

Former or usual residence Owyhee Hotel, Boise, Ida.

19. PLACE OF BURIAL OR REMOVAL Athol Mass DATE OF BURIAL 127 1913
 Removal

20. UNDERTAKER Schreiber & Sidupada ADDRESS Boise, Idaho

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Form V. S. No. 5 20M.1-16-12

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics
File No. 3943

1. PLACE OF DEATH.

Registration District No.

County of Ada

Primary Registration District No.

City of Boise

(No. 410, State St.)

Registered No. 27

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Infant Hamby

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX male 4. COLOR OR RACE Wht 5. SINGLE, MARRIED, WID-OWED OR DIVORCED. Single
(Write the word.)

6. DATE OF BIRTH Jan 28th 1913
(Month) (Day) (Year)

7. AGE _____ yrs. _____ mos. _____ ds.
IF LESS than 1 day how many hrs. or mins.

8. OCCUPATION
(a) Trade, profession or particular kind of work
(b) General nature of industry, business, or establishment in which employed (or employer)

9. BIRTHPLACE Boise, Idaho
(State or Country)

10. NAME OF FATHER L. B. Hamby
11. BIRTHPLACE OF FATHER Mo. Cedar Co
(State or Country)

12. MAIDEN NAME OF MOTHER Louisa Saxton

13. BIRTHPLACE OF MOTHER Mo. Cedar Co
(State or Country)

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) L. B. Hamby
(Address) Boise

15. Filed 1-29 1913 L. S. M. Connel
Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH Jan 28th 1913
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from 1/28 1913, to 1/28 1913, that I last saw him alive on 1/28 1913, and that death occurred on the date stated above, at 1 P. M.
The CAUSE OF DEATH* was as follows:

Inertia

(Duration) yrs. mos. ds.

Contributory (Secondary)

(Duration) yrs. mos. ds.

(Signed) Fred A. Pittenger M. D.

1/29 1913 (Address) Rich Bldg

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death yrs. mos. days. In the State yrs. mos. days.

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL Harris Hill Cemetery DATE OF BURIAL 1/30 1913

20. UNDERTAKER Schreiber & Viduyaden ADDRESS Boise

Form V. S. No. 5 20M.1-16-12

CERTIFICATE OF DEATH

 State of Idaho
 BOARD OF HEALTH
 Bureau of Vital Statistics

1. PLACE OF DEATH.

Registration District No.

County of Ada

Primary Registration District No.

City of Boise(No. 1014, Warm Springs Ave)File No. 394Registered No. 30

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

Infant Chadwick

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX

Male

4. COLOR OR RACE

White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED.

Single
(Write the word.)

6. DATE OF BIRTH

Jan 26 1913
 (Month) (Day) (Year)

7. AGE

4 yrs. 4 mos. 4 ds.

IF LESS than 1 day
 how many hrs. or
 mins.?

8. OCCUPATION

- (a) Trade, profession or particular kind of work
 (b) General nature of industry, business, or establishment in which employed (or employer)

9. BIRTHPLACE

(State or Country)

Idaho

10. NAME OF FATHER

Edward S. Chadwick

11. BIRTHPLACE OF FATHER

(State or Country)

Nebraska

12. MAIDEN NAME OF MOTHER

Maud Myers

13. BIRTHPLACE OF MOTHER

(State or Country)

New York

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

(Address)

1014 Warm Spgs

15.

Filed

1-311913
E. S. Chadwick
Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH

Jan 30 1913
 (Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from

Jan 27 1913, to Jan 30 1913,

 that I last saw her alive on Jan 30 1913,

 and that death occurred on the date stated above, at 3 P M.

The CAUSE OF DEATH* was as follows:

Pneumonia
 (Duration) yrs. mos. 4 ds.

 Contributory
 (Secondary)

(Duration) yrs. mos. ds.

 (Signed) James Stewart M. D.

1/30 1913 (Address) Boise Idaho

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death yrs. mos. days. In the State yrs. mos. days.

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

Morris Hill Cemetery1/31 1913

20. UNDERTAKER

ADDRESS

Schreiber Sidenfaden Boise, Idaho

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Form V. S. No. 5 20M.1-16-12

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH,
Bureau of Vital Statistics

1. PLACE OF DEATH.

Registration District No.

County of Ada

Primary Registration District No.

City of Boise

(No. 410 State Idaho St.)

File No. 3945

Registered No. 12

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

Leslie Gotfred Spaulding

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX

Male

4. COLOR OR RACE

White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED

Single
(Write the word.)

6. DATE OF BIRTH

Feb. 24 1911
(Month) (Day) (Year)

7. AGE

1 yrs. 10 mos. 13 ds.

IF LESS than 1 day
how many hrs. or
..... mins.?

8. OCCUPATION

(a) Trade, profession or particular kind of work

None

(b) General nature of industry, business, or establishment in which employed (or employer)

9. BIRTHPLACE

(State or Country)

Rexburg Ida

10. NAME OF FATHER

Julius Leslie Spaulding

11. BIRTHPLACE OF FATHER

(State or Country)

Utah

12. MAIDEN NAME OF MOTHER

Caroline Klinger

13. BIRTHPLACE OF MOTHER

(State or Country)

Germany

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

Julius Leslie Spaulding

(Address)

Boise Ida

15.

Filed

1-11

1913

L. S. W. Counsel

Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH

1 10 1913
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from

Jan 9th 1913, to Jan 10 1913

that I last saw him alive on Jan 10 1913

and that death occurred on the date stated above, at 9 P.M.

The CAUSE OF DEATH* was as follows:

Bronchial Pneumonia

(Duration) yrs. mos. ds.

Contributory

(Secondary)

(Duration) yrs. mos. ds.

(Signed)

Fred A. Dilling M. D.

1/11 1913 (Address) 724 E. 4th

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death yrs. mos. days. In the State yrs. mos. days.

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

Marion Hill Cemetery

1/12 1913

20. UNDERTAKER

ADDRESS

Schubert & Sidenfaden

Boise

MARGIN RESERVED FOR BINDING
WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Form V. S. No. 5 20M.1-16-12

CERTIFICATE OF DEATH

1. PLACE OF DEATH.

County of Ada

City of Boise Idaho

If death occurs away from usual residence, give facts called for under special information.

Registration District No.

Primary Registration District No.

(No. 517, Idaho St.)

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

File No. 3945

Registered No. 28

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Benjamin Valentine Town

PERSONAL AND STATISTICAL PARTICULARS

3. SEX

Male

4. COLOR OR RACE

White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED.

Single
(Write the word.)

6. DATE OF BIRTH

February 14th 1904
(Month) (Day) (Year)

7. AGE

8 yrs. 11 mos. 14 ds.

IF LESS than 1 day
how many hrs. or
..... mins.?

8. OCCUPATION

(a) Trade, profession or particular kind of work

none

(b) General nature of industry, business, or establishment in which employed (or employer)

school boy

9. BIRTHPLACE

(State or Country)

North Dakota

10. NAME OF FATHER

Ray B Town

11. BIRTHPLACE OF FATHER

(State or Country)

New York

12. MAIDEN NAME OF MOTHER

Belle M Dolphin

13. BIRTHPLACE OF MOTHER

(State or Country)

Minnesota

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

Ray B Town

(Address)

Flaxton N.D.

15.

Filed 1 - 29 1913

W M Connel
Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH

Jan 28th 1913
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from

Jan. 13 1913 to Jan. 28th 1913

that I last saw him alive on Jan 28th 1913

and that death occurred on the date stated above, at 2 P.M.

The CAUSE OF DEATH* was as follows:

Complications following
scarlet fever

(Cause of death from Dakota) at home 14 ds.
(Duration) yrs. mos. ds.

Contributory
(Secondary)

Scarlet fever
(Duration) yrs. mos. ds.

(Signed)

John B. Bump M. D.
Jan 29 1913 (Address) Boise Id

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL OR HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death yrs. mos. days. In the State yrs. mos. days.

Where was disease contracted if not at place of death?

Former or usual residence

517 Idaho St - Boise

19. PLACE OF BURIAL OR REMOVAL DATE OF BURIAL

Harris Hill Cemetery 1/30 1913

20. UNDERTAKER

ADDRESS

Schreiber & Sidenfaden Boise

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Form V. S. No. 5 20M.1-16-12

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH. Registration District No. _____

County of Ada Primary Registration District No. _____

City of Bain (No. 112, E. Bannock St.) File No. 3948

If death occurs away from usual residence, give facts called for under special information. 2. FULL NAME Effie Krounrei Registered No. 26

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX Female 4. COLOR OR RACE White 5. SINGLE, MARRIED, WIDOWED OR DIVORCED. Single
(Write the word.)

6. DATE OF BIRTH Oct. 2 1892
(Month) (Day) (Year)

7. AGE 20 yrs. 3 mos. 24 ds.
IF LESS than 1 day how many _____ hrs. or _____ mins.?

8. OCCUPATION
(a) Trade, profession or particular kind of work _____
(b) General nature of industry, business, or establishment in which employed (or employer) _____

9. BIRTHPLACE Idaho
(State or Country)

10. NAME OF FATHER C. J. Krounrei

11. BIRTHPLACE OF FATHER Germany
(State or Country)

12. MAIDEN NAME OF MOTHER Emma Andregg

13. BIRTHPLACE OF MOTHER Idaho
(State or Country)

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) C. J. Krounrei
(Address) Gary, Idaho

15. Filed 1-27 1913 Wm Connel
Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH Jan. 26 1913
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from Jan 25 1913 to Jan 26 1913, that I last saw her alive on Jan 26 1913 and that death occurred on the date stated above, at 4 A.M.

The CAUSE OF DEATH* was as follows:
apendicitis with
toxic complications

(Duration) _____ yrs. _____ mos. 7 ds.

Contributory _____
(Secondary)

(Duration) _____ yrs. _____ mos. _____ ds.

(Signed) W. S. Lister M. D.
1-28 1913 (Address) Bain

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
St Lukes Hospital
At place of death _____ yrs. _____ mos. _____ days. In the State _____ yrs. _____ mos. _____ days.

Where was disease contracted if not at place of death? _____

Former or usual residence Gary Station Ada Co.

19. PLACE OF BURIAL OR REMOVAL Harris Hill cemetery DATE OF BURIAL 1/28- 1913

20. UNDERTAKER Schreiber & Sidenfader ADDRESS Bain, Idaho.

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Form V. S. No. 5 20M.1-16-12

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH.

Registration District No.

County of *Ada*

Primary Registration District No.

City of *Boise*

(No. *1220* *Idaho* St.)

File No. *3949*

Registered No. *11*

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME *Leola Marie Bess*

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX *Female* 4. COLOR OR RACE *white American* 5. SINGLE, MARRIED, WIDOWED OR DIVORCED. *Single*
(Write the word.)

6. DATE OF BIRTH *Oct 4 1913*
(Month) (Day) (Year)

7. AGE *3 yrs. 7 mos. 7 ds.* IF LESS than 1 day how many hrs. or mins.?

8. OCCUPATION
(a) Trade, profession or particular kind of work *none Infant.*
(b) General nature of industry, business, or establishment in which employed (or employer)

9. BIRTHPLACE *Starr Idaho*
(State or Country)

10. NAME OF FATHER *G. C. Bess*

11. BIRTHPLACE OF FATHER *Idy.*
(State or Country)

12. MAIDEN NAME OF MOTHER *Agness Miley*

13. BIRTHPLACE OF MOTHER *Idy.*
(State or Country)

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

(Address) *G. C. Bess*

15.

Filed *1-11* 191*3* *Ed M. Connel*
Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH *January 11 1913*
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from *Jan. 11th 1913* to *Jan. 11th 1913*
that I last saw her alive on *Jan. 11th 1913*
and that death occurred on the date stated above, at *11:34* M.

The CAUSE OF DEATH* was as follows:
Malnutrition since birth

(Duration) yrs. mos. ds.

Contributory (Secondary) *Tuberculosis*

(Duration) yrs. mos. ds.

(Signed) *Chubbuck* M. D.

Jan 11 1913 (Address) *Boise Idaho*

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death yrs. mos. days. In the State yrs. mos. days.

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL DATE OF BURIAL

Morrist Hill Cemetery 191*3*

20. UNDERTAKER ADDRESS

Fry + Summers.

Form V. S. No. 5 20M.1-16-12

CERTIFICATE OF DEATH

 State of Idaho
 BOARD OF HEALTH
 Bureau of Vital Statistics

1. PLACE OF DEATH.

Registration District No.

County of Ada

Primary Registration District No.

City of Boise(No. 509, Main St.)File No. 3951Registered No. 8

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

Isabel Celaya

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX

Female

4. COLOR OR RACE

White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED.

Married
(Write the word.)

6. DATE OF BIRTH

Mar1873

(Month)

(Day)

(Year)

7. AGE

40 yrs.

mos.

ds.

 IF LESS than 1 day
 how many hrs. or
 mins.?

8. OCCUPATION

(a) Trade, profession or particular kind of work

House Keeper

(b) General nature of industry business, or establishment in which employed (or employer)

9. BIRTHPLACE

(State or Country)

Spain

10. NAME OF FATHER

Manuel M Celaya

11. BIRTHPLACE OF FATHER

(State or Country)

Spain

12. MAIDEN NAME OF MOTHER

Josefa Batista

13. BIRTHPLACE OF MOTHER

(State or Country)

Spain

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

Mateo Arreaga

(Address)

Boise, Idaho

15.

Filed 1-7191 3C. S. McCranel

Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH

Jan61913

(Month)

(Day)

(Year)

17. I HEREBY CERTIFY, That I attended deceased from

Dec. 28 1913, to January 6 1913,that I last saw her alive on January 6 1913,and that death occurred on the date stated above, at 11 A.M.

The CAUSE OF DEATH* was as follows:

Mitral Insufficiency

(Duration) yrs. mos. ds.

Contributory

(Secondary)

(Duration) yrs. mos. ds.

(Signed) Frank A. Mudgett M. D.19. (Address) 2 Falk Bldg.

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place

of death yrs. mos. days.

In the

State yrs. mos. days.

 Where was disease contracted
 if not at place of death?

Former or

usual residence. 509, Main St., Boise, Idaho

19. PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

St John's Cemetery1/8 1913

20. UNDERTAKER

ADDRESS

Schreiber & ChidenfadenBoise, Idaho

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Form V. S. No. 5 20M.1-16-12

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH.

Registration District No.

County of Ada

Primary Registration District No.

City of Boise(No. 1003, N. 8th St.)File No. 3952Registered No. 4-4

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

Louise Ann Tolmaie

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX

F.

4. COLOR OR RACE

W.

5. SINGLE, MARRIED, WIDOWED OR DIVORCED.

Married
(Write the word.)

6. DATE OF BIRTH

Nov 5 1824
(Month) (Day) (Year)

7. AGE

88 yrs. 1 mos. 29 ds.IF LESS than 1 day
how many hrs. or
..... mins.?

8. OCCUPATION

(a) Trade, profession or particular kind of work

Retired Housekeeper

(b) General nature of industry business, or establishment in which employed (or employer)

9. BIRTHPLACE

(State or Country)

Canada

10. NAME OF FATHER

Wm McDonald

11. BIRTHPLACE OF FATHER

(State or Country)

Canada

12. MAIDEN NAME OF MOTHER

Not obtainable

13. BIRTHPLACE OF MOTHER

(State or Country)

Canada

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

Mrs Wm Hutchings

(Address)

Boise, Ida.

15.

Filed

1-31913Wm McConnell

Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH

Jan 2nd 1913
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from

dead Jan 1, 1913, to same 1913that I last saw him alive on 1913and that death occurred on the date stated above, at 10 P.M.

The CAUSE OF DEATH* was as follows:

No Physician in attendance
Cause of death Paralysis
and old age.

(Duration) yrs. mos. ds.

Contributory
(Secondary)

(Duration) yrs. mos. ds.

(Signed)

Adolph Schreiber M.D.

19. (Address)

Boise corner

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death yrs. mos. days. In the State yrs. mos. days.

Where was disease contracted if not at place of death?

Former or usual residence. 1003 N. 8th Boise, Idaho

19. PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

Boise Cemetery 1/4 1913

20. TAKER

ADDRESS

Schreiber & Schenck Boise, Ida

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Form V. S. No. 5 20M.1-16-12

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH. Registration District No. _____
County of Ada Primary Registration District No. _____
City of Boise (No. 1108, Jefferson St.)

File No. 3953
Registered No. 14

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Bridges Martin Gallagher

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX Female 4. COLOR OR RACE White 5. SINGLE, MARRIED, WIDOWED OR DIVORCED. widow
(Write the word.)

6. DATE OF BIRTH February 2nd 1837
(Month) (Day) (Year)

7. AGE 76 yrs. 11 mos. 12 ds.
IF LESS than 1 day how many hrs. or mins.?

8. OCCUPATION
(a) Trade, profession or particular kind of work retired
(b) General nature of industry, business, or establishment in which employed (or employer)

9. BIRTHPLACE
(State or Country) County Tyrone Ireland

10. NAME OF FATHER Patrick Martin

11. BIRTHPLACE OF FATHER Ireland
(State or Country)

12. MAIDEN NAME OF MOTHER Bridget Slavin

13. BIRTHPLACE OF MOTHER Ireland
(State or Country)

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) F. Gallagher
(Address) Walnut, Ia.

15. Filed 1-13 1913 Ed M. Cronley
Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH Jan. 12th 1913
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from 191, to 191, that I last saw h. alive on 191, and that death occurred on the date stated above, at M.

The CAUSE OF DEATH* was as follows:

Senility

(Duration) _____ yrs. _____ mos. _____ ds.

Contributory (Secondary)

(Duration) _____ yrs. _____ mos. _____ ds.

(Signed) Jasper M. D.

Jan 13 1913 (Address) Boise

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death _____ yrs. _____ mos. _____ days. In the State _____ yrs. _____ mos. _____ days.

Where was disease contracted if not at place of death?

Former or usual residence _____

19. PLACE OF BURIAL OR REMOVAL St John's cemetery DATE OF BURIAL Jan 14 1913

20. UNDERTAKER Schreiber & Sidenfeller ADDRESS Boise

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Form V. S. No. 5 20M.1-16-12

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH.

Registration District No.

County of Ada

Primary Registration District No.

City of Boise

(No. 919, North 217 St.)

File No. 3955

Registered No. 73

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Jeanette Tremer

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX

Female

4. COLOR OR RACE

White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED.

Single
(Write the word.)

6. DATE OF BIRTH

Jan 21 1913
(Month) (Day) (Year)

7. AGE

5 yrs. 5 mos. 5 ds.

IF LESS than 1 day
how many hrs. or
..... mins.?

8. OCCUPATION

(a) Trade, profession or particular kind of work
(b) General nature of industry, business, or establishment in which employed (or employer)

Unice

9. BIRTHPLACE

(State or Country)

Boise

10. NAME OF FATHER

Willis H. Tremer

11. BIRTHPLACE OF FATHER

(State or Country)

Washington

12. MAIDEN NAME OF MOTHER

Elizabeth Reckardo

13. BIRTHPLACE OF MOTHER

(State or Country)

Maine

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

Willis H. Tremer

(Address)

Boise

15.

Filed 1-27

1913

Ed M. Connel

Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH

Jan 26 1913
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from

Jan 21 1913, to Jan 26 1913,

that I last saw her alive on 26 1913,

and that death occurred on the date stated above, at 10 A.M.

The CAUSE OF DEATH* was as follows:

Marsupio

(Duration) yrs. mos. ds.

Contributory
(Secondary)

(Duration) yrs. mos. ds.

(Signed) Jud. J. Pittenger M. D.

19 (Address) Boise

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death yrs. mos. days. In the State yrs. mos. days.

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL DATE OF BURIAL

Maris Hill Cemetery 1-27 1913

20. UNDERTAKER

ADDRESS

Schubert & Sidenfaden Boise Idaho

o) da Smith

(ADDRESS

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Form V. S. No. 5. 12½ M. 7-24-11

1. PLACE OF DEATH.
County of Idaho
City of Grangeville

Registration District No. 4042
Primary Registration District No. 10 2042
(No. _____, St.)

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics
File No. 3952
Registered No. 98

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

Elijah Jay Kerlee

If death occurred in a hospital, institution or camp give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX Male 4. COLOR OR RACE white 5. SINGLE, MARRIED, WIDOWED OR DIVORCED. Single
(Write the word.)

6. DATE OF BIRTH Sept. 6 1890
(Month) (Day) (Year)

7. AGE 22 yrs. 4 mos. 29 ds. IF LESS than 1 day how many _____ hrs. or _____ min?

8. OCCUPATION
(a) Trade, profession or particular kind of work.
(b) General nature of industry business or establishment in which employed (or employer)

Raucher

9. BIRTHPLACE
(State or Country)

Idaho

10. NAME OF FATHER

Edward B. Kerlee

11. BIRTHPLACE OF FATHER
(State or Country)

N.C.

12. MAIDEN NAME OF MOTHER

Nancy B. Austin

13. BIRTHPLACE OF MOTHER
(State or Country)

Ark.

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

(Address)

15.

Filed Feb. 1 1913

Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH Jan. 30 1913
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from _____ 191____, to _____ 191____

that I last saw h _____ alive on _____ 191____

and that death occurred on the date stated above, at _____ M.

The CAUSE OF DEATH* was as follows:

poisoning by strychnine with suicidal intent

(Duration) _____ yrs. _____ mos. _____ ds.

Contributory
(Secondary)

(Duration) _____ yrs. _____ mos. _____ ds.

(Signed) Henry D. Allen M. D.

19 (Address) Conner

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place _____ In the _____
of death _____ yrs. _____ mos. _____ ds. State _____ yrs. _____ mos. _____ ds.

Where was disease contracted,

If not at place of death?

Former or

usual residence.

19. PLACE OF BURIAL OR REMOVAL DATE OF BURIAL

Sawtooth Cemetery Feb. 1 1913

20. UNDERTAKER

ADDRESS

W.E. Graham

Grangeville

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Form V, S. No. 5. 12½ M. 7-24-11

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics
File No. 3959
Registered No. 94

1. PLACE OF DEATH. Registration District No. 10
County of Idaho Primary Registration District No. 1001
City of Grangeville (No. St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

Chester John Melkus

If death occurred in a hospital, institution or camp give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX 4. COLOR OR RACE 5. SINGLE, MARRIED, WIDOWED OR DIVORCED.

Male White Single (Write the word.)

6. DATE OF BIRTH

Dec 12 1912
(Month) (Day) (Year)

7. AGE

1 yrs. 3 mos. 3 ds. IF LESS than 1 day how many hrs. or min?

8. OCCUPATION

(a) Trade, profession or particular kind of work.
(b) General nature of industry business or establishment in which employed (or employer)

9. BIRTHPLACE

(State or Country)

Idaho

10. NAME OF FATHER

Chester Melkus

11. BIRTHPLACE OF FATHER

(State or Country)

Nebraska

12. MAIDEN NAME OF MOTHER

Ethel Griddlebaugh

13. BIRTHPLACE OF MOTHER

(State or Country)

Nebraska

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

Mrs. Chester Melkus

(Address)

Grangeville

15.

Filed Jan 18 1913 G. S. Stra

Loc. ar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH

January 15 1913
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from Jan 12 1913, to Jan 15 1913

that I last saw him alive on Jan 15 1913

and that death occurred on the date stated above, at 8 A. M.

The CAUSE OF DEATH* was as follows:

Man Closure of the foramen ovale.

(Duration) 0 yrs. 3 mos. 3 ds.

Contributory (Secondary)

(Duration) yrs. mos. ds.

(Signed) W. H. Warner M. D.

Jan 15 1913 (Address) Grangeville

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place In the of death yrs. mos. ds. State yrs. mos. ds.

Where was disease contracted,

If not at place of death?

Former or

usual residence.

19. PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

Prairie View

Jan 16 1913

20. UNDERTAKER

ADDRESS

W E Graham

Grangeville

WRITE PLAINLY, WITH UNFADE INK—THIS IS A PERMANENT RECORD.
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Form V. S. No. 5 20M.1-16-12

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH.

Registration District No. 10

County of Idaho

Primary Registration District No. 2101

City of Stites

(No. , St.)

File No. 3969

Registered No. 95

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Mary Matilda Downey

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX

F

4. COLOR OR RACE

W

5. SINGLE, MARRIED, WIDOWED OR DIVORCED.

Widowed
(Write the word.)

6. DATE OF BIRTH

Not Known — 1841

(Month)

(Day)

(Year)

7. AGE

72

yrs. — mos. — ds.

IF LESS than 1 day
how many hrs. or mins.?

8. OCCUPATION

(a) Trade, profession or particular kind of work

None

(b) General nature of industry business, or establishment in which employed (or employer)

9. BIRTHPLACE

(State or Country)

Indiana

10. NAME OF FATHER

Not obtainable

11. BIRTHPLACE OF FATHER

(State or Country)

12. MAIDEN NAME OF MOTHER

13. BIRTHPLACE OF MOTHER

(State or Country)

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

(Address)

15.

Filed

Jan 16

1913

H. F. Schradler

Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH

Jan.

16

1913

(Month)

(Day)

(Year)

17. I HEREBY CERTIFY, That I attended deceased from

1913, to

1913,

that I last saw him alive on

1913,

and that death occurred on the date stated above, at 12:05 AM.

The CAUSE OF DEATH* was as follows; Dropped dead

Not under care of Physician at all

Sick Room or Hospital

Chronic interstitial Nephritis

(Duration) 2 yrs. — mos. — ds.

Contributory Chronic Myocarditis

(Secondary) Valvular Insufficiency

(Duration) 2 yrs. — mos. — ds.

(Signed) H. F. Schradler M. D.

Jan 16, 1913 (Address) Stites - Idaho

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death.....yrs.....mos.....days. In the State.....yrs.....mos.....days.

Where was disease contracted if not at place of death? Indiana

Former or usual residence Rochester - Indiana

19. PLACE OF BURIAL OR REMOVAL DATE OF BURIAL

Stites - Idaho Jan 17 1913

20. UNDERTAKER

ADDRESS

Form V. S. No. 5 20M.1-16-12

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH.

Registration District No. 2101 10County of IdahoPrimary Registration District No. 2101City of St. Ives

(No. _____)

St.)

File No. 3961Registered No. 96

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Charles Henry Horn

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX

M.

4. COLOR OR RACE

W.

5. SINGLE, MARRIED, WIDOWED OR DIVORCED

Widowed
(Write the word.)

6. DATE OF BIRTH

Feb. 19 1845
(Month) (Day) (Year)

7. AGE

68 yrs. 11 mos. 1 ds.IF LESS than 1 day
how many hrs. or
..... mins.?

8. OCCUPATION

(a) Trade, profession or particular kind of work

Retired farmer

(b) General nature of industry business, or establishment in which employed (or employer)

9. BIRTHPLACE

(State or Country)

New Jersey

10. NAME OF FATHER

not known

11. BIRTHPLACE OF FATHER

(State or Country)

not known

12. MAIDEN NAME OF MOTHER

not known

13. BIRTHPLACE OF MOTHER

(State or Country)

Not known

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Mrs. G. A. Swain(Address) St. Ives - Idaho

15.

Filed Jan 22 1913Local Registrar H. F. Schrader

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH

Jan. 20 1913
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from

191 to 191,that I last saw him alive on 191,and that death occurred on the date stated above, at M.

The CAUSE OF DEATH* was as follows:

Suicide by Hanging. Body found at about 8 P.M. about two miles from town. This certificate is issued by consent of coroner.
(Duration) yrs. mos. ds.Contributory
(Secondary)

(Duration) yrs. mos. ds.

(Signed) H. F. Schrader

M. D.

Jan. 21 1913 (Address) St. Ives, Idaho

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death yrs. mos. days. In the State yrs. mos. days.

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL

St. Ives - Idaho

DATE OF BURIAL

1-23 1913

20. UNDERTAKER

ADDRESS

MARGIN RESERVED FOR BINDING
WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Form V. S. No. 5. 12½M. 7-24-11

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics
File No. 3962
Registered No. 1

1. PLACE OF DEATH.

County of Idaho
City of Claribel

Registration District No. 22 10

Primary Registration District No. 2128-2043

(No. , St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Mary J Davis

If death occurred in a hospital, institution or camp give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX

Female

4. COLOR OR RACE

White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED.

Married
(Write the word.)

6. DATE OF BIRTH

October 14 1896
(Month) (Day) (Year)

7. AGE

76 yrs. 2 mos. 21 ds.

IF LESS than 1 day
how many.....hrs. or
min?

8. OCCUPATION

(a) Trade, profession or particular kind of work.

House Keeper

(b) General nature of industry business or establishment in which employed (or employer).

9. BIRTHPLACE

(State or Country)

Pa.

10. NAME OF FATHER

John Varratta

11. BIRTHPLACE OF FATHER

(State or Country)

Pa.

12. MAIDEN NAME OF MOTHER

Nancy S. Dinsmore

13. BIRTHPLACE OF MOTHER

(State or Country)

Pa.

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

Ed W. Adams for J. M. Davis

(Address)

Kamiah Idaho

15.

Filed January 7 1913

E. Taylor
Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH

January 4 1913
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from Dec 28 1912, to January 4 1913.

that I last saw her alive on Jan 3 1913

and that death occurred on the date stated above, at 12:40 P.M.

The CAUSE OF DEATH* was as follows:

Pneumonia Fever

14 days (Duration) yrs. mos. ds.

Contributory (Secondary)

(Duration) yrs. mos. ds.

(Signed)

E. Taylor M. D.
Jan 5 1913 (Address) Kamiah

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place

In the

of death yrs. mos. ds. State yrs. mos. ds.

Where was disease contracted,

If not at place of death?

Former or

usual residence.

19. PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

Kamiah

Jan 6 1913

20. UNDERTAKER

ADDRESS

C. E. Johnson

Kamiah

Form V. S. No. 5 20M.1-16-12

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH

Registration District No. 26County of Wash.Primary Registration District No. 2112City of Weiser.(No. 2112 East of Weiser St.)File No. 3963Registered No. 1

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Frank Ray

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX Male4. COLOR OR RACE White5. SINGLE, MARRIED, WIDOWED OR DIVORCED. Single
(Write the word.)6. DATE OF BIRTH Jan. - 18 1893
(Month) (Day) (Year)7. AGE 19 yrs. 11 mos. 28 ds.IF LESS than 1 day
how many hrs. or
..... mins.?

8. OCCUPATION

- (a) Trade, profession or particular kind of work
-
- (b) General nature of industry, business, or establishment in which employed (or employer)

Farmer

9. BIRTHPLACE

(State or Country) Idaho County; Idaho.10. NAME OF FATHER Henry Ray11. BIRTHPLACE OF FATHER State of Ky.
(State or Country)12. MAIDEN NAME OF MOTHER Lura Malhorn13. BIRTHPLACE OF MOTHER State of Calif.
(State or Country)

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Henry Ray(Address) Weiser; Idaho.

15.

Filed Jan 3rd 1913W. R. Hamilton
Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH Jan. - 2 - 1913
(Month) (Day) (Year)17. I HEREBY CERTIFY, That I attended deceased from 191 to 191,
that I last saw him not alive on 191,
and that death occurred on the date stated above, at 4:30 A.M.

The CAUSE OF DEATH* was as follows:

Accidental; by being hit by railway engine.

(Duration) yrs. mos. ds.

Contributory
(Secondary)

(Duration) yrs. mos. ds.

(Signed) R. M. Bowen; CoronerJan 3-1913 (Address) Weiser, Ida.

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death yrs. mos. days. In the State yrs. mos. days.

Where was disease contracted if not at place of death?

Former or usual residence.

19. PLACE OF BURIAL OR REMOVAL Weiser IdahoDATE OF BURIAL Jan - 4 191320. UNDERTAKER A. G. CorbilleADDRESS Weiser; Ida.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Form V. S. No. 5. 12½ M. 7-24-11

CERTIFICATE OF DEATH

1. PLACE OF DEATH
County of Washington
City of Wenatchee

Registration District No. 26
Primary Registration District No. 1010
(No. East Main St.)

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics
File No. 3965
Registered No. 3

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

Albert Sheppard Dawson

If death occurred in a hospital, institution or camp give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX Male 4. COLOR OR RACE Wht 5. SINGLE, MARRIED, WIDOWED OR DIVORCED. Married
(Write the word.)

6. DATE OF BIRTH Dec 13 1849
(Month) (Day) (Year)

7. AGE 66 yrs. 26 mos. 26 ds. IF LESS than 1 day how many.....hrs. or min?

8. OCCUPATION
(a) Trade, profession or particular kind of work
(b) General nature of industry business or establishment in which employed (or employer)

Blacksmith

9. BIRTHPLACE
(State or Country)

Virginia

10. NAME OF FATHER

Thomas Dawson

11. BIRTHPLACE OF FATHER
(State or Country)

Virginia

12. MAIDEN NAME OF MOTHER

Sallie Fortune

13. BIRTHPLACE OF MOTHER
(State or Country)

Virginia

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Rebecca M. Dawson
(Address) Wenatchee Ida

15.

Filed Jan 10 1913

M. R. Hamilton
Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH

Jan 9 1913
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from 1/8 1913, to 1/9 1913
that I last saw him alive on 1/9 1913
and that death occurred on the date stated above, at 12:30 M.

The CAUSE OF DEATH* was as follows:

Lobar Pneumonia and Bronchitis.

(Duration) yrs. mos. 14 ds.

Contributory
(Secondary)

(Duration) yrs. mos. ds.

(Signed) E. T. Anderson, M. D.
1/10 1913 (Address) Wenatchee Ida

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death.....yrs.....mos.....ds. State.....yrs.....mos.....ds.
Where was disease contracted,
If not at place of death?
Former or usual residence.....

19. PLACE OF BURIAL OR REMOVAL DATE OF BURIAL

Wenatchee Jan 11 1913

20. UNDERTAKER ADDRESS

L. C. Northam Wenatchee Ida

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Form V. S. No. 5. 12½ M. 7-24-11

CERTIFICATE OF DEATH

1. PLACE OF DEATH
County of Washington
City of Wenatchee

Registration District No. 21
Primary Registration District No. 2112
(No. R. I. & No. 1 St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

Harry Edward Word.

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

File No. 3967Registered No. 5

If death occurred in a hospital, institution or camp give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX 4. COLOR OR RACE 5. SINGLE, MARRIED, WIDOWED OR DIVORCED.

Male

White

(Write the word.)

6. DATE OF BIRTH

July

10

1913

(Month)

(Day)

(Year)

7. AGE

9

yrs.

6

mos.

7

ds.

IF LESS than 1 day
how many.....hrs. or
.....min?

8. OCCUPATION

(a) Trade, profession or particular kind of work.....

(b) General nature of industry business or establishment in which employed (or employer)

9. BIRTHPLACE

(State or Country)

Dunkirk, Ore

10. NAME OF FATHER

Galen E. Word.

11. BIRTHPLACE OF FATHER

(State or Country)

Kansas

12. MAIDEN NAME OF MOTHER

Kate Redfield

13. BIRTHPLACE OF MOTHER

(State or Country)

Michigan

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

Galen E. Word.

(Address)

Wenatchee

15.

Filed Jan 17 1913

V. R. Kaudin

Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH

Jan

16

1913

(Month)

(Day)

(Year)

17. I HEREBY CERTIFY, That I attended deceased from

Jan. 15 1913, to Jan. 16 1913

that I last saw him alive on Jan. 16 1913

and that death occurred on the date stated above, at 8 A. M.

The CAUSE OF DEATH* was as follows:

Influenza

(Duration)

yrs.

mos.

7

ds.

Contributory
(Secondary)

(Duration)

yrs.

mos.

ds.

(Signed)

H. M. Mitchell

M. D.

Jan. 16 1913 (Address) Dunkirk, Ida

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place

In the

of death.....yrs.....mos.....ds. State.....yrs.....mos.....ds.

Where was disease contracted,

If not at place of death?

Former or

usual residence.....

19. PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

Wenatchee

Jan 18 1913

20. UNDERTAKER

ADDRESS

L. E. North

Wenatchee

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Form V. S. No. 5. 12½ M. 7-24-11

CERTIFICATE OF DEATH

1. PLACE OF DEATH. Registration District No. 26
County of Washington Primary Registration District No. 1010
City of Waukegan (No. _____, _____ St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

Harry A. Robb

BOARD OF HEALTH
Bureau of Vital Statistics

File No. 3968

Registered No. 6

If death occurred in a hospital, institution or camp give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX Male 4. COLOR OR RACE Wht 5. SINGLE, MARRIED, WIDOWED OR DIVORCED. married
(Write the word.)

6. DATE OF BIRTH Jan 7 1896
(Month) (Day) (Year)

7. AGE 36 yrs. 6 mos. 19 ds. IF LESS than 1 day
how many _____ hrs. or _____ min?

8. OCCUPATION
(a) Trade, profession or particular kind of work. Merchant
(b) General nature of industry business or establishment in which employed (or employer) Retail Clothing Store

9. BIRTHPLACE (State or Country) Creston, Iowa

10. NAME OF FATHER W. H. Robb

11. BIRTHPLACE OF FATHER (State or Country) Penn.

12. MAIDEN NAME OF MOTHER Kate White

13. BIRTHPLACE OF MOTHER (State or Country) Penn.

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Glodstone Robb
(Address) Waukegan, Ida

15. Filed Jan 27 1913 W. R. Hauck
Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH Jan 26 1913
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from _____ 191____, to _____ 191____

that I last saw h_____ alive on _____ 191____

and that death occurred on the date stated above, at _____ M.

The CAUSE OF DEATH* was as follows:
Found dead in bed died before
Physician arrived

_____ (Duration) _____ yrs. _____ mos. _____ ds.

Contributory (Secondary) _____

_____ (Duration) _____ yrs. _____ mos. _____ ds.

(Signed) James T. McCann MD
Jan 26 1913 (Address) Waukegan, Ida

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place _____ In the _____
of death _____ yrs. _____ mos. _____ ds. State _____ yrs. _____ mos. _____ ds.

Where was disease contracted, _____
If not at place of death? _____
Former or _____
usual residence _____

19. PLACE OF BURIAL OR REMOVAL DATE OF BURIAL

Waukegan, Ida _____ 191____

20. UNDERTAKER ADDRESS

L. E. McKinnon Waukegan, Ida

Form V. S. No. 5 20M.1-16-12

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics
File No. **3969**
Registered No. **7**

1. PLACE OF DEATH.

Registration District No. **26**

County of **Neach**

Primary Registration District No. **2112**

City of **Weiser**

(No. **Monroe Crk. 18 mi above Weiser**)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

Charles Bronquett Smith

PERSONAL AND STATISTICAL PARTICULARS

3. SEX **M.**

4. COLOR OR RACE **White**

5. SINGLE, MARRIED, WIDOWED OR DIVORCED. **Married**
(Write the word.)

6. DATE OF BIRTH

July - 5 - 1827
(Month) (Day) (Year)

7. AGE

86 yrs. **6** mos. **23** ds.

IF LESS than 1 day
how many hrs. or
..... mins.?

8. OCCUPATION

(a) Trade, profession or particular kind of work

Farmer

(b) General nature of industry business, or establishment in which employed (or employer)

9. BIRTHPLACE

(State or Country)

Trumble Co., Ohio

10. NAME OF FATHER

Walter F. Smith

11. BIRTHPLACE OF FATHER

(State or Country)

State of Vermont

12. MAIDEN NAME OF MOTHER

— Bronquett

13. BIRTHPLACE OF MOTHER

(State or Country)

Unknown

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

J. Will Smith

(Address)

Weiser, Ida.

15.

Filed

Jan - 30

1913

W. R. Hamilton

Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH

Jan. - 27 - 1913
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from **June - 1912**, to **Jan - 25 - 1913**, that I last saw him alive on **Jan - 25 - 1913**, and that death occurred on the date stated above, at **6:30 P.M.**

The CAUSE OF DEATH* was as follows:

Chronic Pericarditis Myocarditis

(Duration) **Several** yrs. mos. ds.

Contributory (Secondary)

(Duration) yrs. mos. ds.

(Signed)

W. R. Hamilton

M. D.

1913 (Address) **Weiser, Ida.**

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death. yrs. mos. days. In the State. yrs. mos. days.

Where was disease contracted if not at place of death?

Former or usual residence.

19. PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

Weiser, Ida.

Jan - 30 - 1913

20. UNDERTAKER

ADDRESS

R. G. Cordell

Weiser, Ida.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Form V. S. No. 5. 12½ M. 7-24-11

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics
File No. 3970
Registered No. 31

1. PLACE OF DEATH. Registration District No. 26
County of Washington Primary Registration District No. 2113
City of Medvale (No. _____, _____ St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

Emma Lorton

If death occurred in a hospital, institution or camp give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX 4. COLOR OR RACE 5. SINGLE, MARRIED, WIDOWED OR DIVORCED.

Female

W

Married
(Write the word.)

6. DATE OF BIRTH

Sept 15 1846
(Month) (Day) (Year)

7. AGE

66 yrs. 4 mos. 12 ds.

IF LESS than 1 day
how many hrs. or
..... min?

8. OCCUPATION

(a) Trade, profession or particular kind of work

House Wife

(b) General nature of industry business or establishment in which employed (or employer)

9. BIRTHPLACE

(State or Country)

Missouri

10. NAME OF FATHER

Richard Estes

11. BIRTHPLACE OF FATHER

(State or Country)

Kentucky

12. MAIDEN NAME OF MOTHER

Sarah Martin

13. BIRTHPLACE OF MOTHER

(State or Country)

Kentucky

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

(Address)

John Hallstrom
Medvale Idaho

15.

Filed Jan 30 1913

Falschmidt
Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH

Jan 27 1913
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from

Jan 1 - 1913, to Jan 27 - 1913

that I last saw her alive on Jan 26 - 1913

and that death occurred on the date stated above, at 9 A.M.

The CAUSE OF DEATH* was as follows:

Senility

..... (Duration) yrs. mos. ds.

Contributory
(Secondary)

..... (Duration) yrs. mos. ds.

(Signed) Falschmidt M. D.

Jan 31 1913 (Address) Medvale

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place

In the

of death yrs. mos. ds. State yrs. mos. ds.

Where was disease contracted,

If not at place of death?

Former or

usual residence

19. PLACE OF BURIAL OR REMOVAL DATE OF BURIAL

Medvale Cemetery

Jan 28 1913

20. UNDERTAKER

ADDRESS

H. G. Irving

Medvale

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PARENTS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

1. PLACE OF DEATH County of <u>Beaver Lake</u> City of <u>Nounaw</u>		Registration District No. <u>29</u> Primary Registration District No. <u>2095</u> (No. _____ St.)	File No. <u>3971</u> Registered No. <u>7</u>
If death occurs away from usual residence, give facts called for under special information.		2. FULL NAME <u>Elizabeth Ann Skinner</u> If death occurred in a hospital, institution or camp give its NAME instead of street and number.	
PERSONAL AND STATISTICAL PARTICULARS			
3. SEX <u>Female</u>	4. COLOR OR RACE <u>White</u>	5. SINGLE, MARRIED, WIDOWED OR DIVORCED. <u>Married</u> (Write the word.)	
6. DATE OF BIRTH <u>June 13 1869</u> (Month) (Day) (Year)			
7. AGE <u>44</u> yrs. <u>5</u> mos. <u>25</u> ds.		IF LESS than 1 day how many _____ hrs. or _____ min?	
8. OCCUPATION (a) Trade, profession or particular kind of work. <u>Housework</u> (b) General nature of industry business or establishment in which employed (or employer) _____			
9. BIRTHPLACE (State or Country) <u>Utah</u>			
10. NAME OF FATHER <u>David Hunter</u>			
11. BIRTHPLACE OF FATHER (State or Country) <u>Scotland</u>			
12. MAIDEN NAME OF MOTHER <u>Mary Hughes</u>			
13. BIRTHPLACE OF MOTHER (State or Country) <u>Scotland</u>			
14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE (Informant) <u>David Skinner</u> (Address) <u>Nounaw, Idaho</u>			
15. Filed <u>John F.</u> - 191 <u>3</u> <u>John F. Skinner</u> Local Registrar			
MEDICAL CERTIFICATE OF DEATH.			
16. DATE OF DEATH <u>Jan 7 1913</u> (Month) (Day) (Year)			
17. I HEREBY CERTIFY, That I attended deceased from <u>Jan 7 1913</u> , to <u>Jan 7 1913</u> that I last saw him alive on <u>Jan 7 1913</u> and that death occurred on the date stated above, at <u>5:58</u> M. The CAUSE OF DEATH* was as follows: <u>Pneumonia (Bronchial)</u>			
_____ (Duration) _____ yrs. _____ mos. _____ ds. Contributory (Secondary) <u>Asphyxia</u> (Duration) _____ yrs. _____ mos. _____ ds. (Signed) <u>Dr. J. B. Skiff</u> <u>Jan 8 1913</u> (Address) <u>Monrovia</u> *State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.			
18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.) At place <u>27</u> yrs. _____ mos. _____ ds. In the _____ of death _____ yrs. _____ mos. _____ ds. State _____ yrs. _____ mos. _____ ds. Where was disease contracted, _____ If not at place of death? _____ Former or usual residence _____			
19. PLACE OF BURIAL OR REMOVAL <u>Nounaw</u>		DATE OF BURIAL <u>Jan 10 1913</u>	
20. UNDERTAKER <u>None</u>		ADDRESS <u>—</u>	

WRITE PROMINENTLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Form V. S. No. 5. 12½ M. 7-24-11

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics
File No. 3972
Registered No. 8

1. PLACE OF DEATH Registration District No. 24
County of Bear Lake Primary Registration District No. 2093
City of Sharon (No. St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

Biechie Long

If death occurred in a hospital, institution or camp give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX F. 4. COLOR OR RACE White 5. SINGLE/MARRIED, WIDOWED OR DIVORCED. Single
(Write the word.)

6. DATE OF BIRTH Jan 20 1905
(Month) (Day) (Year)

7. AGE 7 yrs. 4 mos. 16 ds. IF LESS than 1 day how many hrs. or min?

8. OCCUPATION

(a) Trade, profession or particular kind of work. School girl
(b) General nature of industry business or establishment in which employed (or employer)

9. BIRTHPLACE (State or Country) Bloomington, Ida.

10. NAME OF FATHER Levi H. Long

11. BIRTHPLACE OF FATHER Wyoming Idaho
(State or Country)

12. MAIDEN NAME OF MOTHER Grace Davidson

13. BIRTHPLACE OF MOTHER Wyoming
(State or Country)

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) L. H. Long
(Address) Sharon Ida

15.

Filed Jan 8 1913 J. E. Hymasky Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH Jan. 6 1913
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from Dec 14 1912, to Jan. 6 1913
that I last saw her alive on Jan 1 1913
and that death occurred on the date stated above, at 3:40 P.M.
The CAUSE OF DEATH* was as follows:

Cerebro spinal meningitis
(Duration) yrs. mos. 22 ds.

Contributory (Secondary)

(Duration) yrs. mos. ds.
(Signed) J. E. Hymasky M. D.
Jan 7 1913 (Address) Paris Idaho

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place In the
of death yrs. mos. ds. State yrs. mos. ds.
Where was disease contracted,
If not at place of death?
Former or usual residence.

19. PLACE OF BURIAL OR REMOVAL DATE OF BURIAL
Bloomington Ida Jan. 9 1913

20. UNDERTAKER ADDRESS
D. E. Hymasky Sharon Ida

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Form V. S. No. 5. 12½ M. 7-24-11

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics
File No. 3973
Registered No.

1. PLACE OF DEATH. Registration District 24
County of Bear Lake Primary Registrar
City of Blomington (No. St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

Cleo.

Parlier

If death occurred in a hospital, institution or camp give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX Male
4. COLOR OR RACE White
5. SINGLE, MARRIED, WIDOWED OR DIVORCED Single
(Write the word.)

6. DATE OF BIRTH 9 29 1913
(Month) (Day) (Year)

7. AGE 3 20
yrs. mos. ds. IF LESS than 1 day how many hrs. or min?

8. OCCUPATION

(a) Trade, profession or particular kind of work.

No occupation

(b) General nature of industry business or establishment in which employed (or employer)

9. BIRTHPLACE

(State or Country)

Blomington

10. NAME OF FATHER

G. E. B. Parlier

11. BIRTHPLACE OF FATHER

(State or Country)

Idaho

12. MAIDEN NAME OF MOTHER

Della S. Thorne

13. BIRTHPLACE OF MOTHER

(State or Country)

Idaho

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

(Address)

William J. Parlier

Blomington

15.

Filed

Jan 24 1913

Local Registrar

16. DATE OF DEATH

Jan 21 1913
(Month) (Day) (Year)

17. I HEREBY CERTIFY, I attended deceased from 191 to 191

that I last saw him alive on 191

and that death occurred on the date stated above, at M.

The CAUSE OF DEATH* was as follows:

This baby died very suddenly apparently not sick. His mother awoke and found it dead.

(Duration) yrs. mos. ds.

Contributory

(Secondary)

I saw it P.M.

(Duration) yrs. mos. ds.

(Signed)

M. D.

18-28 1913 (Address) Paris, Idaho
*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place

In the

of death yrs. mos. ds. State yrs. mos. ds.

Where was disease contracted,

If not at place of death?

Former or

usual residence.

19. PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

Blomington

Jan 25 1913

20. UNDERTAKER

ADDRESS

Alma Lively

Blomington

State of Idaho
BOARD OF HEALTH
Bureau of Vital StatisticsFile No. 3974Registered No. 2

If death occurred in a hospital, institution or camp give its NAME instead of street and number.

1. PLACE OF DEATH. Registration District No. 24
County of Bear Lake Primary Registration District No. 2098
City of Montpelier (No. _____, St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Kathrina Agerter

PERSONAL AND STATISTICAL PARTICULARS

3. SEX 4. COLOR OR RACE 5. SINGLE, MARRIED, WIDOWED OR DIVORCED.

Female White Married
(Write the word.)6. DATE OF BIRTH July 9th 1843
(Month) (Day) (Year)7. AGE 69 yrs. 5 mos. 24 ds. IF LESS than 1 day how many _____ hrs. or _____ min?8. OCCUPATION Housewife
(a) Trade, profession or particular kind of work.
(b) General nature of industry business or establishment in which employed (or employer) _____9. BIRTHPLACE Switzerland
(State or Country)10. NAME OF FATHER John Lemon11. BIRTHPLACE OF FATHER Switzerland
(State or Country)12. MAIDEN NAME OF MOTHER Bieri13. BIRTHPLACE OF MOTHER Switzerland
(State or Country)

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Fredrick R. Agerter
(Address) Montpelier15. Filed Jan 8 1913 Justus Wenz
Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH Jan 2 1913
(Month) (Day) (Year)17. I HEREBY CERTIFY, That I attended deceased from Dec 26 1912, to Jan 2 1913
that I last saw her alive on Jan 2 1913
and that death occurred on the date stated above, at Montpelier
The CAUSE OF DEATH* was as follows:
neurotic (Croupous)(Duration) _____ yrs. _____ mos. 7 ds.

Contributory (Secondary) _____

(Signed) Charles E. Bailey M. D.
Jan 4 1913 (Address) Montpelier

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place 24 yrs. _____ mos. _____ ds. In the 24 yrs. _____ mos. _____ ds.
of death _____
Where was disease contracted, _____
If not at place of death? _____
Former or usual residence. _____

19. PLACE OF BURIAL OR REMOVAL DATE OF BURIAL

Montpelier Jan 5th 1913

20. UNDERTAKER ADDRESS

None _____

1. PLACE OF DEATH. Registration District No. 2098
 County of Bear Lake Primary Registration District No. 2098
 City of Montpelier (No. _____, _____ St.)

Bureau of Vital Statistics
 File No. 3975
 Registered No. _____

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Mrs. Rebecca Rees Thomas

If death occurred in a hospital, institution or camp give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX Female 4. COLOR OR RACE White 5. SINGLE, MARRIED, WIDOWED OR DIVORCED. Widowed
 (Write the word.)

6. DATE OF BIRTH December 11th 1842
 (Month) (Day) (Year)

7. AGE 70 yrs. 25 mos. 25 ds. IF LESS than 1 day
 how many hrs. or min?

8. OCCUPATION
 (a) Trade, profession or particular kind of work House work
 (b) General nature of industry business or establishment in which employed (or employer)

9. BIRTHPLACE S.B.
 (State or Country) Pembrokeshire, South Wales

10. NAME OF FATHER Thomas Rees

11. BIRTHPLACE OF FATHER S.B.
 (State or Country) Pembrokeshire, South Wales

12. MAIDEN NAME OF MOTHER Rebecca Williams

13. BIRTHPLACE OF MOTHER S.B.
 (State or Country) Pembrokeshire, South Wales

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
 (Informant) E. J. Thomas
 (Address) Granger Way

15. Filed Jan 8 1913 J. W. H. W. W.
 Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH Jan 5 1913
 (Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from Jan 1 1912, to Jan 5 1913
 that I last saw him alive on Jan 5 1913
 and that death occurred on the date stated above, at M.

The CAUSE OF DEATH* was as follows:

Caesura
of liver
 (Duration) yrs. mos. ds.

Contributory (Secondary)

(Duration) yrs. mos. ds.
 (Signed) Chas. and Esal
Jan 6 1913 (Address) Montpelier

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death yrs. mos. ds. In the yrs. mos. ds.
 Where was disease contracted,
 If not at place of death?
 Former or usual residence.

19. PLACE OF BURIAL OR REMOVAL DATE OF BURIAL

Montpelier Rd 1-8 1913

20. UNDERTAKER ADDRESS

None

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Form V. S. No. 5. 12½ M. 7-24-11

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH
County of Blaine Registration District No. 24
City of Montpelier (No. _____ St.)
Primary Registration District No. 2098

File No. 3976

Registered No. 1

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Charles J. Barker

If death occurred in a hospital, institution or camp give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX Male 4. COLOR OR RACE White 5. SINGLE, MARRIED, WIDOWED OR DIVORCED. Married
(Write the word.)
6. DATE OF BIRTH 6 18 1843
(Month) (Day) (Year)

7. AGE 69 yrs. 7 mos. 11 ds. IF LESS than 1 day
how many hrs. or min?

8. OCCUPATION
(a) Trade, profession or particular kind of work. Day Laborer
(b) General nature of industry business or establishment in which employed (or employer).

9. BIRTHPLACE
(State or Country) England

10. NAME OF FATHER John H. Barker

11. BIRTHPLACE OF FATHER
(State or Country) England

12. MAIDEN NAME OF MOTHER Annie De Lapp

13. BIRTHPLACE OF MOTHER
(State or Country) England

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) E. F. Geyser
(Address) Montpelier Ida.

15. Filed Feb. 8 1913 J. J. Geyser
Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH 1 29 1913.
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from Jan 6 1913, to Jan 29 1913
that I last saw him alive on Jan 29 1913
and that death occurred on the date stated above, at 11 P. M.

The CAUSE OF DEATH* was as follows:
Pulmonary Emphysema
following chronic bronchitis
asthma
(Duration) 2 yrs. — mos. — ds.

Contributory (Secondary) _____
(Duration) _____ yrs. _____ mos. _____ ds.
(Signed) E. F. Geyser M. D.
1/31 1913 (Address) Montpelier Ida.

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; (2) whether ACCIDENTAL, SUICIDAL OR HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place In the
of death. yrs. mos. ds. State. yrs. mos. ds.
Where was disease contracted,
If not at place of death?

Former or usual residence.

19. PLACE OF BURIAL OR REMOVAL Montpelier DATE OF BURIAL 1-31-1913

20. UNDERTAKER Vincent Bros. ADDRESS Montpelier

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Form V. S. No. 5. 12½ M. 7-24-11

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH. Registration District No. 24
County of Bear Lake Primary Registration District No. 2098
City of Montpelier (No. _____, _____ St.)

File No. 3977
Registered No. _____

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME John Messerly

If death occurred in a hospital, institution or camp give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX male 4. COLOR OR RACE White 5. SINGLE, MARRIED, WIDOWED OR DIVORCED. Divorced
(Write the word.)

6. DATE OF BIRTH Jan Tenth 1849
(Month) (Day) (Year)

7. AGE 63 yrs. 11 mos. 27 ds. IF LESS than 1 day how many _____ hrs. or _____ min?

8. OCCUPATION
(a) Trade, profession or particular kind of work. Mason
(b) General nature of industry business or establishment in which employed (or employer)

9. BIRTHPLACE
(State or Country) Bern Switzerland

10. NAME OF FATHER John Messerly

11. BIRTHPLACE OF FATHER
(State or Country) Bern Switzerland

12. MAIDEN NAME OF MOTHER Marije Danzert

13. BIRTHPLACE OF MOTHER
(State or Country) Bern Switzerland

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) John J. Messerly Jr.
(Address) Montpelier Idaho

15. John E. - 1913 John Howard
Filed Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH Jan 6 1913
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from Dec 16 1911, to Jan 6 1913
that I last saw him alive on Jan 3 1913
and that death occurred on the date stated above, at _____ M.
The CAUSE OF DEATH* was as follows:
Croupous

_____ (Duration) _____ yrs. _____ mos. _____ ds.

Contributory (Secondary) Basin

_____ (Duration) _____ yrs. _____ mos. _____ ds.

(Signed) Philip G. Cooley D.
Jan 6 1913 (Address) Montpelier

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death _____ yrs. _____ mos. _____ ds. State _____ yrs. _____ mos. _____ ds.
Where was disease contracted, If not at place of death?
Former or usual residence Montpelier Idaho

19. PLACE OF BURIAL OR REMOVAL DATE OF BURIAL

Montpelier Idaho Jan 9 1913
20. UNDERTAKER ADDRESS
None

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
N. B.—Every item of information should be carefully supplied. AGE should be state EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Form V. S. No. 5. 10M. 6-20-11.

1. PLACE OF DEATH.

County of Ada
City of Boise

If death occurs away from usual residence, give facts called for under special information.

Registration District No. _____

Primary Registration District No. _____

(No. 112, E. Banuock St.)

2. FULL NAME

Lejiti Hausabrow

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

File No. 32981Registered No. 36

If death occurred in a hospital, institution or camp give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX

Male

4. COLOR OR RACE 5. SINGLE, MARRIED, WIDOWED OR DIVORCED.

YellowSingle
(Write the word.)

6. DATE OF BIRTH

1867
(Month) (Day) (Year)

7. AGE

45 yrs. — mos. — ds.
IF LESS than 1 day
how many hrs. or
..... min.?

8. OCCUPATION

(a) Trade, profession, or particular kind of work

book

(b) General nature of industry business, or establishment in which employed (or employer)

9. BIRTHPLACE

(State or Country)

Japan

10. NAME OF FATHER

Not obtainable

11. BIRTHPLACE OF FATHER

(State or Country)

Not obtainable

12. MAIDEN NAME OF MOTHER

Not obtainable

13. BIRTHPLACE OF MOTHER

(State or Country)

not obtainable

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

Charlie Harv

(Address)

Boise

15.

Filed 2 - 31913Ed McConnel

Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

Feb. 3 1913
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from

Jan. 20 - 1913, to Feb. 3 1913
that I last saw him alive on Feb. 3 1913,

and that death occurred on the date stated above, at 9 1/2 M.

The CAUSE OF DEATH* was as follows:

Cardiac failure(Duration) _____ yrs. 6 mos. _____ ds.

Contributory (Secondary)

(Duration) _____ yrs. _____ mos. _____ ds.

(Signed)

Feb. 3 1913 (Address) Boise Idaho

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place St. Lukes Hospital
of death _____ yrs. _____ mos. _____ ds. State _____ yrs. _____ mos. _____ ds.

Where was Disease contracted,

If not at place of death?

Former or

usual residence. C. Nyssa as Ore

19. PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

Harris Hill Cemetery
Ada County Plot

3/4 1913

20. UNDERTAKER

ADDRESS

Schreiber & Sidenfaden

Boise

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Form V. S. No. 5 20M.1-16-12

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH.

Registration District No.

County of *Ada*

Primary Registration District No.

City of *Boise*

(No. *410 State* St.)

File No. *3982*

Registered No. *41*

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME *Peter O. Corner*

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX

Male

4. COLOR OR RACE

White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED.

Single
(Write the word.)

6. DATE OF BIRTH

not obtainable *854*
(Month) (Day) (Year)

7. AGE

68 yrs. — mos. — ds.

IF LESS than 1 day
how many hrs. or
..... mins.?

8. OCCUPATION

(a) Trade, profession or particular kind of work

Miner

(b) General nature of industry, business, or establishment in which employed (or employer)

9. BIRTHPLACE

(State or Country)

Canada

10. NAME OF FATHER

Thos. O. Corner

11. BIRTHPLACE OF FATHER

(State or Country)

Ireland

12. MAIDEN NAME OF MOTHER

Ann Heyburn

13. BIRTHPLACE OF MOTHER

(State or Country)

Ireland

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

F. O. Corner

(Address)

Boise, Idaho

15.

Filed

2 — 10

1913

W. M. Corner

Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH

Feb *9* 1913
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from

2/3 1913, to *2/9* 1913

that I last saw him alive on *2/9* 1913

and that death occurred on the date stated above, at *5 A.M.*

The CAUSE OF DEATH* was as follows:

Bright's disease

(Duration) *1* yrs. mos. ds.

Contributory
(Secondary)

(Duration) yrs. mos. ds.

(Signed) *James H. Stewart* M. D.

10 1913 (Address) *Boise, Idaho*

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

St. Alphonsus Hospital
At place of death yrs. mos. days. In the State yrs. mos. days.

Where was disease contracted if not at place of death?

Former or usual residence *Horse shoe Bend, Idaho*

19. PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

St. Johns Cemetery *2/11* 1913

20. UNDERTAKER

ADDRESS

Schreiber & Tidewater *Boise, Idaho*

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Form V. S. No. 5 20M.1-16-12

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics
File No. **3983**

Registered No. **54**

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

1. PLACE OF DEATH.

Registration District No.

County of Ada

Primary Registration District No.

City of Boise(No. Boise River)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Harry G. Lasky

PERSONAL AND STATISTICAL PARTICULARS

3. SEX 4. COLOR OR RACE 5. SINGLE, MARRIED, WIDOWED OR DIVORCED.

MaleWhiteSingle
(Write the word.)

6. DATE OF BIRTH

Not ascertainable

(Month)

(Day)

(Year)

7. AGE

24

yrs. mos. ds.

IF LESS than 1 day
how many hrs. or
..... mins.?

8. OCCUPATION

(a) Trade, profession or particular kind of work

Lawman

(b) General nature of industry business, or establishment in which employed (or employer)

9. BIRTHPLACE

(State or Country)

Mexico

10. NAME OF FATHER

Nathan T Lasky

11. BIRTHPLACE OF FATHER

(State or Country)

Virginia

12. MAIDEN NAME OF MOTHER

May Murphy

13. BIRTHPLACE OF MOTHER

(State or Country)

American

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

(Address)

Earl A. Lasky
Ontario Ore

15.

Filed

2-201913Ed McConnel

Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH

Feb.171913

(Month)

(Day)

(Year)

17. I HEREBY CERTIFY, That I attended deceased from

dead Feb. 17, 1913
that I last saw alive on 1913

and that death occurred on the date stated above, 1913

The CAUSE OF DEATH* was as follows:

Drowning with suicidal intent

(Duration) yrs. mos. ds.

Contributory
(Secondary)

(Duration) yrs. mos. ds.

(Signed) Adolph Schreyer19 (Address) of Ada County

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death yrs. mos. days. In the State yrs. mos. days.

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

Oulario OregonFeb. 20 1913

20. UNDERTAKER

ADDRESS

Schreyer & HidenfeldBoise

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Form V. S. No. 5 20M.1-16-12

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH.

Registration District No.

County of Ada

Primary Registration District No.

City of Boise(No. 6134 Yadon St.)File No. 3984Registered No. 57

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Tom Prusses

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX

Male

4. COLOR OR RACE

White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED.

Single
(Write the word.)

6. DATE OF BIRTH

Not obtainable
(Month) (Day) (Year)

7. AGE

about
24 yrs. — mos. — ds.IF LESS than 1 day
how many hrs. or
..... mins.?

8. OCCUPATION

(a) Trade, profession or particular kind of work

Labrador

(b) General nature of industry business, or establishment in which employed (or employer)

9. BIRTHPLACE

(State or Country)

Greece

10. NAME OF FATHER

Not obtainable

11. BIRTHPLACE OF FATHER

(State or Country)

"

12. MAIDEN NAME OF MOTHER

"

13. BIRTHPLACE OF MOTHER

(State or Country)

"

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

Adolph Schreiber

(Address)

Boise

15.

Filed

2-221913Edith M. Connel

Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH

Feb. 21 1913
(Month) (Day) (Year)17. I HEREBY CERTIFY, That I ~~attended~~ deceased ~~from~~
dead ~~1913~~ to Feb. 21 1913
that I last saw him alive on 1913and that death occurred on the date stated above, at M.

The CAUSE OF DEATH* was as follows:

asphyxiation by Gas
accident while working with Gas
Heater

(Duration) yrs. mos. ds.

Contributory

(Secondary)

(Duration) yrs. mos. ds.

(Signed)

Adolph Schreiber, M.D.

19.

(Address)

Boise, Ida.

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death yrs. mos. days. In the State yrs. mos. days.

Where was disease contracted if not at place of death?

Former or usual residence.

19. PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

Morris Hill Cemetery 2/23 1913

20. UNDERTAKER

ADDRESS

Schreiber & Hidenfaden Boise

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Form V. S. No. 5 20M.1-16-12

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH.

Registration District No. _____

County of Ada

Primary Registration District No. _____

City of Boise

(No. 803, N. 21st St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Mrs F. S. Hubbell

File No. 38 3985

Registered No. 38

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX Female 4. COLOR OR RACE White 5. SINGLE, MARRIED, WIDOWED OR DIVORCED. Married
(Write the word.)

6. DATE OF BIRTH July 16th 1868
(Month) (Day) (Year)

7. AGE 54 yrs 6 mos 15 ds.
IF LESS than 1 day how many hrs. or mins.?

8. OCCUPATION
(a) Trade, profession or particular kind of work Housekeeper
(b) General nature of industry, business, or establishment in which employed (or employer)

9. BIRTHPLACE Milford, Mich
(State or Country)

10. NAME OF FATHER Alexander Hubbell Finley

11. BIRTHPLACE OF FATHER Scotland
(State or Country)

12. MAIDEN NAME OF MOTHER Ann Riley

13. BIRTHPLACE OF MOTHER Ireland
(State or Country)

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Mrs. V. Stolle
(Address) Boise Idaho.

15. Filed 2-4 1913 LSM Connel
Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH Feb 1st 1913
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from Jan 27 1913, to Feb 1 1913, that I last saw her alive on Feb 1st 1913 and that death occurred on the date stated above, at 12 M.

The CAUSE OF DEATH* was as follows:

Diphtheria

(Duration) yrs. mos. 4 ds.

Contributory (Secondary)

(Duration) yrs. mos. ds.

(Signed) James H. Stewart M. D.

19. (Address)

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death yrs. mos. days. In the State yrs. mos. days.

Where was disease contracted if not at place of death?

Former or usual residence 803 N. 21st Boise, Idaho

19. PLACE OF BURIAL OR REMOVAL Milford Mich DATE OF BURIAL 2/5 1913

20. UNDERTAKER Schubert & Siderupden ADDRESS Boise

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Form V. S. No. 5 20M.1-16-12

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH

Registration District No. _____

County of Ada

Primary Registration District No. _____

City of Boise(No. 110, East Bannock St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Anna ShanahanFile No. 3986Registered No. 55

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX

4. COLOR OR RACE

5. SINGLE, MARRIED, WIDOWED OR DIVORCED.

Female WhiteMarried
(Write the word.)

6. DATE OF BIRTH

March 7th1891

(Month)

(Day)

(Year)

7. AGE

22 yrs. 11 mos. 14 ds.IF LESS than 1 day
how many hrs. or
..... mins.?

8. OCCUPATION

(a) Trade, profession or particular kind of work

House Keeper

(b) General nature of industry business, or establishment in which employed (or employer)

9. BIRTHPLACE

(State or Country)

Harley

10. NAME OF FATHER

Henry Daley

11. BIRTHPLACE OF FATHER

(State or Country)

California

12. MAIDEN NAME OF MOTHER

Cora Skiles

13. BIRTHPLACE OF MOTHER

(State or Country)

American

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

Anna T Daley(Address) 104 W. Bannock St. Boise, Ida.

15.

Filed 2 — 21 1913Ed McCune

Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

Feb211913

(Month)

(Day)

(Year)

17. I HEREBY CERTIFY, That I attended deceased from

Feb 15 1913, to Feb 21 1913,that I last saw her alive on Feb 20 1913,and that death occurred on the date stated above, at 6 A.M.

The CAUSE OF DEATH* was as follows:

Severe Depis(Duration) yrs. mos. 6 ds.Contributory Depis following malarial
(Secondary)(Duration) yrs. mos. 16 ds.(Signed) C. W. S. S. S. M. D.2-21 1913 (Address) Boise

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death yrs. mos. 6 days. In the State yrs. mos. days.Where was disease contracted if not at place of death? Idaho city - IdahoFormer or usual residence Idaho city

19. PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

Idaho City IdahoFeb. 23 1913

20. UNDERTAKER

ADDRESS

Schirba & SiderupadenBoise

WRITE INFORMATION, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Form V. S. No. 5 20M.1-16-12

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH.

Registration District No.

County of Ada

Primary Registration District No.

City of Boise

(No. 1022 N. 13th St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Angeline B. Millard

File No. 3987

Registered No. 122

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX

4. COLOR OR RACE

☒ SINGLE, MARRIED, WIDOWED OR DIVORCED
Married
(Write the word.)

Female

White American

6. DATE OF BIRTH

July 6 1829
(Month) (Day) (Year)

7. AGE

83 yrs. 7 mos. 6 ds.

IF LESS than 1 day
how many hrs. or
..... mins.?

8. OCCUPATION

(a) Trade, profession or particular kind of work

(b) General nature of industry, business, or establishment in which employed (or employer)

House Work

9. BIRTHPLACE

(State or Country)

N. J.

10. NAME OF FATHER

Jno Thorpe

11. BIRTHPLACE OF FATHER

(State or Country)

not obtainable

12. MAIDEN NAME OF MOTHER

Harriet Thorpe

13. BIRTHPLACE OF MOTHER

(State or Country)

not obtainable

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

E. L. Johnson

(Address)

1115 N 12 St

15.

Filed 7-12 1913

W. M. Connel
Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH

Feb 12 1913
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from

1913, to 1913,

that I last saw h..... alive on 1913,

and that death occurred on the date stated above, at 9 A M.

The CAUSE OF DEATH* was as follows:

Glopharyngitis

(Duration) yrs. mos. ds.

Contributory
(Secondary)

(Duration) yrs. mos. ds.

(Signed) E. L. Johnson M. D.

19 (Address) Boise Ida

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death yrs. mos. days. In the State yrs. mos. days.

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL DATE OF BURIAL

Masonic Cemetery Feb 14 1913

20. UNDERTAKER

ADDRESS

Tracy & Summers Boise

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Form V. S. No. 5 20M.1-16-12

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics
File No. 37 3988
Registered No. 37

1. PLACE OF DEATH.

County of Ada
City of Boise

Registration District

Primary Registration District No.

(No. 305, Boise St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Larinda J. White

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX

4. COLOR OR RACE

5. SINGLE, MARRIED, WIDOWED OR DIVORCED.

(Write the word.)

6. DATE OF BIRTH

(Month)

(Day)

(Year)

7. AGE

84 yrs. 2 mos. 17 ds.

IF LESS than 1 day
how many hrs. or
..... mins.?

8. OCCUPATION

(a) Trade, profession or particular kind of work

(b) General nature of industry, business, or establishment in which employed (or employer)

retired housekeeper

9. BIRTHPLACE

(State or Country)

Merica. Mo.

10. NAME OF FATHER

Temple Wayne

11. BIRTHPLACE OF FATHER

(State or Country)

Ky

12. MAIDEN NAME OF MOTHER

Larinda Payton

13. BIRTHPLACE OF MOTHER

(State or Country)

Ky.

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

Mrs R. Rounds

(Address)

Boise Idaho

15.

Filed

2 - 31913W. M. Council

Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH

(Month)

(Day)

1913

(Year)

17. I HEREBY CERTIFY, That I attended deceased from

Dec 13 1911, to Feb 2nd 1913,that I last saw her alive on Feb 2nd 1913,and that death occurred on the date stated above, at 10 P.M.

The CAUSE OF DEATH* was as follows:

Old age

(Duration)

yrs.

mos.

ds.

Contributory (Secondary)

Bronchitis

(Duration)

yrs.

mos.

ds.

(Signed)

J. E. Froosh M. D.1-2-1913 (Address) Boise Ida.

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death

yrs. mos. days.

In the State

yrs. mos. days.

Where was disease contracted if not at place of death?

Former or usual residence.

Baldwell Idaho

19. PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

Baldwell Idaho7 1913

20. UNDERTAKER

ADDRESS

Schmidt Siderfada Boise IdaDr. Froosh

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Form V. S. No. 5 20M.1-16-12

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH.

Registration District No.

County of Ada

Primary Registration District No.

City of Boise

(No. 1702 N. 10th St.)

File No. 3989

Registered No. 46

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Alice P. Conner Powers
If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX Female 4. COLOR OR RACE White 5. SINGLE, MARRIED, WIDOWED OR DIVORCED. Widow
(Write the word.)

6. DATE OF BIRTH Dec 23 1839
(Month) (Day) (Year)

7. AGE 73 yrs. 1 mos. 19 ds.
IF LESS than 1 day how many hrs. or mins.?

8. OCCUPATION
(a) Trade, profession or particular kind of work Retired Housekeeper
(b) General nature of industry, business, or establishment in which employed (or employer)

9. BIRTHPLACE Virginia
(State or Country)

10. NAME OF FATHER Edward Williams

11. BIRTHPLACE OF FATHER Am
(State or Country)

12. MAIDEN NAME OF MOTHER Jane King

13. BIRTHPLACE OF MOTHER Am
(State or Country)

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Eva Watts
(Address) Boise, Idaho.

15. Filed 2-13 1913 Edm. Connel
Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH Feb 12 1913
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from July 1902 to Feb 12 1913, that I last saw her alive on Feb 1 1913, and that death occurred on the date stated above, at 2 M. The CAUSE OF DEATH* was as follows:
Dropsy

(Duration) 3 yrs. mos. ds.
Contributory Nephritis
(Secondary)
(Duration) unknown yrs. mos. ds.
(Signed) W. J. Turkey M. D.
July 1913 (Address) Boise

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death yrs. mos. days. In the State yrs. mos. days.
Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL Worshipful Cemetery DATE OF BURIAL Feb. 13 1913
20. UNDERTAKER Schneiber & Widemeyer ADDRESS Boise

Dr Turkey

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Form V. S. No. 5 20M.1-16-12

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH.

Registration District No.

County of Ada

Primary Registration District No.

City of Boise(No. 1403, 77 15 St.)File No. 3990Registered No. 45

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Mrs Mary Eliza Bush

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX

Female

4. COLOR OR RACE

White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED.

Widow
(Write the word.)

6. DATE OF BIRTH

June 8 1847
(Month) (Day) (Year)

7. AGE

65 yrs. 8 mos. 4 ds.IF LESS than 1 day
how many hrs. or
..... mins.?

8. OCCUPATION

(a) Trade, profession or particular kind of work

Retired

(b) General nature of industry, business, or establishment in which employed (or employer)

9. BIRTHPLACE

(State or Country)

New Jersey

10. NAME OF FATHER

John O Johnson

11. BIRTHPLACE OF FATHER

(State or Country)

American

12. MAIDEN NAME OF MOTHER

Caroline Clark

13. BIRTHPLACE OF MOTHER

(State or Country)

American

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) C O Crane(Address) 1702 N 16 St

15.

Filed 2 - 13 1913C S McConnell
Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH

Feb 12 1913
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from

Feb 8th 1913, to Feb 11th 1913,that I last saw h. alive on Feb 11th 1913,and that death occurred on the date stated above, at 10 P. M.

The CAUSE OF DEATH* was as follows:

Congestion of Kidneys
(Duration) yrs. mos. 6 ds.Contributory
(Secondary)

(Duration) yrs. mos. ds.

(Signed)

John B. Smith M. D.
Feb 13 1913 (Address) Boise Id

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death yrs. mos. days. In the State yrs. mos. days.

Where was disease contracted if not at place of death?

Former or usual residence 1403 N 15 St / Boise

19. PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

Ashland Neb. Feb 14 1913

20. UNDERTAKER

ADDRESS

Schreiber & Hidenfoden Boise

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Form V. S. No. 5 20M.1-16-12

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital StatisticsFile No. 3991Registered No. 40

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

1. PLACE OF DEATH.

Registration District No.

County of Ada

Primary Registration District No.

City of Boise(No. 914 Offard St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Victoria Hamilton

PERSONAL AND STATISTICAL PARTICULARS

3. SEX

4. COLOR OR RACE

5. SINGLE, MARRIED, WIDOWED OR DIVORCED.

FemaleWhite AmericanMarried
(Write the word.)

6. DATE OF BIRTH

not obtainable 1897
(Month) (Day) (Year)

7. AGE

66 yrs. — mos. — ds.IF LESS than 1 day
how many hrs. or
..... mins.?

8. OCCUPATION

(a) Trade, profession or particular kind of work

House work.

(b) General nature of industry business, or establishment in which employed (or employer)

9. BIRTHPLACE

(State or Country)

Indiana

10. NAME OF FATHER

not obtainable

11. BIRTHPLACE OF FATHER

(State or Country)

12. MAIDEN NAME OF MOTHER

13. BIRTHPLACE OF MOTHER

(State or Country)

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

(Address)

V. Hamilton
914 Offard St.

15.

Filed 2 - 10 1913Ed M. Conner

Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH

Feb 9 1913
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from

Feb 9 1913 to Feb 9 1913that I last saw her alive on Feb 9 1913and that death occurred on the date stated above, at 11 P.M.

The CAUSE OF DEATH* was as follows:

Pneumonia

(Duration) yrs. mos. ds.

Contributory

(Secondary)

(Duration) yrs. mos. ds.

(Signed)

O. H. Parker

M. D.

19 (Address) 251 Sonoma Bldg.

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death yrs. mos. days. In the State yrs. mos. days.

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

Morris Hill CemeteryFeb 11 1913

20. UNDERTAKER

ADDRESS

Fry & SummersBoise, Ida.

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Form V. S. No. 5 20M.1-16-12

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH.

County of Ada

Registration District

City of Boise

Primary Registration District No.

(No. 2026 Harrison Beaul)

File No. 32-3992

Registered No. 32

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Alma Sanguinis

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX Female 4. COLOR OR RACE Wht 5. SINGLE, MARRIED, WIDOWED OR DIVORCED. Married
(Write the word)

6. DATE OF BIRTH

(Month) (Day) (Year)

7. AGE

43 yrs. 0 mos. 0 ds.

IF LESS than 1 day
how many hrs. or
mins.?

8. OCCUPATION

(a) Trade, profession or particular kind of work Housekeeper
(b) General nature of industry, business, or establishment in which employed (or employer)

9. BIRTHPLACE

(State or Country) Wis

10. NAME OF FATHER

Mr. Froy

11. BIRTHPLACE OF FATHER

(State or Country) Wis

12. MAIDEN NAME OF MOTHER

Not Obtainable

13. BIRTHPLACE OF MOTHER

(State or Country) Not Obtainable

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Geo Sanguinis
(Address) Boise

15.

Filed 2-3 1913

Wm Council
Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH

Jan 29 1913
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from

Jan. 20 1913, to Jan. 28 1913,

that I last saw h/l alive on Jan. 28 1913,

and that death occurred on the date stated above, at 7:30

The CAUSE OF DEATH* was as follows:

Heart Disease - Valvular

(Duration) 1 yrs. 1 mos.

Contributory (Secondary) Dropsy

(Duration) 1 yrs. 1 mos.

(Signed) Geo P. Haley

19 (Address) Boise Idaho

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death yrs. mos. 21 days. In the 5 State yrs. mos. days.

Where was disease contracted if not at place of death?

Former or usual residence Campscaric Jan.

19. PLACE OF BURIAL, OR REMOVAL DATE OF BURIAL

Harris Hill Cemetery 7/3 1913

20. UNDERTAKER

ADDRESS

Schreiber & Sidenfaden Boise

Dr. Haley

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Form V. S. No. 5 20M.1-16-12

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics
File No. **3993**

1. PLACE OF DEATH.

Registration District No. _____

County of Ada

Primary Registration District No. _____

City of Boise(No. 1114, Tert St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

Frank M. H. ClairRegistered No. 42

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX

Male

4. COLOR OR RACE

White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED.

Married
(Write the word.)

6. DATE OF BIRTH

Oct. 22, 1844
(Month) (Day) (Year)

7. AGE

68 yrs. 3 mos. 19 ds.IF LESS than 1 day
how many hrs. or
..... mins.?

8. OCCUPATION

(a) Trade, profession or particular kind of work

Miner

(b) General nature of industry business, or establishment in which employed (or employer)

9. BIRTHPLACE

(State or Country)

Ky.

10. NAME OF FATHER

Not obtainable

11. BIRTHPLACE OF FATHER

(State or Country)

"

12. MAIDEN NAME OF MOTHER

"

13. BIRTHPLACE OF MOTHER

(State or Country)

"

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

F. H. Clair

(Address)

Silver City, Ida.

15.

Filed

2 - 111913C. S. McConnell

Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH

Feb. 9th, 1913
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from

Oct. 8 - 1912, to Feb. 9, 1913.that I last saw him alive on Feb. 8, 1913.and that death occurred on the date stated above, at P.

The CAUSE OF DEATH* was as follows:

Chr. Bright's Disease
Eulenge. Pusulate(Duration) 2 yrs. mos.Contributory
(Secondary)

(Duration) yrs. mos.

(Signed)

7/10 1913

(Address)

Boise

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death yrs. mos. days. In the State yrs. mos. days.

Where was disease contracted if not at place of death?

Former or usual residence

Silver City

19. PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

Masonic CemeteryFeb. 11, 1913

20. UNDERTAKER

ADDRESS

Schreiber & SchenckBoise

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Form V. S. No. 5 20M.1-16-12

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH.

Registration District No.

County of Ada

Primary Registrar

District No.

City of Boise

(No. St. Luke Hospital St.)

File No. 33994

Registered No. 39

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Charles D. Creed

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX

4. COLOR OR RACE

5. SINGLE, MARRIED, WIDOWED OR DIVORCED.

Male

White American

Married
(Write the word)

6. DATE OF BIRTH

June 21 1844
(Month) (Day) (Year)

7. AGE

68 yrs. 7 mos. 12 ds.

IF LESS than 1 day
how many hrs. or mins.?

8. OCCUPATION

(a) Trade, profession or particular kind of work

(b) General nature of industry, business, or establishment in which employed (or employer)

Retired. C.W. Veteran

9. BIRTHPLACE

(State or Country)

Chil. Maurice C. Ohio

10. NAME OF FATHER

Not obtainable

11. BIRTHPLACE OF FATHER

(State or Country)

12. MAIDEN NAME OF MOTHER

13. BIRTHPLACE OF MOTHER

(State or Country)

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

(Address)

W. H. Creed
Forrest Rd

15.

Filed 2-5

1913

W. H. Creed

Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH

Feb. 3 1913
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from Jan. 20 1913 to Feb 3 1913

that I last saw him alive on Feb 3 1913

and that death occurred on the date stated above, at 12 M.

The CAUSE OF DEATH* was as follows:

Apoplexy

(Duration) yrs. mos. ds.

Contributory (Secondary)

Pneumonia

(Duration) yrs. mos. ds.

(Signed)

W. H. Creed M. D.
(Address) Boise, Idaho

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death yrs. mos. days. In the State yrs. mos. days.

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

Morris Hill Cemetery

Feb 5 1913

20. UNDERTAKER

ADDRESS

Fry & Summers

Boise, Idaho

1. PLACE OF DEATH.

Registration District No.

File No.

County of *Ada*

Primary Registration District No.

Registered No.

City of *Boise*(No. *1110 Franklin* St.)If death occurred in a hospital,
institution or camp, give its name
instead of street and number.If death occurs away from usual
residence, give facts called
for under special information.

2. FULL NAME

John P. Piegas

PERSONAL AND STATISTICAL PARTICULARS

3. SEX

4. COLOR OR RACE

5. SINGLE, MARRIED, WID-
OWED OR DIVORCED.*Male**white*
*Amer.**married*
(Write the word.)

6. DATE OF BIRTH

*Dec**24**1834*

(Month)

(Day)

(Year)

7. AGE

78 yrs. *1* mos. *19* ds.IF LESS than 1 day
how many hrs. or
..... mins.)

8. OCCUPATION

(a) Trade, profession or
particular kind of work(b) General nature of industry
business, or establishment in
which employed (or employer)*Stock man*

9. BIRTHPLACE

(State or Country)

*Tenn*10. NAME OF
FATHER*Linsley Piegas*11. BIRTHPLACE
OF FATHER

(State or Country)

*not obtainable*12. MAIDEN NAME
OF MOTHER13. BIRTHPLACE
OF MOTHER

(State or Country)

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

Mrs. Addie Moore

(Address)

1110 Franklin St

15.

Filed *2 - 14* 1913*Edm Connel*

Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH

*Feb**14**1913*

(Month)

(Day)

(Year)

17. I HEREBY CERTIFY, That I attended deceased from

*Feb 12**1913*, to *Feb 14**1913*,that I last saw him alive on *Feb 13* *1913*,and that death occurred on the date stated above, at *5:45*

The CAUSE OF DEATH* was as follows:

Chronic interstitial nephritis

(Duration) yrs. mos. ds.

Contributory *Cerebral*
(Secondary)

(Duration) yrs. mos. ds.

(Signed) *M. D. Fulmer* M. D.*2-14* 1913 (Address) *Boise Idaho**State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1)
MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.18. LENGTH OF RESIDENCE (For Hospitals, Institutions,
Transients or Recent Residents.)

At place of death yrs. mos. days. In the State yrs. mos. days.

Where was disease contracted
if not at place of death?Former or
usual residence.

19. PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

*Morris Hill Cem**Feb 16* 1913

20. UNDERTAKER

ADDRESS

*Fry & Summers**Boise Ida.*

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Form V. S. No. 5 20M.1-16-12

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH.

Registration District No.

County of Ada

Primary Registration District No.

City of Boise

(No. 2603-8 State St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Joseph S. McEuffin

File No. 3996

Registered No. 43

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX Male 4. COLOR OR RACE White 5. SINGLE, MARRIED, WIDOWED OR DIVORCED. Married
(Write the word.)

6. DATE OF BIRTH March 15th 1836
(Month) (Day) (Year)

7. AGE 76 yrs. 10 mos. 27 ds.
IF LESS than 1 day how many hrs. or mins.

8. OCCUPATION
(a) Trade, profession or particular kind of work retired
(b) General nature of industry, business, or establishment in which employed (or employer)

9. BIRTHPLACE
(State or Country) Pennsylvania

10. NAME OF FATHER William McEuffin

11. BIRTHPLACE OF FATHER
(State or Country) America

12. MAIDEN NAME OF MOTHER Graham

13. BIRTHPLACE OF MOTHER
(State or Country) America

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Wm McEuffin
(Address) 1320 W. Main

15. Filed Feb 72 1913 LSM
Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH Feb 11th 1913
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from Jan 1st 1913 to Feb 12th 1913, that I last saw him alive on Feb 12th 1913, and that death occurred on the date stated above, at 2 A.M.

The CAUSE OF DEATH* was as follows:
Softening of brain

(Duration) number of yrs. mos. ds.

Contributory (Secondary) Apoplexy (several attacks)

(Duration) number of yrs. mos. ds.

(Signed) John Brown M. D.

19. (Address)

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death yrs. mos. days. In the State yrs. mos. days.

Where was disease contracted if not at place of death?

Former or usual residence 2603 W. State, Boise, Ida.

19. PLACE OF BURIAL OR REMOVAL DATE OF BURIAL

Morris Hill Cemetery 2/12 1913

20. UNDERTAKER ADDRESS

Schreiber Undertaker Boise, Ida.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Form V. S. No. 5 20M.1-16-12

CERTIFICATE OF DEATH

1. PLACE OF DEATH.

County of *Ada*
City of *Boise*

Registration District No.

Primary Registrar

(No. *410*) St.

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

Robert Gilmore

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

File No. *35-3997*Registered No. *35*

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX

Male

4. COLOR OR RACE

Blk

5. SINGLE, MARRIED, WIDOWED OR DIVORCED.

Widower
(Write the word.)

6. DATE OF BIRTH

1960
(Month) (Day) (Year)

7. AGE

52 yrs. — mos. — ds.

IF LESS than 1 day
how many hrs. or mins.?

8. OCCUPATION

(a) Trade, profession or particular kind of work

(b) General nature of industry, business, or establishment in which employed (or employer)

Janitor

9. BIRTHPLACE

(State or Country)

Nebr

10. NAME OF FATHER

not obtainable

11. BIRTHPLACE OF FATHER

(State or Country)

not obtainable

12. MAIDEN NAME OF MOTHER

not obtainable

13. BIRTHPLACE OF MOTHER

(State or Country)

not obtainable

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) *Lee McCallum*(Address) *Boise*

15.

Filed *2-3*191*3**Ed McConnell*

Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH

2 *2* *1913*
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from

Jan 10 191*3* to *Feb 2* 191*3*

that I last saw him alive on *Feb 2* 191*3*

and that death occurred on the date stated above, at *7 AM*

The CAUSE OF DEATH* was as follows:

Pneumonia

(Duration) yrs. mos. ds.

Contributory (Secondary)

(Duration) yrs. mos. ds.

(Signed) *Fred A. Lutz*191*3* (Address) *Talk Blgg*

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death *St. Alphonsus Hospital* In the State *Idaho*
yrs. mos. days. yrs. mos. days.

Where was disease contracted if not at place of death?

Former or usual residence *224 1324 Grand Ave Boise*

19. PLACE OF BURIAL OR REMOVAL DATE OF BURIAL

Harris Hill Cemetery 191*3*

20. UNDERTAKER

ADDRESS

Schreiber & Siderfaden Boise

MARGIN RESERVED FOR BINDING
WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Form V. S. No. 5 20M.1-16-12

CERTIFICATE

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH.

Registration District No.

County of

Primary Registration District No.

City of

(No. *St. Luke's Hospital* St.)

File No. *3998*

Registered No. *56*

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

G. W. Gray

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX

4. COLOR OR RACE

5. SINGLE, MARRIED, WIDOWED OR DIVORCED.

Male

White American

Married
(Write the word.)

6. DATE OF BIRTH

Not obtainable

(Month)

(Day)

(Year)

7. AGE

51 yrs. — mos. — ds.

IF LESS than 1 day
how many . . . hrs. or
. . . mins.?

8. OCCUPATION

(a) Trade, profession or particular kind of work

Coal Miner

(b) General nature of industry business, or establishment in which employed (or employer)

9. BIRTHPLACE

(State or Country)

Not obtainable

10. NAME OF FATHER

G. W. Gray

11. BIRTHPLACE OF FATHER

(State or Country)

Not obtainable

12. MAIDEN NAME OF MOTHER

13. BIRTHPLACE OF MOTHER

(State or Country)

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

Geo. H. Hull

(Address)

1318 River St.

15.

Filed *2 - 21* 191*3*

Edm. C. Connel
Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

Feb 20th 191*3*
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from

Feb 19th 191*3*, to *Feb 20th* 191*3*,

that I last saw him alive on *Feb 19th* 191*3*,

and that death occurred on the date stated above, at *7 a.m.*

The CAUSE OF DEATH* was as follows:

Tuberculosis of Lungs

of long standing

(Duration) — yrs. — mos. — ds.

Contributory
(Secondary)

(Duration) — yrs. — mos. — ds.

(Signed)

John Bank M. D.

Feb 21 1913 (Address) *Boise Ida*

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death. . . yrs. . . mos. . . days. In the State. . . yrs. . . mos. . . days.

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

Morris Hill Care.

Feb 22 1913

20. UNDERTAKER

ADDRESS

Fry & Summers

Boise Ida.

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIAN should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Form V. S. No. 5 20M-1-10-12

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH

Registration District

County of Ada

Primary Registrar

District No. Jefferson

File No. 33 3999

City of Boise

(No. 2723)

Registered No. 33

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME William J. Weaver

PERSONAL AND STATISTICAL PARTICULARS

3. SEX

4. COLOR OR RACE

5. SINGLE, MARRIED, WIDOWED, DIVORCED

Male

White

Married

6. DATE OF BIRTH

Oct.

28

1913

(Month)

(Day)

(Year)

7. AGE

58 yrs.

3 mos.

4 ds.

If LESS than day how many hours or

8. OCCUPATION

(a) Trade, profession or particular kind of work

(b) General nature of industry, business, or establishment in which employed (or employer)

Plasterer

9. BIRTHPLACE

(State or Country)

Ill.

10. NAME OF FATHER

John B. Weaver

11. BIRTHPLACE OF FATHER

(State or Country)

Ill.

12. MAIDEN NAME OF MOTHER

Not obtainable

13. BIRTHPLACE OF MOTHER

(State or Country)

Ill.

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Mrs. Stuart Weaver

(Address) Boise, Ida.

15.

Filed 2 - 3

1913

W. McCounel

Local Registrar

CERTIFICATE OF DEATH

16. I HEREBY CERTIFY, That I attended deceased from

1913, to

2nd

1913

(Month)

(Day)

(Year)

that I last saw him alive on

1913

and that death occurred on the date stated above, at 9 A.M.

The CAUSE OF DEATH* was as follows:

Dropsy

(Duration)

2 yrs.

mos.

ds.

Contributory

(Secondary)

(Duration)

2 yrs.

mos.

ds.

(Signed)

May 3 1913

(Address)

Boise, Ida.

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death

...yrs. ...mos. ...days.

In the State

...yrs. ...mos. ...days.

Where was disease contracted if not at place of death?

Former or usual residence

Ashton, Idaho

19. PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

Ashton, Ida.

3/3

1913

20. UNDERTAKER

ADDRESS

Chrubert Siderfaden, Boise

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Form V. S. No. 5 20M.1-1

1. PLACE OF DEATH..... Registration District No.....
County of Buda Primary Registration District No.....
City of Boise (No. 213, South 7 St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Louis Gung

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

File No. 4009Registered No. 118

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX Male 4. COLOR OR RACE Chinese 5. SINGLE, MARRIED, WIDOWED OR DIVORCED. Single
(Write the word.)

6. DATE OF BIRTH Not Obtainable
(Month) (Day) (Year)

7. AGE Not Obtainable IF LESS than 1 day
3 yrs. 1 mos. 1 ds. how many hrs. or mins.?

8. OCCUPATION

(a) Trade, profession or particular kind of work Cook
(b) General nature of industry, business, or establishment in which employed (or employer)

9. BIRTHPLACE

(State or Country) Immersion

10. NAME OF FATHER Not Obtainable

11. BIRTHPLACE OF FATHER Not Obtainable
(State or Country)

12. MAIDEN NAME OF MOTHER Not Obtainable

13. BIRTHPLACE OF MOTHER Not Obtainable
(State or Country)

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Ellyde Summers(Address) Boise Id.

15.

Filed 2 - 13 1913 CSM Cornel
Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

Feb 13 1913
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from on Feb 13 1913, to 191

that I last saw him alive on Feb 13 1913,

and that death occurred on the date stated above, at 11 P.M.

The CAUSE OF DEATH* was as follows:

Tuberculosis

(Duration) yrs. mos. ds.

Contributory

(Secondary)

(Duration) yrs. mos. ds.

(Signed) Officer M. D.19 (Address) 257 South Blvd

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death.....yrs.....mos.....days. In the State.....yrs.....mos.....days.

Where was disease contracted if not at place of death?

Former or usual residence.....

19. PLACE OF BURIAL OR REMOVAL DATE OF BURIAL

Chinese Cemetery Feb 13 1913

20. UNDERTAKER ADDRESS

Try & Summers Boise Id.

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. If death occurs away from usual residence, give facts called for under special information. 2. FULL NAME. If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

ment of OCCUPATION is very important. See instructions on back of certificate.

M.1-16-12

EATH.

TIFICATE

EATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registra District No.
Primary Registration District No.
(No. 1220, Idaho Street, St.)

File No. 4001
Registered No. 57

If death occurs away from usual residence, give facts called for under special information.

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX Male 4. COLOR OR RACE White 5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.)

6. DATE OF BIRTH Dec 27 1913 (Month) (Day) (Year)

7. AGE 1 mos. 20 ds. IF LESS than 1 day how many hrs. or mins.?

8. OCCUPATION (a) Trade, profession or particular kind of work. (b) General nature of industry business, or establishment in which employed (or employer).

9. BIRTHPLACE (State or Country) Boise Idaho

10. NAME OF FATHER R. C. Blackmar

11. BIRTHPLACE OF FATHER (State or Country) Nebraska

12. MAIDEN NAME OF MOTHER Nellie Miller

13. BIRTHPLACE OF MOTHER (State or Country) Wisconsin

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE (Informant) R. C. Blackmar (Address) 1220 Idaho

15. Filed 2 - 17 1913 C. McConnell Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH Feb 17 1913 (Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from Dec 27 1913 to Feb 17 1913 that I last saw him alive on 10 Feb 1913 and that death occurred on the date stated above, at 9 A.M.

The CAUSE OF DEATH* was as follows: Probably Smothered

(Duration) yrs. mos. ds. Contributory (Secondary) none

(Signed) R. C. Blackmar M. D. (Address) Boise Idaho

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL OR HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death yrs. mos. days. In the State yrs. mos. days.

Where was disease contracted if not at place of death?

Former or usual residence.

19. PLACE OF BURIAL OR REMOVAL Morris Hill DATE OF BURIAL Feb 17 1913

20. UNDERTAKER Fry & Summers ADDRESS Boise Id

A stillbirth must be registered both as a birth and death. The date of death should be the date of delivery and the death certificate should further state, if known, the cause of the stillbirth and the period of utero gestation in months.

STATEMENT OF OCCUPATION.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer, Physician, Stenographer, Compositor, Architect, Locomotive engineer, Civil engineer, Stationary fireman, etc.* But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner*, (b) *Cotton mill*; (a) *Salesman*, (b) *Grocery*; (a) *Foreman*, (b) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification, as *Day laborer, Farm laborer, Laborer—Coal mine*, etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers*, who receive a definite salary), may be entered as *Housewife, Housework*, or *At home*, and children, not gainfully employed, as *At school* or *At home*. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer (retired, 6 yrs.)*. For persons who have no occupation whatever, write *None*.

STATEMENT OF CAUSE OF DEATH.—Name, first the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebro-*

spinal fever (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid Pneumonia") *Lobar pneumonia; Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritoneum, etc.*, *Carcinoma, Sarcoma, etc.*, of (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis, etc.* The contributory (secondary or intercurrent affection need not be stated unless important. Example: *Measles* (disease causing death), 29 ds.; *Bronchopneumonia* (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "Asthenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility," ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Haemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uraemia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify as "PUERPERAL, septicemia", "PUERPERAL peritonitis," etc., all diseases resulting from childbirth or miscarriage. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning; Struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid—probably suicide.* The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "Contributory."

9 # 2

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Form V. S. No. 5 20M.1-16-12

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH.

Registration District No.

County of Ada

Primary Registration District No.

City of Boise

(No. 122, W. Jefferson St.)

File No. 4002

Registered No. 52

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME John H. Schultz

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX Male 4. COLOR OR RACE White 5. SINGLE, MARRIED, WIDOWED OR DIVORCED. Single
(Write the word.)

6. DATE OF BIRTH Sept 23 1886
(Month) (Day) (Year)

7. AGE 27 yrs. 4 mos. 22 ds. IF LESS than 1 day how many hrs. or mins.

8. OCCUPATION
(a) Trade, profession or particular kind of work Battler in
(b) General nature of industry, business, or establishment in which employed (or employer) Idaho B & H Co

9. BIRTHPLACE Boise, Idaho.
(State or Country)

10. NAME OF FATHER Geo Schultz

11. BIRTHPLACE OF FATHER Germany
(State or Country)

12. MAIDEN NAME OF MOTHER Dora Rucktaschel

13. BIRTHPLACE OF MOTHER Germany
(State or Country)

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) G. J. Schultz
(Address) Boise

15. Filed 1 - 18 1913 Edm McConnel
Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH Feb 17 1913
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from Aug 1911, to May 16 1913, that I last saw him alive on May 16 1913, and that death occurred on the date stated above, at 2 A M. The CAUSE OF DEATH* was as follows:
Pulmonary Tuberculosis

(Duration) 2 yrs. 6 mos. ds.
Contributory (Secondary)
(Duration) 2 yrs. 6 mos. ds.
(Signed) W. J. McKinney M. D.
May 18 1913 (Address) Boise

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death yrs. mos. days. In the State yrs. mos. days.
Where was disease contracted if not at place of death?
Former or usual residence

19. PLACE OF BURIAL OR REMOVAL Woods Hill Cemetery DATE OF BURIAL 2 / 19 1913
20. UNDERTAKER Schreib & Hidenfaden ADDRESS Boise

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Form V. S. No. 5 20M.1-16-12

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH.

Registration District

County of *Ada*

Primary Registrar

File No. *4003*

City of *Boise*

(No. *410*, *2* St.)

Registered No. *39*

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME *Harlow Karr*

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX

Male

4. COLOR OR RACE

Blk

5. SINGLE, MARRIED, WIDOWED OR DIVORCED.

Single
(Write the word.)

6. DATE OF BIRTH

April
(Month)

1897
(Year)

7. AGE

15 yrs. *10* mos. — ds.

IF LESS than 1 day
how many hrs. or
..... mins.?

8. OCCUPATION

(a) Trade, profession or particular kind of work

Ranchman

(b) General nature of industry, business, or establishment in which employed (or employer)

9. BIRTHPLACE

(State or Country)

Gunnison, Colo

10. NAME OF FATHER

Ellis Karr

11. BIRTHPLACE OF FATHER

(State or Country)

Ky

12. MAIDEN NAME OF MOTHER

Levie Cowan

13. BIRTHPLACE OF MOTHER

(State or Country)

Colo

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

Beatrice Thompson

(Address)

Boise Ida.

15.

Filed

4-6

1913

Elmwood

413 Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH

Feb 4 1913
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from

Feb 1st 1913, to *Feb 4* 1913,

that I last saw him alive on *Feb 4* 1913,

and that death occurred on the date stated above, at *2 A.M.*

The CAUSE OF DEATH* was as follows:

Acute suppurative appendicitis

(Duration) yrs. mos. ds.

Contributory (Secondary)

peritonitis

(Duration) yrs. mos. ds.

(Signed)

Maurice Hallman M. D.

2-6 1913 (Address) *Boise, Idaho*

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death yrs. mos. days. In the State yrs. mos. days.

Where was disease contracted if not at place of death?

Former or usual residence

415 W. S. Ave Boise

19. PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

St John Cemetery

2/6 1913

20. UNDERTAKER

ADDRESS

Schubert & Widenfaden

Boise

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Form V. S. No. 5 20M.1-16-12

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH.

Registration District No.

County of Ada

Primary Registration District No.

City of Prise

(No. St. Alphonsus Hosp. St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Fred. Head

File No. 34 4004

Registered No. 34

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX

4. COLOR OR RACE

5. SINGLE, MARRIED, WIDOWED OR DIVORCED.

Male

white

Single
(Write the word.)

6. DATE OF BIRTH

Not Obtainable
(Month) (Day) (Year)

7. AGE

About 60. Not obtainable
yrs. mos. ds.

IF LESS than 1 day
how many hrs. or mins.?

8. OCCUPATION

(a) Trade, profession or particular kind of work
(b) General nature of industry, business, or establishment in which employed (or employer)

Retired Oregon Short Line Train Conductor

9. BIRTHPLACE

(State or Country)

Not Obtainable

10. NAME OF FATHER

Not Obtainable

11. BIRTHPLACE OF FATHER

(State or Country)

Not Obtainable

12. MAIDEN NAME OF MOTHER

Not Obtainable

13. BIRTHPLACE OF MOTHER

(State or Country)

Not Obtainable

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Chas. Summers

(Address) Prise Id.

15.

Filed 2 - 3 1913

Ed McConnel
Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH

2 1913
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from

Jan 1st 1913 to Feb 7 1913

that I last saw him alive on Feb 1 1913

and that death occurred on the date stated above, at 2 P. M.

The CAUSE OF DEATH* was as follows:

Septic Chronic Cystitis

(Duration) yrs. mos. ds.

Contributory (Secondary) Enlarged Prostate

(Duration) yrs. mos. ds.

(Signed) Chas. G. Summers, M. D.

19. (Address) Prise Id.

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death yrs. mos. days. In the State yrs. mos. days.

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL DATE OF BURIAL

Masonic Cemetery Feb 4 1913

20. UNDERTAKER ADDRESS

Chas. G. Summers Boise Id.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Form V. S. No. 5 20M.1-16-12

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH.

Registration District No.

County of Ada

Primary Registration District No.

City of Boise(No. 1902, Washington St.)File No. 4005Registered No. 59

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Margate Overholser

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX

Female

4. COLOR OR RACE

White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED.

Single
(Write the word.)

6. DATE OF BIRTH

Feb. 6th 1913
(Month) (Day) (Year)

7. AGE

.....yrs.mos. 21 ds.

IF LESS than 1 day
how manyhrs. or
.....mins.?

8. OCCUPATION

(a) Trade, profession or particular kind of work

(b) General nature of industry business, or establishment in which employed (or employer)

9. BIRTHPLACE

(State or Country)

Boise

10. NAME OF FATHER

Perry Overholser

11. BIRTHPLACE OF FATHER

(State or Country)

Kan.

12. MAIDEN NAME OF MOTHER

Ellen Carter

13. BIRTHPLACE OF MOTHER

(State or Country)

Ida.

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) William Edwards(Address) Boise

15.

Filed 2 - 28 1913

Ed McCune
Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH

Feb 28 1913
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from Feb 26 1913, to Feb 27 1913 that I last saw her alive on Feb 26 1913, and that death occurred on the date stated above, at.....M.

The CAUSE OF DEATH* was as follows:

Pneumonia.....(Duration).....yrs.mos. 3 ds.Contributory Pneumonia
(Secondary)

.....(Duration).....yrs.mos.ds.

(Signed) W. S. Titus M. D.2-28 1913 (Address) Boise Idaho

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death.....yrs.mos.days. In the State.....yrs.mos.days.

Where was disease contracted if not at place of death?

Former or usual residence.....

19. PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

Morris Hill Cemetery2/28 1913

20. UNDERTAKER

ADDRESS

Schubert & SonsBoiseTitus

MARGIN RESERVED FOR BINDING
WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Form V. S. No. 5 20M.1-16-12

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH.

Registration District No.

County of Ada

Primary Registration District No.

City of Boise

(No. 1209 Grand Ave St.)

File No. 4006

Registered No. 49

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Mildred Ahmo Powers
If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX Female 4. COLOR OR RACE white 5. SINGLE, MARRIED, WIDOWED OR DIVORCED. Single
(Write the word.)

6. DATE OF BIRTH Feb 4 1913
(Month) (Day) (Year)

7. AGE 10 yrs. mos. ds.
IF LESS than 1 day how many hrs. or mins.

8. OCCUPATION
(a) Trade, profession or particular kind of work None Infant
(b) General nature of industry, business, or establishment in which employed (or employer)

9. BIRTHPLACE
(State or Country) Boise

10. NAME OF FATHER H. M. Powers

11. BIRTHPLACE OF FATHER
(State or Country) Ido.

12. MAIDEN NAME OF MOTHER Glossy Leonard

13. BIRTHPLACE OF MOTHER
(State or Country) Kan.

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) W. M. Powers
(Address) Boise Ida.

15. Filed 2-15 1913 W. M. Powers
Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH 2 14 1913
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from Feb 10 1913, to Feb 14 1913, that I last saw her alive on Feb 14 1913, and that death occurred on the date stated above, at 5 p.m.

The CAUSE OF DEATH* was as follows:

Pneumonia
(Duration) yrs. mos. ds.

Contributory Atelectasis
(Secondary)

(Duration) yrs. mos. ds.

(Signed) W. H. Hallman M. D.

2-14 1913 (Address) Boise, Idaho

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death yrs. mos. days. In the State yrs. mos. days.

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL Meridian Cemetery DATE OF BURIAL Feb 15 1913

20. UNDERTAKER Fry & Summers ADDRESS Boise Ida.

Form V. S. No. 5 20M.1-16-12

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH.

Registration District No. 18County of OneidaPrimary Registration District No. 2/19City of Wiston

(No. _____ St.)

File No. 1007Registered No. 1

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Leslie Aultman Christensen

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX

4. COLOR OR RACE

5. SINGLE, MARRIED, WIDOWED OR DIVORCED.

male whiteSingle
(Write the word.)

6. DATE OF BIRTH

Dec 29 1912
(Month) (Day) (Year)

7. AGE

4 yrs. 4 mos. 4 ds.IF LESS than 1 day
how many hrs. or
..... mins.?

8. OCCUPATION

(a) Trade, profession or particular kind of work

(b) General nature of industry business, or establishment in which employed (or employer)

9. BIRTHPLACE

(State or Country)

Wiston, Ida

10. NAME OF FATHER

Olaf Christensen

11. BIRTHPLACE OF FATHER

(State or Country)

Utah

12. MAIDEN NAME OF MOTHER

Emma Crockett

13. BIRTHPLACE OF MOTHER

(State or Country)

Utah

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

Olaf Christensen

(Address)

Wiston

15.

Filed

Jan 3 1913
Dr. Ray Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH

Jan 2 1913
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from

1912, to Dec 29 1912
that I last saw him alive on Dec 27 1912and that death occurred on the date stated above, at 6 P.M.

The CAUSE OF DEATH* was as follows:

Insanition(Duration) yrs. mos. 4 ds.Contributory
(Secondary)

(Duration) yrs. mos. ds.

(Signed)

G. B. Gruen M. D.
Jan 3 1913 (Address) Wiston, Ida

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death yrs. mos. days. In the State yrs. mos. days.

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

Wiston Jan 4 1913

20. UNDERTAKER

ADDRESS

P. J. Hansen Wiston

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Form V. S. No. 5. 12½ M. 7-24-11

CERTIFICATE OF DEATH

1. PLACE OF DEATH. Registration District No. 18
County of Oneida Primary Registration District No. 2119
City of Preston (No. 1 St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Emily Tinsbury

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics
File No. 4009
Registered No. 4

If death occurred in a hospital, institution or camp give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX 4. COLOR OR RACE 5. SINGLE, MARRIED, WIDOWED OR DIVORCED.

Female White married
(Write the word.)

6. DATE OF BIRTH

Nov 1 November (Month) (Day) (Year)

7. AGE

50 yrs. mos. ds.

IF LESS than 1 day
how many hrs. or min?

8. OCCUPATION

(a) Trade, profession or particular kind of work.

(b) General nature of industry business or establishment in which employed (or employer)

House Wiper

9. BIRTHPLACE

(State or Country)

England

10. NAME OF FATHER

Not Known

11. BIRTHPLACE OF FATHER

(State or Country)

England

12. MAIDEN NAME OF MOTHER

Not Known

13. BIRTHPLACE OF MOTHER

(State or Country)

England

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) James H. Barnes
(Address) Preston

15.

Filed Jan 9 1913

G. E. Gentry
Sub Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH

Jan. 6 1913
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from Dec 1 1912, to Jan 6 1913

that I last saw her alive on Jan 4 1913

and that death occurred on the date stated above, at 11:45 P. M.

The CAUSE OF DEATH* was as follows:

Dropsy - probably
consequence of liver trouble

(Duration) yrs. mos. ds.

Contributory Poor health for many years
(Secondary)

(Duration) yrs. mos. ds.

(Signed) Alvin K. Curtis M. D.
Jan 7 1913 (Address) Preston Idaho

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place In the
of death yrs. mos. ds. State yrs. mos. ds.

Where was disease contracted,

If not at place of death?

Former or

usual residence.

19. PLACE OF BURIAL OR REMOVAL DATE OF BURIAL

Preston Jan 7 1913

20. UNDERTAKER

ADDRESS

O. H. Hansen Preston

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Form V. S. No. 5. 12½ M. 7-24-11

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics
File No. 1010
Registered No. 6

1. PLACE OF DEATH. Registration District No. 18
County of Oneida Primary Registration District No. 2119
City of Cedarville (No. _____ St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

Stine Kingford

If death occurred in a hospital, institution or camp give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX Female 4. COLOR OR RACE White 5. SINGLE, MARRIED, WIDOWED OR DIVORCED. Widowed
(Write the word.)

6. DATE OF BIRTH January 17th 1893
(Month) (Day) (Year)

7. AGE 89 yrs. 11 mos. 10 ds. IF LESS than 1 day how many _____ hrs. or _____ min?

8. OCCUPATION
(a) Trade, profession or particular kind of work. Farmers Wife.
(b) General nature of industry business or establishment in which employed (or employer)

9. BIRTHPLACE (State or Country) Denmark

10. NAME OF FATHER Neils Neilsen

11. BIRTHPLACE OF FATHER (State or Country) Hoyer; Denmark.

12. MAIDEN NAME OF MOTHER Annie Neilsen.

13. BIRTHPLACE OF MOTHER (State or Country) Hoyer; Denmark.

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Katherine Georgeson
(Address) Weston, Idaho.

15. Filed Jan 15th 1913 G. E. Greney
Sub Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH January 18 1913
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from January 9 1913, to Jan 9 1913
that I last saw her alive on Jan 9 1913
and that death occurred on the date stated above, at 11:50 a.m.

The CAUSE OF DEATH* was as follows:

Pneumonia

(Duration) _____ yrs. _____ mos. 7 ds.
Contributory (Secondary) Senility

(Duration) _____ yrs. _____ mos. _____ ds.
(Signed) R. W. Litch M. D.
1/12 1913 (Address) Weston, Idaho

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place _____ In the _____
of death _____ yrs. _____ mos. _____ ds. State _____ yrs. _____ mos. _____ ds.
Where was disease contracted, _____
If not at place of death? _____
Former or _____
usual residence _____

19. PLACE OF BURIAL OR REMOVAL Franklin DATE OF BURIAL 1/13 1913

20. UNDERTAKER R. G. Lowe ADDRESS Franklin, Idaho.

Filed Jan 8 1913

J. P. Gray Local Registrar

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. A should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Form No. 5. 12½ M. 7-24-11

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics
File No. 1011
Registered No. 6

1. PLACE OF DEATH. Registration District No. 18
County of Oneida Primary Registration District No. 2119
City of Preston (No. _____, _____ St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

Harold Ernest

If death occurred in a hospital, institution or camp give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX Male 4. COLOR OR RACE White 5. SINGLE, MARRIED, WIDOWED OR DIVORCED. Single
(Write the word.)

6. DATE OF BIRTH 10 14 1913
(Month) (Day) (Year)

7. AGE 3 yrs. 0 mos. 0 ds. IF LESS than 1 day how many hrs. or min?

8. OCCUPATION

(a) Trade, profession or particular kind of work.
(b) General nature of industry business or establishment in which employed (or employer)

9. BIRTHPLACE

(State or Country) Preston Idaho

10. NAME OF FATHER

William R Smith

11. BIRTHPLACE OF FATHER

(State or Country) England

12. MAIDEN NAME OF MOTHER

Troyin

13. BIRTHPLACE OF MOTHER

(State or Country) England

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) W R Smith

(Address) Preston

15.

Filed Jan 25 1913

G. B. Evans Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH

Jan. 20 1913
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from

Jan. 19 1913, to Jan. 20 1913
that I last saw him alive on Jan. 20 1913
and that death occurred on the date stated above, at 12:30 M.

The CAUSE OF DEATH* was as follows:

Pneumonia

(Duration) yrs. mos. ds.

Contributory (Secondary)

Fagif

(Duration) yrs. mos. ds.

(Signed)

Allyn Cuthbert M. D.
Jan 21 1913 (Address) Preston Idaho

State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place In the
of death yrs. mos. ds. State yrs. mos. ds.

Where was disease contracted,

If not at place of death?

Former or

usual residence.

19. PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

Preston

Jan 22 1913

20. UNDERTAKER

ADDRESS

P J Benson

Preston

Feb 8 1913

D. C. Ray Local Registrar

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Form V. S. No. 5. 12½ M. 7-24-11

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH. Registration District No. 18
County of Blaine Primary Registration District No. 2119
City of Blaine (No. _____, _____ St.)

File No. 40138
Registered No. 8

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

Lennis Sparrow

If death occurred in a hospital, institution or camp give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX 4. COLOR OR RACE 5. SINGLE, MARRIED, WIDOWED OR DIVORCED.

Male White (Write the word.)
6. DATE OF BIRTH 8 21 1902
(Month) (Day) (Year)

7. AGE IF LESS than 1 day
5 yrs. 21 mos. 21 ds. how many hrs. or min?

8. OCCUPATION

- (a) Trade, profession or particular kind of work
(b) General nature of industry business or establishment in which employed (or employer)

9. BIRTHPLACE (State or Country) Togon Mah

10. NAME OF FATHER Willard Sparrow

11. BIRTHPLACE OF FATHER (State or Country) Mah

12. MAIDEN NAME OF MOTHER Jensen

13. BIRTHPLACE OF MOTHER (State or Country) Mah

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Willard Sparrow
(Address) Blaine Idaho

15. Filed Jan 31 1913 G. B. Gentry
Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH Jan 28 1913
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from Jan 26 1913, to Jan 28 1913 that I last saw him alive on Jan 25 1913 and that death occurred on the date stated above, at 9:15 A.M.
The CAUSE OF DEATH* was as follows:

Bronchial Pneumonia

(Duration) yrs. mos. ds.
Contributory (Secondary) Whooping Cough

(Duration) yrs. mos. ds.
(Signed) Arthur C. Smith M. D.
Jan 29 1913 (Address) Blaine Idaho

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place In the
of death yrs. mos. ds. State yrs. mos. ds.
Where was disease contracted,
If not at place of death?
Former or
usual residence.....

19. PLACE OF BURIAL OR REMOVAL DATE OF BURIAL

Togon Mah Jan 30 1913

20. UNDERTAKER ADDRESS
G. B. Gentry Blaine

Feb 8 1913 J. C. Ray Loc Reg

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Form V. S. No. 5. 12½ M. 7-24-11

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH *Idaho* Registration District No. *18*
County of *Franklin* Primary Registration District No. *2119*
City of *Crandon* (No. _____, _____ St.)

File No. *4014*
Registered No. _____

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME *Mar McNeil*

If death occurred in a hospital, institution or camp give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX *Female* 4. COLOR OR RACE *White* 5. SINGLE, MARRIED, WIDOWED OR DIVORCED. *Single*
(Write the word.)
6. DATE OF BIRTH *5* *2* *1913*
(Month) (Day) (Year)

7. AGE _____ yrs. *9* mos. _____ ds. IF LESS than 1 day how many _____ hrs. or _____ min?

8. OCCUPATION

(a) Trade, profession or particular kind of work.
(b) General nature of industry business or establishment in which employed (or employer)

9. BIRTHPLACE

(State or Country) *Crandon Id*10. NAME OF FATHER *J. R. McNeil*11. BIRTHPLACE OF FATHER *Seallan*
(State or Country)12. MAIDEN NAME OF MOTHER *Milson*13. BIRTHPLACE OF MOTHER *Idaho*
(State or Country)

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) *J. R. McNeil*(Address) *Crandon*

15.

Filed *Feb 1* 1913 *G. B. Green*

Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH

Jan *29* 1913
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from

Jan 27 1913, to *Jan 29* 1913

that I last saw her alive on *Jan 25* 1913

and that death occurred on the date stated above, at *2 A. M.*

The CAUSE OF DEATH* was as follows:

Bronchial Pneumonia

(Duration) _____ yrs. _____ mos. *10* ds.

Contributory (Secondary) *Whooping Cough*

(Duration) _____ yrs. _____ mos. *25* ds.

(Signed) *Allyn K. Carter* M. D.

Jan 30 1913 (Address) *Crandon*

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place _____ In the _____
of death _____ yrs. _____ mos. _____ ds. State _____ yrs. _____ mos. _____ ds.

Where was disease contracted,

If not at place of death?

Former or

usual residence.

19. PLACE OF BURIAL OR REMOVAL DATE OF BURIAL

Crandon *Jan 31* 1913

20. UNDERTAKER

ADDRESS

P. H. Mann *Crandon Id*

Feb 8 1913*D. Taylor Reg*

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Form V. S. No. 5 20M.1-16-12

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH

Registration District No. 18

County of Oneida

Primary Registration District No. 2069

City of Malad

(No. _____ St.)

File No. 4024

Registered No. 19

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Milton Davis

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX

4. COLOR OR RACE

5. SINGLE, MARRIED, WIDOWED OR DIVORCED.

Male White Single (Write the word.)

6. DATE OF BIRTH

January 18 1898
(Month) (Day) (Year)

7. AGE

18 yrs. 11 mos. 15 ds.

IF LESS than 1 day
how many _____ hrs. or
_____ mins.

8. OCCUPATION

(a) Trade, profession or particular kind of work

(b) General nature of industry, business, or establishment in which employed (or employer)

Plumber + trimmer

9. BIRTHPLACE

(State or Country)

Samaria

10. NAME OF FATHER

Samuel D. Davis

11. BIRTHPLACE OF FATHER

(State or Country)

Salt Lake City Ut.

12. MAIDEN NAME OF MOTHER

Mary J. Williams

13. BIRTHPLACE OF MOTHER

(State or Country)

Ogden Utah

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

Samuel D. Davis
Malad Idaho

(Address)

15.

Filed Jan 5 1913

D. C. Ray
Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

Jan. 3 1913
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from

Jan 3 1913, to 191,

that I last saw h. alive on 191,

and that death occurred on the date stated above, at M.

The CAUSE OF DEATH* was as follows:

Dead when seen
accidentally electrocuted.

(Duration) _____ yrs. _____ mos. _____ ds.

Contributory
(Secondary)

(Duration) _____ yrs. _____ mos. _____ ds.

(Signed) D. C. Ray M. D.

19. (Address) Malad City

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death _____ yrs. _____ mos. _____ days. In the State _____ yrs. _____ mos. _____ days.

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL DATE OF BURIAL

Samaria Idaho Jan 7th 1913

20. UNDERTAKER

ADDRESS

W. E. Johnson Malad

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Form V. S. No. 5 20M.1-16-12

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH _____
County of Conida Registration District No. 2069
City of Malad R. & N. T. (No. _____ St.)

File No. 4026
Registered No. 21

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

Orniell V Jones

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX Male 4. COLOR OR RACE White 5. SINGLE, MARRIED, WIDOWED OR DIVORCED. Single
(Write the word.)

6. DATE OF BIRTH

Oct 22 1912
(Month) (Day) (Year)

7. AGE

3 yrs. 21 mos. 21 ds.

IF LESS than 1 day
how many hrs. or
..... mins.?

8. OCCUPATION

- (a) Trade, profession or particular kind of work
(b) General nature of industry, business, or establishment in which employed (or employer)

9. BIRTHPLACE

(State or Country) Pleasant View

10. NAME OF FATHER

Jeremiah M. Jones

11. BIRTHPLACE OF FATHER

(State or Country) Samaria Ida.

12. MAIDEN NAME OF MOTHER

Margaret S. Vaughn

13. BIRTHPLACE OF MOTHER

(State or Country) Malad Idaho

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Pay L. Allen

(Address) Pleasant View

15.

Filed 2-12 1913

O. C. Ray

Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH

Feb 13 1913
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from

Feb 12 1913, to Feb 12 1913,

that I last saw him alive on Feb 12 1913,

and that death occurred on the date stated above, at 7²⁹ A.M.

The CAUSE OF DEATH* was as follows:

La Grippe

(Duration) yrs. mos. 10 ds.

Contributory
(Secondary) pneumonia

(Duration) yrs. mos. 4 ds.

(Signed) O. C. Ray M. D.

2-14 1913 (Address) Malad

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death yrs. mos. days. In the State yrs. mos. days.

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL

Malad Idaho

DATE OF BURIAL

Feb 15 1913

20. UNDERTAKER

W. S. Johnson

ADDRESS

Malad

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Form V. S. No. 5. 12½ M. 7-24-11

STATE OF DEATH

1. PLACE OF DEATH.

Registration District

County of *Malad*Primary Registration District No. *2069*

City of _____

(No. _____, St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

Sarah Belle Thomas

If death occurred in a hospital, institution or camp give its NAME instead of street and number.

State of Idaho

BOARD OF HEALTH
Bureau of Vital StatisticsFile No. *4027*Registered No. *27*

PERSONAL AND STATISTICAL PARTICULARS

3. SEX

Female

4. COLOR OR RACE

white

5. SINGLE, MARRIED, WIDOWED OR DIVORCED.

Single
(Write the word.)

6. DATE OF BIRTH

13
(Month)*13*
(Day)*1913*
(Year)

7. AGE

1 yrs. *1* mos. *—* ds.IF LESS than 1 day
how many hrs. or
..... min?

8. OCCUPATION

(a) Trade, profession or particular kind of work.
(b) General nature of industry business or establishment in which employed (or employer)*Boy*

9. BIRTHPLACE

(State or Country)

Malad Ida.

10. NAME OF FATHER

Frank Thomas

11. BIRTHPLACE OF FATHER

(State or Country)

Malad Ida.

12. MAIDEN NAME OF MOTHER

Maggie Jones

13. BIRTHPLACE OF MOTHER

(State or Country)

Cochin Utah

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

(Address)

J. M. Harris, md
Malad Ida.

15.

Filed *2-15* 191 *3*

Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH

2 - *13* - 191 *3*
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from

2/9 191 *3*, to *2/13* 191 *3*that I last saw her alive on *2/12* 191 *3*and that death occurred on the date stated above, at *8:20* A.M.

The CAUSE OF DEATH* was as follows:

Bronchitis(Duration) yrs. mos. *4* ds.Contributory
(Secondary)

(Duration) yrs. mos. ds.

(Signed) *J. M. Harris, M. D.**2/13* 191 *3* (Address) *Malad Ida.*

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place In the
of death yrs. mos. ds. State yrs. mos. ds.

Where was disease contracted,

If not at place of death?

Former or

usual residence

19. PLACE OF BURIAL OR REMOVAL DATE OF BURIAL

Malad Idaho *Feb. 15* 191 *3*

20. UNDERTAKER ADDRESS

W. S. Johnson *Malad*

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statements of OCCUPATION is very important. See instructions on back of certificate.

Form V. S. No. 5 20M.1-16-12

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH.
County of Bonneville
City of Boise
Registration District No. 7
Primary Registration District No. 2027
(No. _____ St.)

File No. 4028
Registered No. 1

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Anna Pospisil

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX Female 4. COLOR OR RACE White 5. SINGLE, MARRIED, WIDOWED OR DIVORCED. Widow
(Write the word.)

6. DATE OF BIRTH July 31 1849
(Month) (Day) (Year)

7. AGE 63 yrs. 5 mos. 7 ds.
IF LESS than 1 day how many hrs. of mins.?

8. OCCUPATION
(a) Trade, profession or particular kind of work Housewife
(b) General nature of industry business, or establishment in which employed (or employer)

9. BIRTHPLACE Germany
(State or Country)

10. NAME OF FATHER Albert Kopsch

11. BIRTHPLACE OF FATHER Germany
(State or Country)

12. MAIDEN NAME OF MOTHER Annie

13. BIRTHPLACE OF MOTHER Germany
(State or Country)

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) James Pospisil
(Address) Boise, Idaho

15. Filed Jan 7 1913 Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH Jan 7 1913
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from Jan 30 1912 to Jan 7 1913, that I last saw her alive on Jan 6 1913, and that death occurred on the date stated above, at 19 M.
The CAUSE OF DEATH* was as follows:

Lobar Pneumonia

(Duration) yrs. mos. 10 ds.

Contributory (Secondary)

(Duration) yrs. mos. ds.

(Signed) W. J. Fanning M. D.

117 1913 (Address) 1114 Fair St.

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL OR HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death yrs. mos. days. In the State yrs. mos. days.

Where was disease contracted if not at place of death?

Former or usual residence.

19. PLACE OF BURIAL OR REMOVAL DATE OF BURIAL

Idaho Falls 1/9 1913

20. UNDERTAKER ADDRESS

B. B. Woodward Idaho Falls

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Form V. S. No. 5 20M.1-16-12

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH.

Registration District No.

County of *B. Merrill*Primary Registration District No. *2027*City of *Idaho Falls*

(No. St.)

File No. *1030*

Registered No.

If death occurs away from usual residence, give facts called for under special information.

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME

Mosima S. Kingsbury

PERSONAL AND STATISTICAL PARTICULARS

3. SEX

Female

4. COLOR OR RACE

White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED.

Widowed
(Write the word.)

6. DATE OF BIRTH

Oct 4 1890
(Month) (Day) (Year)

7. AGE

*92 yrs. 3 mos. 3 ds.*IF LESS than 1 day
how many hrs. or
..... mins.?

8. OCCUPATION

(a) Trade, profession or particular kind of work

at Home

(b) General nature of industry business, or establishment in which employed (or employer)

9. BIRTHPLACE

(State or Country)

Mass. U.S.

10. NAME OF FATHER

Ezra Thayer

11. BIRTHPLACE OF FATHER

(State or Country)

U.S.

12. MAIDEN NAME OF MOTHER

13. BIRTHPLACE OF MOTHER

(State or Country)

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) *H. A. Kingsbury*(Address) *Rd 40 - Idaho Falls*

15.

Filed *Jan 4*

1913

H. A. Kingsbury
Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH

Jan 7 1913
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from

Jan 6 1913, to *Jan 6 1913*,
that I last saw her alive on *Jan 6 1913*.and that death occurred on the date stated above, at *1230 M.*

The CAUSE OF DEATH* was as follows:

Pneumonia(Duration) yrs. mos. *3* ds.Contributory
(Secondary)

(Duration) yrs. mos. ds.

(Signed)

J. C. Hollister M. D.1913 (Address) *Idaho Falls, Ida.*

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death yrs. mos. days. In the State yrs. mos. days.

Where was disease contracted if not at place of death?

Former or usual residence.

19. PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

Paumotu, Neb. *Jan 1913*

20. UNDERTAKER

ADDRESS

B. E. Deenwoody *Idaho Falls*

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Form V. S. No. 5 20M.1-16-12

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH.

Registration District No.

County of

Primary Registration District No.

City of

(No.)

St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

File No.

Registered No.

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX

4. COLOR OR RACE

5. SINGLE, MARRIED, WID-

OWED OR DIVORCED

(Write the word.)

6. DATE OF BIRTH

7. AGE

IF LESS than 1 day
how many hrs. or
mins.?

8. OCCUPATION

(a) Trade, profession or
particular kind of work(b) General nature of industry
business, or establishment in
which employed (or employer)

9. BIRTHPLACE

(State or Country)

10. NAME OF
FATHER11. BIRTHPLACE
OF FATHER

(State or Country)

12. MAIDEN NAME
OF MOTHER13. BIRTHPLACE
OF MOTHER

(State or Country)

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

(Address)

15.

Filed

1913

Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH

17. I HEREBY CERTIFY, That I attended deceased from

Jan. 2, 1913, to Jan. 10, 1913

that I last saw him alive on Jan. 10, 1913

and that death occurred on the date stated above, at 3:30 P.M.

The CAUSE OF DEATH* was as follows:

(Duration) yrs. mos. 12 ds.

Contributory

(Secondary)

(Duration) yrs. mos. 1 ds.

(Signed)

M. D.

19

(Address)

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death yrs. mos. days. In the State yrs. mos. days.

Where was disease contracted if not at place of death?

Former or usual residence.

19. PLACE OF BURIAL OR REMOVAL DATE OF BURIAL

Idaho Falls Ida 1-12 1913

20. UNDERTAKER ADDRESS

E. E. Hinwood Idaho Falls

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Form V. S. No. 5 20M.1-16-12

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH. Registration District No. _____
County of Bonneville Primary Registration District No. 1227
City of Idaho Falls (No. _____ St.)

File No. 4032
Registered No. 5

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Laura Sweath

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX Female 4. COLOR OR RACE White 5. SINGLE, MARRIED, WIDOWED OR DIVORCED married
(Write the word.)

6. DATE OF BIRTH mech 5 1877
(Month) (Day) (Year)

7. AGE 35 yrs. 10 mos. 9 ds.
IF LESS than 1 day how many hrs. or mins.?

8. OCCUPATION
(a) Trade, profession or particular kind of work at Home
(b) General nature of industry business, or establishment in which employed (or employer) _____

9. BIRTHPLACE Utah
(State or Country)

10. NAME OF FATHER Wm Page

11. BIRTHPLACE OF FATHER New York
(State or Country)

12. MAIDEN NAME OF MOTHER Henrietta Snyder

13. BIRTHPLACE OF MOTHER Utah
(State or Country)

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Fred Sweath
(Address) Idaho Falls

15. Filed Jan 16 1913
Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH Jan 14 1913
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from Jan 8 1913, to Jan 13 1913, that I last saw her alive on Jan 14 1913, and that death occurred on the date stated above, at 4 A M.

The CAUSE OF DEATH* was as follows:
Properal sepsis

(Duration) yrs. mos. ds.
Contributory Child birth
(Secondary)

(Duration) yrs. mos. ds.
(Signed) B. E. Coultard M. D.
19 (Address) Idaho Falls Id.

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death yrs. mos. days. In the State yrs. mos. days.

Where was disease contracted if not at place of death?

Former or usual residence.

19. PLACE OF BURIAL OR REMOVAL Idaho Falls DATE OF BURIAL 1/16 1913

20. UNDERTAKER B. E. Coultard ADDRESS Idaho Falls

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Form V. S. No. 5 20M.1-16-12

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH. Registration District No. 1
County of Boyer Primary Registration District No. 2027
City of Idaho Falls (No. _____ St.)

File No. 4033
Registered No. 6

If death occurs away from usual residence, give facts called for under special information.

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Annetta F. Morgan

PERSONAL AND STATISTICAL PARTICULARS

3. SEX Female 4. COLOR OR RACE White 5. SINGLE, MARRIED, WIDOWED OR DIVORCED. Married
(Write the word:)

6. DATE OF BIRTH Oct 16 1866
(Month) (Day) (Year)

7. AGE 46 yrs. 3 mos. 8 ds. IF LESS than 1 day how many hrs. or mins.?

8. OCCUPATION
(a) Trade, profession or particular kind of work at Home
(b) General nature of industry, business, or establishment in which employed (or employer)

9. BIRTHPLACE Canada
(State or Country)

10. NAME OF FATHER Robert Armstrong

11. BIRTHPLACE OF FATHER Canada
(State or Country)

12. MAIDEN NAME OF MOTHER Mary Simpson

13. BIRTHPLACE OF MOTHER Canada
(State or Country)

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) H. S. Morgan
(Address) Idaho Falls

15. Filed Jan 27 1913 Mumford Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH Jan 24 1913
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from Jan Nov. 1912 to 1913, that I last saw her alive on Jan 21 1913, and that death occurred on the date stated above, at 3-35 P.M.
The CAUSE OF DEATH* was as follows:

Carcinoma Larynx

(Duration) 6 yrs. 6 mos. 6 ds.

Contributory (Secondary)

(Duration) 6 yrs. 6 mos. 6 ds.

(Signed) E. M. Clive M. D.

Jan 16 1913 (Address) Idaho Falls, Ida

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death 6 yrs. 6 mos. 6 days. In the State 6 yrs. 6 mos. 6 days.

Where was disease contracted if not at place of death?

Former or usual residence.

19. PLACE OF BURIAL OR REMOVAL DATE OF BURIAL

Idaho Falls - Idaho Jan 27 1913

20. UNDERTAKER ADDRESS

E. M. Clive Idaho Falls

Form V. S. No. 5. 12½ M. 7-24-11

CERTIFICATE OF DEATH

State of Idaho

BOARD OF HEALTH
Bureau of Vital Statistics

File No. 4035

Registered No. 9

If death occurred in a hospital, institution or camp give its NAME instead of street and number.

1. PLACE OF DEATH. Registration District No. 9
 County of Fremont Primary Registration District No. 2037
 City of Driggs (No. St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

Eligbeth Price

PERSONAL AND STATISTICAL PARTICULARS

3. SEX 7 4. COLOR OR RACE W 5. SINGLE, MARRIED, WIDOWED OR DIVORCED. Widdows
 (Write the word.)

6. DATE OF BIRTH Apr. 19 1880
 (Month) (Day) (Year)

7. AGE 82 yrs. 9 mos. 4 ds. IF LESS than 1 day how many hrs. or min?

8. OCCUPATION

(a) Trade, profession or particular kind of work.
 (b) General nature of industry business or establishment in which employed (or employer)

Housekeeper

9. BIRTHPLACE

(State or Country)

Scotland

10. NAME OF FATHER

John Ferguson

11. BIRTHPLACE OF FATHER

(State or Country)

Scotland

12. MAIDEN NAME OF MOTHER

Sarah Donald

13. BIRTHPLACE OF MOTHER

(State or Country)

Scotland

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

W. R. Dunsant

(Address)

Driggs

15.

Filed

Feb 10 1913

Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH

Jan 23 1913
 (Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from Jan 20 1913, to Jan 20 1913 that I last saw h. 4 alive on Jan 20 1913 and that death occurred on the date stated above, at M.

The CAUSE OF DEATH* was as follows:

Sagrippe

(Duration) yrs. mos. ds.

Contributory (Secondary)

(Duration) yrs. mos. ds.

(Signed) M. P. Dunsant M. D.

Jan 20 1913 (Address) Driggs, Ida.

*State the DISEASE CAUSING DEATH; or in deaths from violent CAUSES, state (1) MEANS OF INJURY; (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place In the
 of death yrs. mos. ds. State yrs. mos. ds.

Where was disease contracted,
 If not at place of death?
 Former or usual residence.

19. PLACE OF BURIAL OR REMOVAL DATE OF BURIAL

Driggs Jan 26 1913
 ADDRESS

20. UNDERTAKER

C. Sherrington Driggs

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Form V. S. No. 5. 12½ M. 7-24-11

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics
File No. 4036
Registered No. 8

1. PLACE OF DEATH. Registration District No. 9
County of Pringet Primary Registration District No. 2038
City of St. Anthony (No. _____, _____ St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

M. Cowan

If death occurred in a hospital, institution or camp give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX M 4. COLOR OR RACE W 5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.)

6. DATE OF BIRTH

Jan 14 1862
(Month) (Day) (Year)

7. AGE

57 yrs. — mos. — ds.

IF LESS than 1 day
how many.....hrs. or
min?

8. OCCUPATION

(a) Trade, profession or particular kind of work
(b) General nature of industry business or establishment in which employed (or employer)

Miner

9. BIRTHPLACE

(State or Country)

Utah

10. NAME OF FATHER

Wm Cowan

11. BIRTHPLACE OF FATHER

(State or Country)

Scotland

12. MAIDEN NAME OF MOTHER

Mary Brewer

13. BIRTHPLACE OF MOTHER

(State or Country)

Scotland

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

(Address)

Chas. J. Durran
Reid

15. Filed

Feb 10 1913 Ray Fisher
Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH

Jan 16 1913
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from Jan 14 1913, to Jan 16 1913 that I last saw him alive on Jan 16 1913 and that death occurred on the date stated above, at — M.

The CAUSE OF DEATH* was as follows:

Organic heart disease, Myocarditis

(Duration) yrs. 2 mos. — ds.

Contributory (Secondary)

last illness

(Duration) yrs. — mos. — ds.

(Signed)

W. B. West M. D.

Jan 19 1913 (Address) St. Anthony

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place In the
of death.....yrs.....mos.....ds. State.....yrs.....mos.....ds.

Where was disease contracted,

If not at place of death?

Former or

usual residence.

19. PLACE OF BURIAL OR REMOVAL DATE OF BURIAL

Salt Lake City Jan 20 1913

20. UNDERTAKER

ADDRESS

Wm D. ... St. Anthony

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Form V. S. No. 5. 12½ M. 7-24-11

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics
File No. 1031
Registered No. 7

1. PLACE OF DEATH. Registration District No. 9
County of Fremont Primary Registration District No. 2038
City of St. Anthony (No. _____, _____ St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Kenneth A. Bowman

If death occurred in a hospital, institution or camp give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX M 4. COLOR OR RACE W 5. SINGLE, MARRIED, WIDOWED OR DIVORCED. single
(Write the word.)

6. DATE OF BIRTH Jan 11 1913
(Month) (Day) (Year)

7. AGE yrs. mos. ds. IF LESS than 1 day how many hrs. or min? 13 hrs. or 20 min?

8. OCCUPATION

(a) Trade, profession or particular kind of work.
(b) General nature of industry business or establishment in which employed (or employer)

9. BIRTHPLACE

(State or Country)

10. NAME OF FATHER

11. BIRTHPLACE OF FATHER

(State or Country)

12. MAIDEN NAME OF MOTHER

13. BIRTHPLACE OF MOTHER

(State or Country)

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) M. V. Bowman
(Address) St. Anthony

15. Filed Feb 10 1913 Ray H. H. Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH Jan 17 1913
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from Jan 11 1913, to Jan 17 1913 that I last saw him alive on Jan 17 1913 and that death occurred on the date stated above, at 11 A. M.

The CAUSE OF DEATH* was as follows:

Hypostatic pneumonia

(Duration) yrs. mos. ds.

Contributory (Secondary) atelectasis

(Duration) yrs. mos. ds.

(Signed) K. R. Malott M. D.

Jan 13 1913. (Address) St. Anthony

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place In the
of death yrs. mos. ds. State yrs. mos. ds.
Where was disease contracted,
If not at place of death?
Former or
usual residence.

19. PLACE OF BURIAL OR REMOVAL DATE OF BURIAL

Wierford Jan 13 1913

20. UNDERTAKER ADDRESS

Wm. B. Yager St. Anthony

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Form V. S. No. 5. 12½ M. 7-24-11

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics
File No. 1939
Registered No. 5

1. PLACE OF DEATH. Registration District No. 9
County of Blaine Primary Registration District No. 2038
City of St. Anthony (No. St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

Christina O. Anderson

If death occurred in a hospital, institution or camp give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX MA 4. COLOR OR RACE W. 5. SINGLE, MARRIED, WIDOWED OR DIVORCED. Married
(Write the word.)

6. DATE OF BIRTH July 12 1883
(Month) (Day) (Year)

7. AGE 29 yrs. 6 mos. 26 ds. IF LESS than 1 day how many hrs. or min?

8. OCCUPATION

(a) Trade, profession or particular kind of work
(b) General nature of industry business or establishment in which employed (or employer)

Elevator
Employee

9. BIRTHPLACE

(State or Country)

Utah

10. NAME OF FATHER

Manas Anderson

11. BIRTHPLACE OF FATHER

(State or Country)

Denmark

12. MAIDEN NAME OF MOTHER

Caroline Olson

13. BIRTHPLACE OF MOTHER

(State or Country)

Sweden

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

Mrs. C. O. Anderson

(Address)

Int Pleasant Utah

15.

Filed

Feb 10 1913

Ray H. H. H.

Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH

Jan 8 1913
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from Jan 8 1913, to Jan 8 1913, that I last saw him alive on Jan 8 1913, and that death occurred on the date stated above, at 11 P. M.

The CAUSE OF DEATH* was as follows:

Found dead.
Accidental. Fractured ribs - Broken neck - and internal injuries.
(Duration) yrs. mos. ds.

Contributory (Secondary)

(Duration) yrs. mos. ds.
(Signed) H. B. West M. D.
Jan 9 1913 (Address) St. Anthony

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place In the
of death yrs. mos. ds. State yrs. mos. ds.
Where was disease contracted,
If not at place of death?
Former or
usual residence.

19. PLACE OF BURIAL OR REMOVAL DATE OF BURIAL

Int Pleasant Utah 1913

20. UNDERTAKER

ADDRESS

Wm D. Younger St. Anthony

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Form V. S. No. 5. 12½ M. 7-24-11

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics
File No. 1010
Registered No. 11

1. PLACE OF DEATH. Registration District No. 9
County of Armstrong Primary Registration District No. 2039
City of Titon (No. _____, _____ St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

Elizabeth Wood

If death occurred in a hospital, institution or camp give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX F. 4. COLOR OR RACE W. 5. SINGLE, MARRIED, WIDOWED OR DIVORCED married
(Write the word.)

6. DATE OF BIRTH July 18 1877
(Month) (Day) (Year)

7. AGE 35 yrs. 6 mos. 1 ds. IF LESS than 1 day
how many _____ hrs. or _____ min?

8. OCCUPATION

- (a) Trade, profession or particular kind of work
(b) General nature of industry business or establishment in which employed (or employer)

Housewife

9. BIRTHPLACE
(State or Country)

Utah

10. NAME OF FATHER

Rob. Riggs

11. BIRTHPLACE OF FATHER
(State or Country)

Mass.

12. MAIDEN NAME OF MOTHER

Agnes Smith

13. BIRTHPLACE OF MOTHER
(State or Country)

Utah

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) G. G. Spradley
(Address) Rehburg

15. Filed Feb 20 1913 Ray H. Phillips
Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH Jan 19 1913
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from _____ 191____, to _____ 191____
that I last saw h _____ alive on _____ 191____
and that death occurred on the date stated above, at _____ M.
The CAUSE OF DEATH* was as follows:

Cancer of Stomach and Liver
(Duration) _____ yrs. _____ mos. _____ ds.

Contributory (Secondary) _____
(Duration) _____ yrs. _____ mos. _____ ds.
(Signed) J. R. Shupe M. D.
Jan 19 1913 (Address) Shupe City

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place _____ In the _____
of death _____ yrs. _____ mos. _____ ds. State _____ yrs. _____ mos. _____ ds.
Where was disease contracted, _____
If not at place of death? _____
Former or usual residence _____

19. PLACE OF BURIAL OR REMOVAL DATE OF BURIAL

Titon Jan 21 1913

20. UNDERTAKER ADDRESS

John Phillips Rehburg

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Form V. S. No. 5. 12½ M. 7-24-11

CERTIFICATE OF DEATH

State of Idaho

BOARD OF HEALTH
Bureau of Vital Statistics

File No. 1911

Registered No. 10

If death occurred in a hospital, institution or camp give its NAME instead of street and number.

1. PLACE OF DEATH.
County of Jerome
City of ReelingRegistration District No. 9
Primary Registration District No. 2089
(No. 2089 St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

Clara E. Mason

PERSONAL AND STATISTICAL PARTICULARS

3. SEX F 4. COLOR OR RACE W 5. SINGLE, MARRIED, WIDOWED OR DIVORCED.
Married
(Write the word.)6. DATE OF BIRTH Feb 11 1849
(Month) (Day) (Year)7. AGE 63 yrs. 11 mos. 21 ds. IF LESS than 1 day how many.....hrs. or.....min?

8. OCCUPATION

(a) Trade, profession or particular kind of work.....
(b) General nature of industry business or establishment in which employed (or employer).....Housewife

9. BIRTHPLACE

(State or Country)

England

10. NAME OF FATHER

John E. Cordley11. BIRTHPLACE OF FATHER
(State or Country)England
Don't know

12. MAIDEN NAME OF MOTHER

England13. BIRTHPLACE OF MOTHER
(State or Country)Don't know

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

(Address)

John E. Mason
St. Anthony

15.

Filed

Feb 10 1913Registrar

Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH

Feb 7 1913
(Month) (Day) (Year)17. I HEREBY CERTIFY, That I attended deceased from Jan 4 1913, to Feb 1 1913 that I last saw h alive on Feb 1 1913 and that death occurred on the date stated above, at 6 A. M.

The CAUSE OF DEATH* was as follows:

Pernicious
Anemia

(Duration)yrs.mos.ds.

Contributory
(Secondary)(Duration)yrs. 4 mos.ds.(Signed) N. A. O'Connell M. D.Feb 7 1913 (Address) Reeling

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place In the
of death yrs.mos.ds. State yrs.mos.ds.
Where was disease contracted,
If not at place of death?
Former or
usual residence.....

19. PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

ParkerFeb 5 1913

20. UNDERTAKER

ADDRESS

John PhillipsReeling

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Form V, S. No. 5. 12½ M. 7-24-11

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH. Registration District No. 9
County of Idaho Primary Registration District No. 2039
City of Idaho (No. _____, _____ St.)

File No. 4013Registered No. 3

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

Martha Schurndine

If death occurred in a hospital, institution or camp give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX F 4. COLOR OR RACE W 5. SINGLE, MARRIED, WIDOWED OR DIVORCED. Married

(Write the word.)

6. DATE OF BIRTH

1 6 1913
(Month) (Day) (Year)

7. AGE

_____ yrs. _____ mos. 3 ds.

IF LESS than 1 day
how many _____ hrs. or
_____ min?

8. OCCUPATION

- (a) Trade, profession or particular kind of work
(b) General nature of industry business or establishment in which employed (or employer)

9. BIRTHPLACE

(State or Country)

Idaho

10. NAME OF FATHER

Godfrey Schurndine

11. BIRTHPLACE OF FATHER

(State or Country)

Switzerland

12. MAIDEN NAME OF MOTHER

Maud Hughes

13. BIRTHPLACE OF MOTHER

(State or Country)

Idaho

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

(Address)

Godfrey Schurndine
Idaho City

15.

Filed

Feb 10th1913Ray H. Fisher

Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH

1 9 1913
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from

1913 to 1913

that I last saw him alive on all limbs

and that death occurred on the date stated above at _____ M.

The CAUSE OF DEATH* was as follows

Hemorrhage from
bowels

_____ (Duration) _____ yrs. _____ mos. _____ ds.

Contributory (Secondary)

_____ (Duration) _____ yrs. _____ mos. _____ ds.

Signed) g. y. s. p. M. D.Jan 10 1913 (Address) Rehling

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place _____ In the _____
of death _____ yrs. _____ mos. _____ ds. State _____ yrs. _____ mos. _____ ds.

Where was disease contracted,

If not at place of death?

Former or

usual residence

19. PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

Idaho CityJan 10 1913

20. UNDERTAKER

ADDRESS

John Phillips Rehling

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Form V. S. No. 5. 12½ M. 7-24-11

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH.

Registration District No. 9County of JeromePrimary Registration District No. 2040City of Ruby

(No. _____, _____ St.)

File No. 1014Registered No. 1

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

Dorcas Morgan Anderson

If death occurred in a hospital, institution or camp give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX

M

4. COLOR OR RACE

White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED.

Babe
(Write the word.)

6. DATE OF BIRTH

Jan.
(Month)7
(Day)1913
(Year)

7. AGE

1 yrs. 26 mos. 26 ds.

IF LESS than 1 day
how many _____ hrs. or
_____ min?

8. OCCUPATION

- (a) Trade, profession or particular kind of work
(b) General nature of industry business or establishment in which employed (or employer)

Babe

9. BIRTHPLACE

(State or Country)

Idaho

10. NAME OF FATHER

James C. Anderson

11. BIRTHPLACE OF FATHER

(State or Country)

Utah

12. MAIDEN NAME OF MOTHER

Maud Martha Perry

13. BIRTHPLACE OF MOTHER

(State or Country)

Utah

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

J. C. Anderson
Ruby, ID.

(Address)

15.

Filed

Feb 10, 1913Ray H. Fisher, M.D.
Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH

Feb.
(Month)7
(Day)1913
(Year)

17. I HEREBY CERTIFY, That I attended deceased from

191

to

191that I last saw him alive on 191

and that death occurred on the date stated above, at _____ M.

The CAUSE OF DEATH* was as follows:

Not known. Sudden death
before physician could be
called. (Duration) Call yrs. Pos mos. ds.
Contributory Constitutional heart condition
(Secondary) Two hrs.
(Duration) Two yrs. mos. ds.
(Signed) Ray H. Fisher M. D.
Feb 3 1913 (Address) Ruby, Ida.

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place _____ In the _____
of death _____ yrs. _____ mos. _____ ds. State _____ yrs. _____ mos. _____ ds.
Where was disease contracted,
If not at place of death? _____
Former or
usual residence. _____

19. PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

Ruby IdaFeb 3, 1913

20. UNDERTAKER

ADDRESS

DruidsRubyRuby ID.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Form V. S. No. 5. 12½ M. 7-24-11

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics
File No. 4015
Registered No. 3

1. PLACE OF DEATH. Registration District No. 9
County of Immun Primary Registration District No. 2040
City of Rigby (No. _____, _____ St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Rita Mary Later.

If death occurred in a hospital, institution or camp give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX F. 4. COLOR OR RACE W. 5. SINGLE, MARRIED, WIDOWED OR DIVORCED. Babr.
(Write the word.)

6. DATE OF BIRTH Aug 18 1913
(Month) (Day) (Year)

7. AGE 5 yrs. 5 mos. 13 ds. IF LESS than 1 day how many _____ hrs. or _____ min?

8. OCCUPATION

(a) Trade, profession or particular kind of work
(b) General nature of industry business or establishment in which employed (or employer)

Baby.

9. BIRTHPLACE

(State or Country)

Idaho

10. NAME OF FATHER

Louis Later.

11. BIRTHPLACE OF FATHER

(State or Country)

Idaho.

12. MAIDEN NAME OF MOTHER

Chloe C. Call.

13. BIRTHPLACE OF MOTHER

(State or Country)

Idaho.

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

Louis Later.

(Address)

Rigby - Idaho

15.

Filed

Feb 10 1913 Ray H. Fisher
Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH Jan 31 1913
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from _____ 191____, to _____ 191____

that I last saw h_____ alive on _____ 191____

and that death occurred on the date stated above, at _____ M.

The CAUSE OF DEATH* was as follows:

No physician in attendance.
Died very suddenly.
Possible heart defect.

(Duration) _____ yrs. _____ mos. _____ ds.

Contributory (Secondary)

(Duration) _____ yrs. _____ mos. _____ ds.

(Signed) Ray H. Fisher M. D.

Feb 3 1913, (Address) Rigby.

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place _____ In the _____

of death _____ yrs. _____ mos. _____ ds. State _____ yrs. _____ mos. _____ ds.

Where was disease contracted,

If not at place of death?

Former or

usual residence.

19. PLACE OF BURIAL OR REMOVAL DATE OF BURIAL

Rigby, Ida Feb 7 1913.

20. UNDERTAKER

ADDRESS

Frieds Rigby Ida.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Form V. S. No. 5. 12½ M. 7-24-11

1. PLACE OF DEATH. Registration District No. 9
County of Franklin Primary Registration District No. 2081
City of Ashton (No. _____, St.)

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics
File No. 1046
Registered No. 4

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

Helen E. Romkin

If death occurred in a hospital, institution or camp give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX F 4. COLOR OR RACE W 5. SINGLE, MARRIED, WIDOWED OR DIVORCED. Single
(Write the word.)

6. DATE OF BIRTH Dec. 3 1893
(Month) (Day) (Year)

7. AGE 19 yrs. 23 mos. 23 ds.
IF LESS than 1 day how many _____ hrs. or _____ min?

8. OCCUPATION

(a) Trade, profession or particular kind of work.
(b) General nature of industry business or establishment in which employed (or employer)

at home

9. BIRTHPLACE

(State or Country)

Idaho

10. NAME OF FATHER

J. H. Romkin

11. BIRTHPLACE OF FATHER

(State or Country)

Virginia

12. MAIDEN NAME OF MOTHER

Sarah E.

13. BIRTHPLACE OF MOTHER

(State or Country)

Virginia

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

(Address)

Sarah E. Romkin
Ashton Ida

15.

Filed

File 1046 1913 Ray S. Fishman
Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH

Jan 3 1913
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from

1912, to Jan 3 1913
that I last saw him alive on Nov. 1912

and that death occurred on the date stated above, at _____ M.

The CAUSE OF DEATH* was as follows:

Paralysis

_____ (Duration) 4 yrs. _____ mos. _____ ds.

Contributory
(Secondary)

_____ (Duration) _____ yrs. _____ mos. _____ ds.

(Signed)

E. K. Hargis M. D.
Jan 3 1913 (Address) Ashton

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place _____ In the _____
of death _____ yrs. _____ mos. _____ ds. State _____ yrs. _____ mos. _____ ds.

Where was disease contracted,

If not at place of death?

Former or

usual residence.

19. PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

St. Anthony

Jan 5 1913

20. UNDERTAKER

ADDRESS

W. D. Yager

St. Anthony

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Form V, S. No. 5. 12½ M. 7-24-11

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics
File No. 1017
Registered No. 239

1. PLACE OF DEATH. Registration District No. 12
County of Booleman Primary Registration District No. 2051
City of Parktown (No. _____ St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Martin Hansen

If death occurred in a hospital, institution or camp give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX M 4. COLOR OR RACE W 5. SINGLE, MARRIED, WIDOWED OR DIVORCED. Single
(Write the word.)

6. DATE OF BIRTH _____
(Month) (Day) (Year)

7. AGE about IF LESS than 1 day
80 yrs. 0 mos. 0 ds. how many _____ hrs. or min?

8. OCCUPATION
(a) Trade, profession or particular kind of work. C. Charge
(b) General nature of industry business or establishment in which employed (or employer) _____

9. BIRTHPLACE
(State or Country) Norman

10. NAME OF FATHER _____

11. BIRTHPLACE OF FATHER
(State or Country) Norman

12. MAIDEN NAME OF MOTHER _____

13. BIRTHPLACE OF MOTHER
(State or Country) Norman

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) S. S. Spuman
(Address) Parktown

15. Filed 2/10 1913 S. S. Spuman
Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH Jan 30 1913
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from Jan 27 1913, to Jan 30 1913
that I last saw h. alive on " 30 1913
and that death occurred on the date stated above, at 5 PM.

The CAUSE OF DEATH* was as follows:
Encephalitis Facial

(Duration) _____ yrs. _____ mos. 03 ds.
Contributory Old age
(Secondary)
(Duration) _____ yrs. _____ mos. _____ ds.
(Signed) S. S. Spuman M. D.
1/30 1913 (Address) Parktown

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place County Hosp. In the _____
of death. _____ yrs. _____ mos. _____ ds. State _____ yrs. _____ mos. _____ ds.
Where was disease contracted, "
If not at place of death?
Former or
usual residence. C. Charge for 12 yrs

19. PLACE OF BURIAL OR REMOVAL Parktown DATE OF BURIAL 1/31 1913

20. UNDERTAKER Robt. R. Sore ADDRESS _____

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Form V. S. No. 5. 12½ M. 7-24-11

1. PLACE OF DEATH. Registration District No. 1003
County of Boonville Primary Registration District No. 1003
City of Cour D'Alene (No. _____, St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Gen. S. Blakeslee

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

File No. 1018
Registered No. 238

If death occurred in a hospital, institution or camp give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX Male 4. COLOR OR RACE white 5. SINGLE, MARRIED, WIDOWED OR DIVORCED. Single
(Write the word.)

6. DATE OF BIRTH Mar. 11 1906
(Month) (Day) (Year)

7. AGE 6 yrs. 10 mos. 17 ds. IF LESS than 1 day
how many hrs. or min?

8. OCCUPATION

(a) Trade, profession or particular kind of work. at home
(b) General nature of industry business or establishment in which employed (or employer)

9. BIRTHPLACE

(State or Country) Cal.

10. NAME OF FATHER W.E. Blakeslee

11. BIRTHPLACE OF FATHER

(State or Country) Iowa

12. MAIDEN NAME OF MOTHER Ada Powell

13. BIRTHPLACE OF MOTHER

(State or Country) Nebr.

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) W.E. Blakeslee
(Address) Cour D'Alene Idaho

15. 710 1913 S. S. Drumm
Filed Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH Jan 28 1913
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from Dec 18 1912 to Jan 28 1913

that I last saw him alive on Jan 27 1913

and that death occurred on the date stated above, at 5 A.M.

The CAUSE OF DEATH* was as follows:

Pulmonary Edema

(Duration) yrs. mos. 2 ds.
Contributory (Secondary) Infantile Paralysis

(Duration) yrs. 6 mos. ds.
(Signed) J. E. Drumm M. D.
Jan 29 1913 (Address) Cour D'Alene Idaho

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place In the
of death yrs. mos. ds. State yrs. mos. ds.
Where was disease contracted,
If not at place of death?
Former or
usual residence.....

19. PLACE OF BURIAL OR REMOVAL DATE OF BURIAL
Forest Grove Jan 30 1913

20. UNDERTAKER ADDRESS
Cassedy & Nelson Cour D'Alene

MARGIN RESERVED FOR BINDING
WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Form V. S. No. 5. 12½ M. 7-24-11

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics
File No. 4049
Registered No. 287

1. PLACE OF DEATH.
County of Kootenai
City of E. Ida

Registration District No. 12
Primary Registration District No. 1053
(No. , St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

John Gatchel

If death occurred in a hospital, institution or camp give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX male 4. COLOR OR RACE white 5. SINGLE, MARRIED, WIDOWED OR DIVORCED. married
(Write the word.)

6. DATE OF BIRTH

1841
(Month) (Day) (Year)

7. AGE

72 yrs. mos. ds.

IF LESS than 1 day
how many hrs. or min?

8. OCCUPATION

(a) Trade, profession or particular kind of work.
(b) General nature of industry business or establishment in which employed (or employer)

no record

9. BIRTHPLACE

(State or Country)

Idaho

10. NAME OF FATHER

John Gatchel

11. BIRTHPLACE OF FATHER

(State or Country)

12. MAIDEN NAME OF MOTHER

13. BIRTHPLACE OF MOTHER

(State or Country)

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) E. E. Gatchel

(Address)

15.

Filed 2/10 1913

Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH

Jan 28th 1913
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from Dec 20th 1913, to Jan 28 1913 that I last saw him alive on Jan 28 1913 and that death occurred on the date stated above, at 129 M.

The CAUSE OF DEATH* was as follows:

Calculus disease of head

(Duration) 5 yrs. mos. ds.
Contributory (Secondary) Secondary disease

(Duration) 6 yrs. mos. ds.
(Signed) J. B. B. M. D.
Jan 29 1913 (Address) Pres. H. H. H.

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place In the
of death yrs. mos. ds. State yrs. mos. ds.
Where was disease contracted,
If not at place of death?
Former or usual residence

19. PLACE OF BURIAL OR REMOVAL DATE OF BURIAL

Funeral Home Jan 30 1913

20. UNDERTAKER

Address E. Ida

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Form V. S. No. 5. 12½ M. 7-24-11

CERTIFICATE OF DEATH

1. PLACE OF DEATH. Registration District No. 12
 County of Booninai Primary Registration District No. 1063
 City of Cover D'Alen (No. _____, _____ St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

Anne Esqate

State of Idaho
 BOARD OF HEALTH
 Bureau of Vital Statistics
 File No. 4050
 Registered No. 236

If death occurred in a hospital, institution or camp give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX Female 4. COLOR OR RACE White 5. SINGLE, MARRIED, WIDOWED OR DIVORCED. Married
 (Write the word.)

6. DATE OF BIRTH July 29 1884
 (Month) (Day) (Year)

7. AGE 78 yrs. 5 mos. 25 ds. IF LESS than 1 day how many _____ hrs. or _____ min?

8. OCCUPATION

(a) Trade, profession or particular kind of work. Housewife
 (b) General nature of industry, business or establishment in which employed (or employer)

9. BIRTHPLACE (State or Country) England

10. NAME OF FATHER John Regester

11. BIRTHPLACE OF FATHER (State or Country) England

12. MAIDEN NAME OF MOTHER Harriet Laws

13. BIRTHPLACE OF MOTHER (State or Country) England

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) J. W. Esqate

(Address) _____

15.

Filed 2/10 1913

A. S. Suman
 Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH

January 23 1913
 (Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from Nov. 20 1913 to January 22 1913

that I last saw him alive on January 22 1913 and that death occurred on the date stated above, at _____ M.

The CAUSE OF DEATH* was as follows:

Cerebral embolism.

(Duration) _____ yrs. 2 mos. _____ ds.

Contributory (Secondary)

(Duration) _____ yrs. _____ mos. _____ ds.

(Signed) John D. Wood M. D.

Jan. 24 1913 (Address) Cover D'Alen, Ida.

(State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place _____ In the _____
 of death _____ yrs. _____ mos. _____ ds. State _____ yrs. _____ mos. _____ ds.
 Where was disease contracted, _____
 If not at place of death? _____
 Former or _____
 usual residence _____

19. PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

Forest Cem.

Jan 25 1913

20. UNDERTAKER

ADDRESS

Cassidy & Nelson Cover D'Alen

WRITE PLAINLY, WITH UNFADEING INK—THIS IS A PERMANENT RECORD. PHYSICIANS should be carefully supplied. AGE should be stated EXACTLY. Exact state-ment of CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact state-ment of OCCUPATION is very important. See instructions on back of certificate.

Form V. S. No. 5. 12½M.7-24-11

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics
File No. 1051
Registered No. 235

1. PLACE OF DEATH. Registration District No. 12
County of Boone Primary Registration District No. 1003
City of Boone (No. _____ St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Johanna M. Olson

If death occurred in a hospital, institution or camp give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX Female 4. COLOR OR RACE White 5. SINGLE, MARRIED, WIDOWED OR DIVORCED. Married
(Write the word.)

6. DATE OF BIRTH Apr. 18 1862
(Month) (Day) (Year)

7. AGE 50 yrs. 9 mos. 3 ds. IF LESS than 1 day
how many _____ hrs. or _____ min?

8. OCCUPATION

(a) Trade, profession or particular kind of work. Housewife
(b) General nature of industry business or establishment in which employed (or employer)

9. BIRTHPLACE
(State or Country) Danmark

10. NAME OF FATHER Mattson

11. BIRTHPLACE OF FATHER
(State or Country) Danmark

12. MAIDEN NAME OF MOTHER

13. BIRTHPLACE OF MOTHER
(State or Country) Danmark

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Christian Olson
(Address) _____

15. Filed 2/10 1913 J. J. Brennan
Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH Jan 22 1913
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from June 1st 1912 to Jan 22nd 1913
that I last saw her alive on Jan 21st 1913
and that death occurred on the date stated above, at 1:20 M.

The CAUSE OF DEATH* was as follows:

Valvular disease of the heart
Cerebral Hemiplegia

(Duration) 8 yrs. — mos. — ds.
Contributory (Secondary) Wroemia

(Duration) 3 yrs. — mos. — ds.
(Signed) Jno. B. Smith M. D.
Jan 22nd 1913 (Address) Cornell College

State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place _____ In the _____
of death _____ yrs. _____ mos. _____ ds. State _____ yrs. _____ mos. _____ ds.
Where was disease contracted, _____
If not at place of death? _____
Former or _____
usual residence _____

19. PLACE OF BURIAL OR REMOVAL Forest Cem. DATE OF BURIAL Jan 23 1913
20. UNDERTAKER Cassidy & Nelson ADDRESS Cornell College

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Form V. S. No. 5. 12½ M. 7-24-11

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics
File No. 1052
Registered No. 2340

1. PLACE OF DEATH. Registration District No. 14
County of Boone Primary Registration District No. 1003
City of Corn D'Alene (No. _____, St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

Eliza Roderick

If death occurred in a hospital, institution or camp give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX Female 4. COLOR OR RACE White 5. SINGLE, MARRIED, WIDOWED OR DIVORCED. married
(Write the word.)

6. DATE OF BIRTH Sept 18 1844
(Month) (Day) (Year)

7. AGE 66 yrs. 4 mos. 1 ds. IF LESS than 1 day
how many _____ hrs. or _____ min?

8. OCCUPATION

(a) Trade, profession or particular kind of work. Housewife
(b) General nature of industry business or establishment in which employed (or employer)

9. BIRTHPLACE
(State or Country) Ohio

10. NAME OF FATHER Henry Bergoy

11. BIRTHPLACE OF FATHER
(State or Country) Penn

12. MAIDEN NAME OF MOTHER Giesinger

13. BIRTHPLACE OF MOTHER
(State or Country) Penn

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) E. E. Roderick
(Address) Corn D'Alene

15. Filed 2/10 1913 J. S. Sreeman
Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH Jan 20 1913
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from Dec 23 1912 to Jan 20 1913
that I last saw h. lv alive on Jan 20 1913
and that death occurred on the date stated above, at 1230 P M.
The CAUSE OF DEATH* was as follows:

Nephritis

(Duration) 1 yrs. 6 mos. _____ ds.
Contributory (Secondary)

(Duration) _____ yrs. _____ mos. _____ ds.
(Signed) J. O. Dyer M. D.
Jan 21 1913 (Address) Corn D'Alene Ida

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place _____ In the _____
of death _____ yrs. _____ mos. _____ ds. State _____ yrs. _____ mos. _____ ds.
Where was disease contracted,
If not at place of death? _____
Former or
usual residence _____

19. PLACE OF BURIAL OR REMOVAL DATE OF BURIAL

Forest Cem Jan 27 1913

20. UNDERTAKER ADDRESS

Cassedy & Nelson Corn D'Alene

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Form V. S. No. 5. 12½ M. 7-24-11

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics
File No. 4053
Registered No. 233

1. PLACE OF DEATH. Registration District No. 14
County of Boone Primary Registration District No. 1003
City of Coeur D'Alene (No. _____, St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

Frank Bishop

If death occurred in a hospital, institution or camp give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX Male 4. COLOR OR RACE White 5. SINGLE, MARRIED, WIDOWED OR DIVORCED. Married
(Write the word.)

6. DATE OF BIRTH July 5 1869
(Month) (Day) (Year)

7. AGE 43 yrs. 6 mos. 13 ds. IF LESS than 1 day
how many hrs. or min?

8. OCCUPATION

(a) Trade, profession or particular kind of work.
(b) General nature of industry business or establishment in which employed (or employer)

Drayman

9. BIRTHPLACE

(State or Country)

Mich.

10. NAME OF FATHER

Orin Bishop

11. BIRTHPLACE OF FATHER

(State or Country)

New York

12. MAIDEN NAME OF MOTHER

Mary Smith

13. BIRTHPLACE OF MOTHER

(State or Country)

England

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

Hattie Bishop

(Address)

Coeur D'Alene

15.

Filed 2/10 1913

J. D. Greenman
Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH

Jan 18 1913
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I ~~attended deceased from~~
191 to 191

that I last saw him alive on Jan 18 1913
and that death occurred on the date stated above, at 12:28 M.

The CAUSE OF DEATH* was as follows:

Hemorrhage from lung

(Duration) 45 min yrs. — mos. — ds.

Contributory (Secondary)

(Duration) — yrs. — mos. — ds.

(Signed)

W. H. Holden M. D.

Jan 18 1913 (Address) Coeur D'Alene

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place In the
of death yrs. mos. ds. State yrs. mos. ds.
Where was disease contracted,
If not at place of death?
Former or
usual residence.

19. PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

Forest Cemetery 191—

20. UNDERTAKER

ADDRESS

Coeur D'Alene Idaho

WRITE PLAINLY, WITH UNFADE INK—THIS IS A PERMANENT RECORD. N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Form V. S. No. 5. 12½ M. 7-24-11

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics
File No. 4054
Registered No. 232

1. PLACE OF DEATH. Registration District No. 12
County of Butte Primary Registration District No. 1 A 5 2
City of Boise (No. _____, _____ St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Colmora Sawyer

If death occurred in a hospital, institution or camp give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX Female 4. COLOR OR RACE W 5. SINGLE, MARRIED, WIDOWED OR DIVORCED. Single
(Write the word.)

6. DATE OF BIRTH Dec 1912
(Month) (Day) (Year)

7. AGE 6 weeks ds. IF LESS than 1 day
how many _____ hrs. or _____ min?

8. OCCUPATION

- (a) Trade, profession or particular kind of work.
(b) General nature of industry business or establishment in which employed (or employer)

9. BIRTHPLACE

(State or Country) Over 2 years

10. NAME OF FATHER

W. J. Sawyer

11. BIRTHPLACE OF FATHER

(State or Country) Pen

12. MAIDEN NAME OF MOTHER

Sally Cassmora

13. BIRTHPLACE OF MOTHER

(State or Country) Pen

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) W. J. Sawyer

(Address) 1000 1st St

15.

Filed 2/10 1913

W. J. Sawyer
Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH Jan. 15 1913
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from Dec. 23 1912, to Jan. 14 1913

that I last saw him alive on Jan. 14 1913
and that death occurred on the date stated above, at _____ M.

The CAUSE OF DEATH* was as follows:

Follicular Tonsillitis

(Duration) _____ yrs. _____ mos. 4 ds.
Contributory (Secondary) Ophthalmitis

(Duration) _____ yrs. _____ mos. 21 ds.
(Signed) John O'Leary M. D.
Jan. 15 1913 (Address) Coeur d'Alene, Ida

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place _____ In the _____
of death _____ yrs. _____ mos. _____ ds. State _____ yrs. _____ mos. _____ ds.
Where was disease contracted,
If not at place of death? _____
Former or
usual residence. _____

19. PLACE OF BURIAL OR REMOVAL DATE OF BURIAL

Forest Ave Jan 16 1913
20. UNDERTAKER ADDRESS
S. J. Sawyer Boise

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics
File No. 1055
Registered No. 231

If death occurred in a hospital, institution or camp give its **NAME** instead of street and number.

1. PLACE OF DEATH. Registration District No. 12
County of Koutina Primary Registration District No. 1003
City of Evansdale (No. 2 St. 2)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Wesley - M^e Vinal

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED OR DIVORCED.
Female	White	Single (Write the word.)

6. DATE OF BIRTH Nov 1 1912
(Month) (Day) (Year)

7. AGE _____ yrs. 2 mos. _____ ds. IF LESS than 1 day
how many hrs. or
..... min?

8. OCCUPATION

- (a) Trade, profession or particular kind of work.....
(b) General nature of industry business or establishment in which employed (or employer)

9. BIRTHPLACE
(State or Country) D. C.

10. NAME OF FATHER *James Mc Donald*

**11. BIRTHPLACE
OF FATHER**
(State or Country)

12. MAIDEN NAME
OF MOTHER *Amin G. Am/2 son*

**13. BIRTHPLACE
OF MOTHER**
(State or Country)

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Mr. J. J. J. J.
(Address) 1234 Main St.

15. Filed 2/10 1919 W. W. Newman
Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH

Jan 11 1913
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from Oct 30 1912, to Jan 1st 1913
that I last saw her alive on about Dec 8. 1912
and that death occurred on the date stated above, at 6 P. M.
The CAUSE OF DEATH* was as follows:

..... (Duration) yrs. mos. 41 ds.

Contributory -----
(Secondary)

(Duration) yrs. mos. ds.
(Signed) M. D. *June 11 1913* (Address) *C. D. Allen*

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place	In the
of death.....yrs.....mos.....ds.	State.....yrs.....mos.....ds.
Where was disease contracted,	
If not at place of death?.....	
Former or	
usual residence.....	

19. PLACE OF BURIAL OR REMOVAL DATE OF BURIAL

20. UNDERTAKER	Jan 13 1913
ADDRESS	

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Form V. S. No. 5. 12½ M. 7-24-11

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics
File No. 1056
Registered No. 230

1. PLACE OF DEATH. Registration District No. 12
County of Butte Primary Registration District No. 1003
City of C. B. A. (No. 1003 St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

Infant son of
John Mc Taggart

If death occurred in a hospital, institution or camp give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX male 4. COLOR OR RACE W 5. SINGLE, MARRIED, WIDOWED OR DIVORCED. Single
(Write the word.)

6. DATE OF BIRTH Dec 29 1912
(Month) (Day) (Year)

7. AGE yrs. 12 mos. ds. IF LESS than 1 day how many hrs. or min?

8. OCCUPATION

- (a) Trade, profession or particular kind of work.
(b) General nature of industry business or establishment in which employed (or employer)

9. BIRTHPLACE

(State or Country) Conn & Alen

10. NAME OF FATHER

John Mc Taggart

11. BIRTHPLACE OF FATHER

(State or Country) Mich

12. MAIDEN NAME OF MOTHER

Bill Andrews

13. BIRTHPLACE OF MOTHER

(State or Country) Kent y

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) J Mc Taggart

(Address) 1014 Pine

15.

Filed 2/10 1913

1913

D. S. Newman
Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH

Jan 11 1913
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from Dec 29 1912, to Jan 11 1913.

that I last saw him alive on Jan 11 1913 and that death occurred on the date stated above, at 8 P. M.

The CAUSE OF DEATH* was as follows:

Jaundice with suppression of urine

(Duration) yrs. mos. 12 ds.

Contributory (Secondary)

(Duration) yrs. mos. ds.

(Signed) J. H. Hadden M. D.

Jan 12 1913 (Address) Conn & Alen
*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place In the
of death yrs. mos. ds. State yrs. mos. ds.
Where was disease contracted,
If not at place of death?
Former or
usual residence.

19. PLACE OF BURIAL OR REMOVAL DATE OF BURIAL

Forest Cem Jan 13 1913

20. UNDERTAKER

ADDRESS

J. H. Hadden
C. B. A.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Form V. S. No. 5. 12½ M. 7-24-11

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH. Registration District No. 2118
County of Boise Primary Registration District No. 2118
City of Boise (No. _____, _____ St.)

File No. 1057
Registered No. 229

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Magdalena Kalispele

If death occurred in a hospital, institution or camp give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX Female 4. COLOR OR RACE Indian 5. SINGLE, MARRIED, WIDOWED OR DIVORCED. Widow
(Write the word.)

6. DATE OF BIRTH March 18 33
(Month) (Day) (Year)

7. AGE 80 yrs. — mos. — ds. IF LESS than 1 day how many.....hrs. or min?

8. OCCUPATION

(a) Trade, profession or particular kind of work. Housewife
(b) General nature of industry business or establishment in which employed (or employer)

9. BIRTHPLACE

(State or Country) Not known

10. NAME OF FATHER

" "

11. BIRTHPLACE OF FATHER

(State or Country) " "

12. MAIDEN NAME OF MOTHER

" "

13. BIRTHPLACE OF MOTHER

(State or Country) " "

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Father Paul
(Address) Desmet Ida

15. July 10/13 J. J. Drewman
Filed Jan. 14 1913 her J. J. Drewman
Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH

Jan 10 1913
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from 191 to 191

that I last saw h. alive on 191

and that death occurred on the date stated above, at M.

The CAUSE OF DEATH* was as follows:

Paralysis

No physician in attendance

(Duration) yrs. mos. ds.

Contributory (Secondary)

(Duration) yrs. mos. ds.

(Signed) J. R. Leppard M. D.

19 (Address) Desmet

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place In the
of death yrs. mos. ds. State yrs. mos. ds.

Where was disease contracted,

If not at place of death?

Former or

usual residence.

19. PLACE OF BURIAL OR REMOVAL DATE OF BURIAL

Desmet Jan 11 1913

20. UNDERTAKER

ADDRESS

Desmet

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Form V. S. No. 5. 12½ M. 7-24-11

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics
File No. 1058
Registered No. 228

1. PLACE OF DEATH. Registration District No. 14
County of Kootenai Primary Registration District No. 1003
City of Coeur d'Alene (No. _____, St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

Jessie Mildred Philips

If death occurred in a hospital, institution or camp give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX Female 4. COLOR OR RACE White 5. SINGLE, MARRIED, WIDOWED OR DIVORCED.

(Write the word.)

6. DATE OF BIRTH Oct 22 1912
(Month) (Day) (Year)

7. AGE 1 yrs. 2 mos. 15 ds. IF LESS than 1 day how many hrs. or min?

8. OCCUPATION

- (a) Trade, profession or particular kind of work.....
(b) General nature of industry business or establishment in which employed (or employer).....

9. BIRTHPLACE

(State or Country)

Ida

10. NAME OF FATHER

Franklin Philips

11. BIRTHPLACE OF FATHER

(State or Country)

Mich.

12. MAIDEN NAME OF MOTHER

Sarah House

13. BIRTHPLACE OF MOTHER

(State or Country)

Mich.

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Mrs. Sarah Philips
(Address) Coeur d'Alene

15.

Filed Feb 4 1913

D. D. Newman
Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH

Jan - 9 1913
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from about 10 min after death 1913

that I last saw her alive at 4:30 Dec 9 1913

and that death occurred on the date stated above, at 4:30 A.M.

The CAUSE OF DEATH* was as follows:

acute gastric intestinal disturbance died suddenly
(Duration) _____ yrs. _____ mos. _____ ds.

Contributory (Secondary)

(Duration) _____ yrs. _____ mos. _____ ds.

(Signed) W. H. Stodden M. D.

Jan 9 1913 (Address) Coeur d'Alene

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place _____ In the _____
of death yrs. mos. ds. State yrs. mos. ds.

Where was disease contracted,

If not at place of death?

Former or

usual residence.

19. PLACE OF BURIAL OR REMOVAL DATE OF BURIAL

Forest Cemetery Jan. 12 1913

20. UNDERTAKER

ADDRESS

Cassidy & Nelson Coeur d'Alene

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

1. PLACE OF DEATH. Registration District No. 218
County of Western Primary Registration District No. 2118
City of Grand Mission (No. _____, _____ St.)

Bureau of Vital Statistics
File No. 1059
Registered No. 227

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

Julia Prand

If death occurred in a hospital, institution or camp give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX Female 4. COLOR OR RACE Indian 5. SINGLE, MARRIED, WIDOWED OR DIVORCED. married
(Write the word.)

6. DATE OF BIRTH Aloud 1867
(Month) (Day) (Year)

7. AGE 40 yrs. — mos. — ds. IF LESS than 1 day how many hrs. or min?

8. OCCUPATION

(a) Trade, profession or particular kind of work Housewife
(b) General nature of industry business or establishment in which employed (or employer) _____

9. BIRTHPLACE

(State or Country) Reservation

10. NAME OF FATHER

Edward

11. BIRTHPLACE OF FATHER

(State or Country) Reservation

12. MAIDEN NAME OF MOTHER

Mary Julia

13. BIRTHPLACE OF MOTHER

(State or Country) Reservation

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Arthur D. Pratt
(Address) Grand, Ida

15. at J. D. Prand
Filed July 10/15 1915 Mr. J. L. Langley
Ind Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH

Jan 6 1915
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from 191 to 191

that I last saw h. alive on 191

and that death occurred on the date stated above, at M.

The CAUSE OF DEATH* was as follows:

The result of blows upon the head - a case of homicide.

(Duration) yrs. mos. ds.

Contributory (Secondary)

(Duration) yrs. mos. ds.

(Signed) J. R. Ballard M. D.

16 (Address) Grand, Ida

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place In the
of death yrs. mos. ds. State yrs. mos. ds.

Where was disease contracted,

If not at place of death?

Former or

usual residence.

19. PLACE OF BURIAL OR REMOVAL DATE OF BURIAL

at J. D. Prand 1/7 1915

20. UNDERTAKER

ADDRESS

None

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Form V. S. No. 5. 12½ M. 7-24-11

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH.
County of Kootenai
City of Coeur D'Alene

Registration District No. 12
Primary Registration District No. 1443
(No. _____, _____ St.)

File No. 4069
Registered No. 226

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Infant

If death occurred in a hospital, institution or camp give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX Male 4. COLOR OR RACE White 5. SINGLE, MARRIED, WIDOWED OR DIVORCED.
(Write the word.)

6. DATE OF BIRTH January 4th 1913
(Month) (Day) (Year)

7. AGE _____ yrs. _____ mos. 1 ds. IF LESS than 1 day
how many _____ hrs. or _____ min?

8. OCCUPATION

- (a) Trade, profession or particular kind of work
(b) General nature of industry business or establishment in which employed (or employer)

9. BIRTHPLACE
(State or Country)

10. NAME OF FATHER Clair B. Pershall

11. BIRTHPLACE OF FATHER
(State or Country)

12. MAIDEN NAME OF MOTHER Esther Weir

13. BIRTHPLACE OF MOTHER
(State or Country)

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Clair B. Pershall
(Address) Coeur d'Alene

15. Filed 2/10 1913 S. S. Muman
Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH January 5th 1913
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from January 4th 1913, to January 5th 1913
that I last saw him alive on January 4th 1913
and that death occurred on the date stated above, at 2 P. M.

The CAUSE OF DEATH* was as follows:

aspiration pneumonia

(Duration) _____ yrs. _____ mos. _____ ds.
Contributory (Secondary)

(Duration) _____ yrs. _____ mos. _____ ds.
(Signed) Louis H. Most M. D.
January 5th 1913 (Address) Coeur d'Alene

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place _____ In the _____
of death _____ yrs. _____ mos. _____ ds. State _____ yrs. _____ mos. _____ ds.
Where was disease contracted,
If not at place of death?
Former or
usual residence _____

19. PLACE OF BURIAL OR REMOVAL DATE OF BURIAL

Forest Cem. Jan 7 1913
20. UNDERTAKER ADDRESS

Cassedy & Nelson Coeur D'Alene

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Form V. S. No. 5 20M.1-16-12

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH.

Registration District No. 12

County of Kootenai

Primary Registration District No. 2049

City of St. Maries

(No. _____, St.)

File No. 1901

Registered No. 225

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

Lyle L. Sweet

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX

4. COLOR OR RACE

5. SINGLE, MARRIED, WIDOWED, OR DIVORCED.

Female White

Single
(Write the word.)

6. DATE OF BIRTH

_____. _____. _____.
(Month) (Day) (Year)

7. AGE

20 yrs. ____ mos. ____ ds.

IF LESS than 1 day
how many ____ hrs. or
____ mins.?

8. OCCUPATION

(a) Trade, profession or particular kind of work

(b) General nature of industry business, or establishment in which employed (or employer)

House work

9. BIRTHPLACE

(State or Country)

Wash.

10. NAME OF FATHER

A. L. Sweet

11. BIRTHPLACE OF FATHER

(State or Country)

Mich.

12. MAIDEN NAME OF MOTHER

M. Kirkham

13. BIRTHPLACE OF MOTHER

(State or Country)

Kolo.

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

A. L. Sweet

(Address)

St. Maries Id.

15.

Filed

7/10

1913

A. L. Sweet

Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH

Jan. 2 1913
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from

Dec. 27 1912, to Jan 2 1913

that I last saw her alive on Dec. 27 1912

and that death occurred on the date stated above, at 9 A. M.

The CAUSE OF DEATH* was as follows:

Epilepsy & Insanity

(Duration) 13 yrs. 1 mos. ____ ds.

Contributory (Secondary)

Epilepsy

(Duration) 13 yrs. ____ mos. ____ ds.

(Signed)

Owen D. Platt M. D.

Jan 2 1913 (Address) St. Maries Id.

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death

____ yrs. ____ mos. ____ days.

In the State

____ yrs. ____ mos. ____ days.

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

St. Maries

Jan. 4 1913

20. UNDERTAKER

ADDRESS

H. L. Muleady

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Form V. S. No. 5. 12½M.7-24-11

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics
File No. 1002
Registered No. 1

1. PLACE OF DEATH. Registration District No. 16
County of My Perce Primary Registration District No. 2076
City of Lenora (No. _____, _____ St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME George Grant Harp

If death occurred in a hospital, institution or camp give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX male 4. COLOR OR RACE white 5. SINGLE, MARRIED, WIDOWED OR DIVORCED. single
(Write the word.)

6. DATE OF BIRTH Nov. 27 1912
(Month) (Day) (Year)

7. AGE 2 yrs. 1 mos. 13 ds. IF LESS than 1 day
how many _____ hrs. or _____ min?

8. OCCUPATION
(a) Trade, profession or particular kind of work _____
(b) General nature of industry business or establishment in which employed (or employer) _____

9. BIRTHPLACE (State or Country) Idaho

10. NAME OF FATHER Frank Harp

11. BIRTHPLACE OF FATHER (State or Country) Penn.

12. MAIDEN NAME OF MOTHER Nora Pippinger

13. BIRTHPLACE OF MOTHER (State or Country) Iowa

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Frank Harp
(Address) Lenora Idaho

15. W. E. Stoddard
Filed Feb 20-1913 1913 W. E. Stoddard Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH Jan. 1 1913
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from Dec. 23 1912, to Jan. 1, 1913
that I last saw him alive on Jan. 1 1913
and that death occurred on the date stated above, at 10 P.M.
The CAUSE OF DEATH* was as follows:

Scarlet Fever.

(Duration) _____ yrs. _____ mos. _____ ds.
Contributory (Secondary) _____

(Signed) W. E. Stoddard M. D.
2/1 1913 (Address) Idaho

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place _____ In the _____
of death _____ yrs. _____ mos. _____ ds. State _____ yrs. _____ mos. _____ ds.
Where was disease contracted, _____
If not at place of death? _____
Former or _____
usual residence. _____

19. PLACE OF BURIAL OR REMOVAL DATE OF BURIAL

Southwick Idaho Jan. 2 1913
20. UNDERTAKER ADDRESS

W. E. Stoddard Siford, Ida.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Form V. S. No. 5. 12½ M. 7-24-11

1. PLACE OF DEATH. Registration District No. 707
County of Nez Perce Primary Registration District No. 2076
City of Leland (No. _____, _____ St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Francis Gertrude Richardson

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics
File No. 4063
Registered No. 2

If death occurred in a hospital, institution or camp give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX Female 4. COLOR OR RACE White 5. SINGLE, MARRIED, WIDOWED OR DIVORCED. Single
(Write the word.)

6. DATE OF BIRTH May 4 1909
(Month) (Day) (Year)

7. AGE 3 yrs. 7 mos. 27 ds. IF LESS than 1 day
how many _____ hrs. or _____ min?

8. OCCUPATION

- (a) Trade, profession or particular kind of work.
(b) General nature of industry business or establishment in which employed (or employer)

9. BIRTHPLACE

(State or Country) Idaho10. NAME OF FATHER Edra Richardson

BIRTHPLACE OF FATHER

(State or Country) Oregon12. MAIDEN NAME OF MOTHER Gerilda J. Blankinship

13. BIRTHPLACE OF MOTHER

(State or Country) Idaho

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Roy Richardson
(Address) Leland

15.

Filed Feb. 20 - 1913 W. E. Stoddard Local Registrar
1913

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH

Jan 1 1913
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from Dec 26 1912, to Jan 1 1913

that I last saw her alive on Jan Dec 31 1912
and that death occurred on the date stated above, at 10 A. M.

The CAUSE OF DEATH* was as follows:

congestion of the Bowels(Duration) _____ yrs. _____ mos. 5 ds.

Contributory (Secondary)

(Duration) _____ yrs. _____ mos. _____ ds.

(Signed) J. W. Stonebume M. D.
2/1 1913 (Address) Leland Idaho

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place _____ In the _____
of death _____ yrs. _____ mos. _____ ds. State _____ yrs. _____ mos. _____ ds.

Where was disease contracted,
If not at place of death?

Former or
usual residence.

19. PLACE OF BURIAL OR REMOVAL DATE OF BURIAL

CameronJan 2 1913

20. UNDERTAKER

ADDRESS

W. E. StoddardGifford

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIAN should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Form V. S. No. 5. 12½ M. 7-24-11

CERTIFICATE OF DEATH

1. PLACE OF DEATH. Registration District No. 6
County of Nezperce Primary Registration District No. 2074
City of Gifford (No. _____, St.)

BOARD OF HEALTH
Bureau of Vital Statistics
File No. 4064
Registered No. 3

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Chas Henry Aldrich

If death occurred in a hospital, institution or camp give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX Male 4. COLOR OR RACE White 5. SINGLE, MARRIED, WIDOWED OR DIVORCED. Married
(Write the word.)

6. DATE OF BIRTH Jan - 3 - 1913
(Month) (Day) (Year)

7. AGE 1 yrs. 1 mos. 1 ds. IF LESS than 1 day how many 6 hrs. or 10 min?

8. OCCUPATION
(a) Trade, profession or particular kind of work, _____
(b) General nature of industry business or establishment in which employed (or employer) _____

9. BIRTHPLACE Gifford Idaho
(State or Country)

10. NAME OF FATHER Henry Aldrich

11. BIRTHPLACE OF FATHER Oregon
(State or Country)

12. MAIDEN NAME OF MOTHER Velma Hays
Sant Fe

13. BIRTHPLACE OF MOTHER Iowa
(State or Country) Sant Fe

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Ray Stinson
(Address) Gifford Ida

15. _____

Filed Feb 20 1913 E. E. Watts Local Registrar
L. J. Cullen

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH Jan - 3 - 1913
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from Jan 3rd 1913 to Jan 3rd 1913
that I last saw him alive on Jan 4th 1913
and that death occurred on the date stated above, at 6:00 P.M.

The CAUSE OF DEATH* was as follows:

Premature Birth

(Duration) _____ yrs. _____ mos. _____ ds.
Contributory Physical Debility
(Secondary)

(Duration) _____ yrs. _____ mos. _____ ds.
(Signed) J. J. Hemmington M. D.
Jan 13th 1913 (Address) Gifford Ida

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death _____ yrs. _____ mos. _____ ds. In the State _____ yrs. _____ mos. _____ ds.
Where was disease contracted, _____
If not at place of death? _____
Former or usual residence _____

19. PLACE OF BURIAL OR REMOVAL Our Home Ranch DATE OF BURIAL Jan 4th 1913

20. UNDERTAKER A. M. Hooley ADDRESS Gifford Ida
"J. J. Hemmington" R. F. 02602

"Dr. Hemmington"

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Form V. S. No. 5. 12½ M. 7-24-11

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics
File No. 4065
Registered No. 4

1. PLACE OF DEATH. Registration District No. 16
County of Nez Perce Primary Registration District No. 2073
City of Culdesac (No. _____, St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Chyde S. Daley

If death occurred in a hospital, institution or camp give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX male 4. COLOR OR RACE white 5. SINGLE, MARRIED, WIDOWED OR DIVORCED. single
(Write the word.)

6. DATE OF BIRTH Oct 2 1913
(Month) (Day) (Year)

7. AGE 3 yrs. 2 mos. 2 ds. IF LESS than 1 day how many _____ hrs. or _____ min?

8. OCCUPATION
(a) Trade, profession or particular kind of work. none
(b) General nature of industry business or establishment in which employed (or employer) _____

9. BIRTHPLACE Culdesac Idaho
(State or Country)

10. NAME OF FATHER Frank S Daley

11. BIRTHPLACE OF FATHER Mich.
(State or Country)

12. MAIDEN NAME OF MOTHER Fay Davis

13. BIRTHPLACE OF MOTHER Mich.
(State or Country)

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Fay Daley (mother)
(Address) Culdesac Ida.

15. Jan. 6 1913
Feb. 20 1913 L. J. Pagsdals Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH Jan 5 1913
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from _____ 191____, to _____ 191____

that I last saw h. _____ alive on _____ 191____

and that death occurred on the date stated above, at _____ M.

The CAUSE OF DEATH* was as follows:

The child died in the night in bed from an unknown cause.

_____ (Duration) _____ yrs. _____ mos. _____ ds.

Contributory (Secondary) unknown if any.

_____ (Duration) _____ yrs. _____ mos. _____ ds.

(Signed) J. A. Pagsdals M. D.

15 1913 (Address) Culdesac

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place _____ In the _____
of death _____ yrs. _____ mos. _____ ds. State _____ yrs. _____ mos. _____ ds.

Where was disease contracted, _____
If not at place of death? _____

Former or usual residence _____

19. PLACE OF BURIAL OR REMOVAL DATE OF BURIAL

Culdesac _____ 191____

20. UNDERTAKER ADDRESS

Parents Culdesac

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Form V. S. No. 5. 12½ M. 7-24-11

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics
File No. 4086
Registered No. 5

1. PLACE OF DEATH. Registration District No. 16
County of Mya Puce Primary Registration District No. 1009
City of Lewiston (No. _____, St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

Martha A Bullard

If death occurred in a hospital, institution or camp give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX Female 4. COLOR OR RACE white 5. SINGLE, MARRIED, WIDOWED OR DIVORCED. widowed
(Write the word.)

6. DATE OF BIRTH Jan 7th 1913
(Month) (Day) (Year)

7. AGE 85 yrs. mos. ds. IF LESS than 1 day how many hrs. or min?

8. OCCUPATION
(a) Trade, profession or particular kind of work. none
(b) General nature of industry business or establishment in which employed (or employer)

9. BIRTHPLACE (State or Country) not known

10. NAME OF FATHER

11. BIRTHPLACE OF FATHER (State or Country)

12. MAIDEN NAME OF MOTHER

13. BIRTHPLACE OF MOTHER (State or Country)

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) C. F. Stranahan
(Address) Lewiston

15. Filed Feb. 20 1913 L. J. Bullard
Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH Jan 7th 1913
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from Dec 6th 1912, to Jan 7th 1913
that I last saw h. ed alive on Jan 6th 1913
and that death occurred on the date stated above, at 5 A. M.

The CAUSE OF DEATH* was as follows:
Heart-failure. died in
Pen. Farm

(Duration) yrs. mos. ds.

Contributory (Secondary)

(Duration) yrs. mos. ds.

(Signed) C. F. Stranahan Supl. Co Hospital
Jan. 8 1913 (Address) Lewiston Idaho

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place Mya Puce Camp Hosp In the
of death yrs. one mos. ds. State. yrs. mos. ds.

Where was disease contracted,
If not at place of death?
Former or usual residence Trasler Idaho

19. PLACE OF BURIAL OR REMOVAL DATE OF BURIAL

Lewiston Jan 8 1913

20. UNDERTAKER ADDRESS

C. J. Vassar Lewiston

WRITE PLAINLY, WITH UNFADING INK. THIS IS A PERMANENT RECORD. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain language. See margin for binding. MARGIN RESERVE. Exact state-ment of OCCUPATION is very important. See margin for binding.

Form No. 5. 12½ M. 7-24-11

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics
File No. 4007
Registered No. 1007

1. PLACE OF DEATH. Registration District No. 12
County of Blaine Primary Registration District No. 2076
City of Southwick (No. _____, St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Delah Baldwin

If death occurred in a hospital, institution or camp give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX Female 4. COLOR OR RACE White 5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.)
6. DATE OF BIRTH 2 (Month) 10 (Day) 1913 (Year)
7. AGE _____ yrs. _____ mos. _____ ds. IF LESS than 1 day how many 12 hrs. or _____ min?

8. OCCUPATION

(a) Trade, profession

(State or Country) Southwick

10. NAME OF FATHER Wm Baldwin

11. BIRTHPLACE OF FATHER Canada
(State or Country)

12. MAIDEN NAME OF MOTHER Alpha Gorge

13. BIRTHPLACE OF MOTHER Kansas
(State or Country)

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Wm Baldwin Father
(Address) Southwick

15. Filed Feb 20 1913 L. Perkins
Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH 2 (Month) 10 (Day) 1913 (Year)

17. I HEREBY CERTIFY, That I attended deceased from 191 to 191 that I last saw h_____ alive on 191 and that death occurred on the date stated above, at _____ M.

The CAUSE OF DEATH* was as follows:

Lack of vitality - no attending physician

(Duration) _____

Contributory (Secondary) _____

(Duration) _____ yrs. _____ mos. _____ ds.
(Signed) _____ M. D.

19. (Address) _____

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death _____ yrs. _____ mos. _____ ds. State _____ yrs. _____ mos. _____ ds.
Where was disease contracted, _____
If not at place of death? _____
Former or usual residence _____

19. PLACE OF BURIAL OR REMOVAL Southwick DATE OF BURIAL Feb 2 1913

20. UNDERTAKER Marrion Holton ADDRESS Southwick Idaho

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Form V. S. No. 5. 12½ M. 7-24-11

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics
File No. 1008
Registered No. 7

1. PLACE OF DEATH. Registration District No. 16
County of Nez Perce Primary Registration District No. 1009
City of Arbuckle (No. 1309, 10th Ave St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Mrs O E Stone

If death occurred in a hospital, institution or camp give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX Female 4. COLOR OR RACE White 5. SINGLE, MARRIED, WIDOWED OR DIVORCED.
Married
(Write the word.)

6. DATE OF BIRTH Oct 14 1868
(Month) (Day) (Year)

7. AGE 44 yrs 9 mos 27 ds IF LESS than 1 day
how many hrs. or min?

8. OCCUPATION

(a) Trade, profession or particular kind of work, Housewife
(b) General nature of industry business or establishment in which employed (or employer)

9. BIRTHPLACE

(State or Country) Idaho10. NAME OF FATHER W P Rucker

11. BIRTHPLACE OF FATHER

(State or Country) Idaho12. MAIDEN NAME OF MOTHER Francis L Anderson

13. BIRTHPLACE OF MOTHER

(State or Country) Idaho

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

(Address) O E Stone

15.

Filed Feb 20 1913 P J Perkins
Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH

Jan 11 1913
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from Did not attend at all she was dead when I was called
that I last saw her alive on about six months ago 1911

and that death occurred on the date stated above, at 4 M.

The CAUSE OF DEATH* was as follows:

Probable heart disease. Doctor of Clapton was treating her for cancer.

(Duration) yrs. mos. ds.

Contributory (Secondary)

(Duration) yrs. mos. ds.

(Signed) M B Harris M. D.

Jan 11 1913 (Address) Arbuckle Idaho

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; (2) whether ACCIDENTAL, SUICIDAL OR HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place In the
of death yrs. mos. ds. State yrs. mos. ds.
Where was disease contracted,
If not at place of death?
Former or
usual residence.

19. PLACE OF BURIAL OR REMOVAL DATE OF BURIAL

Lewiston Jan 13 1913
20. UNDERTAKER ADDRESS

O J Vassar Lewiston

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Form V. S. No. 5. 12½ M. 7-24-11

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics
File No. 4069
Registered No. 8

1. PLACE OF DEATH. Registration District No. 16
County of Nezperce Primary Registration District No. 1009
City of Lewiston (No. 15th St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

Cornie Hadley

If death occurred in a hospital, institution or camp give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX F 4. COLOR OR RACE W. 5. SINGLE, MARRIED, WIDOWED OR DIVORCED. Married
(Write the word.)

6. DATE OF BIRTH March 18 1882
(Month) (Day) (Year)

7. AGE 30 yrs. 8 mos. 27 ds. IF LESS than 1 day
how many hrs. or min?

8. OCCUPATION

(a) Trade, profession or particular kind of work.....
(b) General nature of industry business or establishment in which employed (or employer).....

Housewife

9. BIRTHPLACE

(State or Country)

10. NAME OF FATHER

John P. Huse

11. BIRTHPLACE OF FATHER

(State or Country)

Germany

12. MAIDEN NAME OF MOTHER

Catherine Rauch

13. BIRTHPLACE OF MOTHER

(State or Country)

Germany

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

Mrs. H. Hadley

(Address)

15.

Filed Feb. 20 1913

S. Perkins

Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH

Jan 12 1913
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from Sept 1 1912, to Jan 14 1913 that I last saw h. fr. alive on Jan 14 1913 and that death occurred on the date stated above, at A. M. The CAUSE OF DEATH* was as follows:

Hodgkin's disease

(Duration) yrs. mos. ds.

Contributory
(Secondary)

(Duration) yrs. mos. ds.

(Signed)

D. H. Huse M. D.
Jan 13 1913 (Address) Lewiston Idaho

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place yrs. mos. ds. In the
of death yrs. mos. ds. State yrs. mos. ds.
Where was disease contracted,
If not at place of death?
Former or
usual residence.

19. PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

C. J. Vassar

Jan 14 1913

20. UNDERTAKER

ADDRESS

Lewiston

Idaho

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Form V. S. No. 5. 12½M.7-24-11

CERTIFICATE OF DEATH

1. PLACE OF DEATH. Registration District No. 16
 County of No. 1 Primary Registration District No. 1009
 City of Lewiston (No. 6134, 8 st St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

B. D. Del

State of Idaho
 BOARD OF HEALTH
 Bureau of Vital Statistics

File No. 1070Registered No. 9

If death occurred in a hospital, institution or camp give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX M. 4. COLOR OR RACE W. 5. SINGLE, MARRIED, WIDOWED OR DIVORCED.
Married
 (Write the word.)

6. DATE OF BIRTH May 12 1906
 (Month) (Day) (Year)

7. AGE 52 yrs. 8 mos. 5 ds. IF LESS than 1 day how many.....hrs. or min?

8. OCCUPATION
 (a) Trade, profession or particular kind of work.....Merchant
 (b) General nature of industry business or establishment in which employed (or employer).....

9. BIRTHPLACE (State or Country) Ireland

10. NAME OF FATHER John Del

11. BIRTHPLACE OF FATHER (State or Country) Ireland

12. MAIDEN NAME OF MOTHER Anne Forrest

13. BIRTHPLACE OF MOTHER (State or Country) Ireland

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
 (Informant) John Del
 (Address).....

15. Filed Feb. 20 1913 M. Perkins
 Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH Jan 14 1913
 (Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from 1911, to Jan 7 1913
 that I last saw him live on Jan 6 1913
 and that death occurred on the date stated above, at 2 A. M.
 The CAUSE OF DEATH* was as follows:

Diabetes mellitus

(Duration) 16 yrs. fall mos. ds.

Contributory (Secondary)

(Duration) yrs. mos. ds.

(Signed) C. W. Graft M. D.

Jan 19 1913 (Address) Lewiston

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death.....yrs.....mos.....ds. State.....yrs.....mos.....ds.
 In the
 Where was disease contracted,
 If not at place of death?
 Former or usual residence.....

19. PLACE OF BURIAL OR REMOVAL DATE OF BURIAL

Lewiston Jan 19 1913

20. UNDERTAKER ADDRESS

C. G. Graft Lewiston

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Form V. S. No. 5. 12½ M. 7-24-11

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics
File No. 4071
Registered No. 10

1. PLACE OF DEATH. Registration District No. 16
County of Nez Perce Primary Registration District No. 1009
City of Lewiston (No. 312, New 16th St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

Mrs. Rosina W. Ford

If death occurred in a hospital, institution or camp give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX Fr 4. COLOR OR RACE W 5. SINGLE, MARRIED, WIDOWED OR DIVORCED.
Married
(Write the word.)

6. DATE OF BIRTH April 4 1929
(Month) (Day) (Year)

7. AGE 65 yrs. 9 mos. 19 ds. IF LESS than 1 day
how many..... hrs. or min?

8. OCCUPATION
(a) Trade, profession or particular kind of work..... Housewife
(b) General nature of industry business or establishment in which employed (or employer).....

9. BIRTHPLACE (State or Country) Mo.

10. NAME OF FATHER not known

11. BIRTHPLACE OF FATHER (State or Country) "

12. MAIDEN NAME OF MOTHER "

13. BIRTHPLACE OF MOTHER (State or Country) "

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE (Informant) Charles D. Ford
(Address).....

15. Filed Feb. 20 1913 L. G. Clark
Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH Jan 17 1913
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from July 3 1911, to Nov 13 1912
that I last saw her alive on Nov 13 1913
and that death occurred on the date stated above, at 5 P. M.

The CAUSE OF DEATH* was as follows:

Chronic Valvular Disease of Heart

(Duration) about 3 yrs. " mos. " ds.
Contributory Chronic Nephritis
(Secondary)

(Duration) 1 yrs. " mos. " ds.
(Signed) Edgar L. White M. D.
Jan. 18 1913 (Address) Lewiston

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place In the
of death..... yrs..... mos..... ds. State..... yrs..... mos..... ds.
Where was disease contracted,
If not at place of death?.....
Former or
usual residence.....

19. PLACE OF BURIAL OR REMOVAL DATE OF BURIAL
Lewiston Jan 18 1913

20. UNDERTAKER ADDRESS
C. J. Vassar Lewiston

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Form V. S. No. 5. 12½ M. 7-24-11

CERTIFICATE OF DEATH

1. PLACE OF DEATH.
County of My Peru
City of Culdesac

Registration District No. 16
Primary Registration District No. 2073
(No. _____, _____ St.)

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics
File No. 4072
Registered No. 11

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

Margaret A Farris

If death occurred in a hospital, institution or camp give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX Female 4. COLOR OR RACE white 5. SINGLE, MARRIED, WIDOWED OR DIVORCED. Single
(Write the word.)

6. DATE OF BIRTH Mar. 9 1842
(Month) (Day) (Year)

7. AGE 70 yrs. 9 mos. 8 ds. IF LESS than 1 day
how many _____ hrs. or _____ min?

8. OCCUPATION
(a) Trade, profession or particular kind of work. Housework
(b) General nature of industry business or establishment in which employed (or employer)

9. BIRTHPLACE Indiana
(State or Country)

10. NAME OF FATHER Alexander Reeves

11. BIRTHPLACE OF FATHER unknown
(State or Country)

12. MAIDEN NAME OF MOTHER Ruggles

13. BIRTHPLACE OF MOTHER unknown
(State or Country)

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Samuel G Douglas
(Address) Culdesac, Ida.

15. Jan 18 1913
Feb. 20 - 1913
J. A. Randall
Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH Jan. 17 1913
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from Jan. 1 1913, to Jan. 15 1913, that I last saw her alive on Jan. 15 1913 and that death occurred on the date stated above, at 7 a.m.
The CAUSE OF DEATH* was as follows:

Endocarditis

(Duration) _____ yrs. _____ mos. 17 ds.
Contributory (Secondary) Rheumatism
(Duration) _____ yrs. _____ mos. _____ ds.
(Signed) J. A. Randall M. D.
Jan. 18 1913 (Address) Culdesac Ida

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place _____ In the _____
of death _____ yrs. _____ mos. _____ ds. State _____ yrs. _____ mos. _____ ds.
Where was disease contracted, _____
If not at place of death? _____
Former or _____
usual residence _____

19. PLACE OF BURIAL OR REMOVAL DATE OF BURIAL

Culdesac

Jan. 19 1913

20. UNDERTAKER

Friends

ADDRESS

Culdesac

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Form V. S. No. 5. 12½ M. 7-24-11

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics
File No. 4054
Registered No. 13

1. PLACE OF DEATH. Registration District No. 16
County of Ney Perce Primary Registration District No. 1669
City of Blawie (No. _____, St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Everett Lee Lancaster

If death occurred in a hospital, institution or camp give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX Male 4. COLOR OR RACE White 5. SINGLE, MARRIED, WIDOWED OR DIVORCED. Single
(Write the word.)

6. DATE OF BIRTH July 4 1893
(Month) (Day) (Year)

7. AGE 20 yrs. 6 mos. 16 ds. IF LESS than 1 day how many _____ hrs. or _____ min?

8. OCCUPATION
(a) Trade, profession or particular kind of work. Mo
(b) General nature of industry business or establishment in which employed (or employer)

9. BIRTHPLACE Minn.
(State or Country)

10. NAME OF FATHER F L Lancaster

11. BIRTHPLACE OF FATHER Wisconsin
(State or Country)

12. MAIDEN NAME OF MOTHER Hilda Mobry

13. BIRTHPLACE OF MOTHER Sweden
(State or Country)

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) F L Lancaster
(Address) Asotin Wash

15. Filed Feb 20 1913 R. G. Perkins
Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH Jan. 19 1913
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from Jan 16 1913, to Jan 17 1913
that I last saw h. _____ alive on _____ 1913
and that death occurred on the date stated above, at 11 P. M.
The CAUSE OF DEATH* was as follows:

appendicitis
(Duration) _____ yrs. _____ mos. _____ ds.

Contributory (Secondary) _____
(Duration) _____ yrs. _____ mos. _____ ds.
(Signed) L Woodroff M. D.
Jan 20 1913 (Address) Asotin Wash

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place _____ In the _____
of death _____ yrs. _____ mos. _____ ds. State _____ yrs. _____ mos. _____ ds.
Where was disease contracted, _____
If not at place of death? _____
Former or _____
usual residence _____

19. PLACE OF BURIAL OR REMOVAL Asotin Wash DATE OF BURIAL Jan 21 1913

20. UNDERTAKER H R Merchant ADDRESS Asotin Wash

Form V. S. No. 5. 12½ M. 7-24-11

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
 Bureau of Vital Statistics
 File No. 1075
 Registered No. 14

1. **PLACE OF DEATH.** Registration District No. 16
 County of Koshuc Primary Registration District No. 1059
 City of Orchard Tracts (No. 1059, Orayden Ave 9th St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

Lorenzo Dow Cogswell

If death occurred in a hospital, institution or camp give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX Male 4. COLOR OR RACE White 5. SINGLE, MARRIED, WIDOWED OR DIVORCED. Widower
 (Write the word.)

6. DATE OF BIRTH February 15 1831
 (Month) (Day) (Year)

7. AGE 81 yrs. 11 mos. 5 ds. IF LESS than 1 day how many.....hrs. or.....min?

8. OCCUPATION

(a) Trade, profession or particular kind of work Mechanical Engineer
 (b) General nature of industry business or establishment in which employed (or employer) Wood working

9. BIRTHPLACE

(State or Country) Western, Oneida Co. Ny

10. NAME OF FATHER

William

11. BIRTHPLACE OF FATHER

(State or Country) New York

12. MAIDEN NAME OF MOTHER

Anna Turner

13. BIRTHPLACE OF MOTHER

(State or Country) New York

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Joseph B. White
 (Address) Lewiston, Orchard

15.

Filed Feb. 20 1913 L. J. Perkins
 Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH Jan 20 1913
 (Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from Nov 15 1913, to Jan 20 1913 that I last saw him alive on Nov 15 1913 and that death occurred on the date stated above, at 11 P. M.
 The CAUSE OF DEATH* was as follows:
Heart disease

(Duration) untimely yrs. mos. ds.
 Contributory Paralysis
 (Secondary)
 (Duration) yrs. mos. ds.
 (Signed) J. B. Morris M. D.
 19 (Address) Lewiston

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place In the
 of death yrs. mos. ds. State yrs. mos. ds.
 Where was disease contracted,
 If not at place of death?
 Former or usual residence

19. PLACE OF BURIAL OR REMOVAL DATE OF BURIAL

Lewiston Idaho Jan 22 1913
 20. UNDERTAKER ADDRESS
C. J. Vassar Lewiston

MARGIN
WRITE PLAINLY, WITH UNFOLDING THE RECORD.
N. B.—Every item of information should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Form V. S. No. 5. 12½ M. 7-24-11

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics
File No. 4076
Registered No. 15

1. PLACE OF DEATH.
County of Tray Bee
City of Myrtle
Registration District No. 16
Primary Registration District No. 2117
(No. _____, _____ St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME John Zigler

If death occurred in a hospital, institution or camp give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX m 4. COLOR OR RACE w 5. SINGLE, MARRIED, WIDOWED OR DIVORCED.
(Write the word.) married

6. DATE OF BIRTH Jan 20 1833
(Month) (Day) (Year)

7. AGE 80 yrs. _____ mos. _____ ds.
IF LESS than 1 day how many _____ hrs. or _____ min?

8. OCCUPATION
(a) Trade, profession or particular kind of work. Trainer
(b) General nature of industry business or establishment in which employed (or employer)

9. BIRTHPLACE
(State or Country) Per

10. NAME OF FATHER John Zigler

11. BIRTHPLACE OF FATHER
(State or Country) Ger

12. MAIDEN NAME OF MOTHER I do not know

13. BIRTHPLACE OF MOTHER
(State or Country) Ger

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) John N. Alley
(Address) Lafayette

15. John N. Alley
Filed Jan 21 1913
Feb 20 1913 Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH Jan 20 1913
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from Jan 20 1913, to Jan 20 1913 that I last saw him alive on Jan 20 1913 and that death occurred on the date stated above, at 10 P. M.
The CAUSE OF DEATH* was as follows:
Broncho Pneumonia

_____ (Duration) _____ yrs. _____ mos. 6 ds.
Contributory (Secondary) Influenza
_____ (Duration) _____ yrs. _____ mos. 7 ds.
(Signed) John N. Alley M. D.
Jan 21 1913 (Address) Lafayette

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place _____ In the _____
of death _____ yrs. _____ mos. _____ ds. State _____ yrs. _____ mos. _____ ds.
Where was disease contracted,
If not at place of death?
Former or
usual residence _____

19. PLACE OF BURIAL OR REMOVAL Myrtle DATE OF BURIAL 1-22-1913

20. UNDERTAKER Carlisle Hardman Co. ADDRESS Caldesac, Ida.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Form V. S. No. 5. 12½ M. 7-24-11

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics
File No. 1077
Registered No. 16

1. PLACE OF DEATH. Registration District No. 16
County of Nez Perce Primary Registration District No. 2076
City of Cameron (No. _____, _____ St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME John Henry Brammer

If death occurred in a hospital, institution or camp give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX male 4. COLOR OR RACE White 5. SINGLE, MARRIED, WIDOWED OR DIVORCED. married
(Write the word.)

6. DATE OF BIRTH Sept 15 1840
(Month) (Day) (Year)

7. AGE 73 yrs. 4 mos. 6 ds. IF LESS than 1 day how many _____ hrs. or _____ min?

8. OCCUPATION

(a) Trade, profession or particular kind of work. Carpenter
(b) General nature of industry business or establishment in which employed (or employer)

9. BIRTHPLACE

(State or Country)

10. NAME OF FATHER

11. BIRTHPLACE OF FATHER

(State or Country)

12. MAIDEN NAME OF MOTHER

13. BIRTHPLACE OF MOTHER

(State or Country)

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

(Address)

15.

Filed Feb 20 1913 J. W. Stoneburner Local Registrar
Feb 20 1913

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH

Jan. 21 1913
X (Month) 26 (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from Nov 26 1912, to Jan. 21 1913

that I last saw him alive on Jan. 20 1913
and that death occurred on the date stated above, at 10 A. M.

The CAUSE OF DEATH* was as follows:

Paralysis.

(Duration) _____ yrs. _____ mos. _____ ds.

Contributory
(Secondary)

(Duration) _____ yrs. _____ mos. _____ ds.
(Signed) J. W. Stoneburner M. D.
2/1 1913 (Address) Peland Lake

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place _____ In the _____
of death _____ yrs. _____ mos. _____ ds. State _____ yrs. _____ mos. _____ ds.
Where was disease contracted,
If not at place of death? _____
Former or
usual residence. _____

19. PLACE OF BURIAL OR REMOVAL DATE OF BURIAL

Cameron Jan. 24 1913
20. UNDERTAKER ADDRESS

C. J. Roland, Hendricks,

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
 3.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Form V. S. No. 5. 12½ M. 7-24-11

CERTIFICATE OF DEATH

 State of Idaho
 BOARD OF HEALTH
 Bureau of Vital Statistics

 1. PLACE OF DEATH.
 County of Negata
 City of Lewiston

 Registration District No. 16
 Primary Registration District No. 1009
 (No. _____, St.)

 File No. 1078
 Registered No. 17

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

Louis Bazish

If death occurred in a hospital, institution or camp give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

 3. SEX M 4. COLOR OR RACE W 5. SINGLE, MARRIED, WIDOWED OR DIVORCED. Single
 (Write the word.)

 6. DATE OF BIRTH not known
 (Month) (Day) (Year)

 7. AGE not known IF LESS than 1 day
 yrs. mos. ds. how many hrs. or min?

 8. OCCUPATION
 (a) Trade, profession or particular kind of work. Employee Railroad
 (b) General nature of industry business or establishment in which employed (or employer)

 9. BIRTHPLACE
 (State or Country) not known

10. NAME OF FATHER

 11. BIRTHPLACE OF FATHER
 (State or Country)

12. MAIDEN NAME OF MOTHER

 13. BIRTHPLACE OF MOTHER
 (State or Country)

 14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
 (Informant) E. J. Vassar
 (Address)

 15. Filed Feb 20 1913 L. G. Kishia
 Local Registrar

MEDICAL CERTIFICATE OF DEATH.

 16. DATE OF DEATH Jan 27 1913
 (Month) (Day) (Year)

 17. I HEREBY CERTIFY, That I attended deceased from Dec 8 1913, to Jan 27 1913, that I last saw h. alive on Jan 27 1913 and that death occurred on the date stated above, at 5 P. M.

The CAUSE OF DEATH* was as follows:

Malignant growth of tumor and right lung
unknown
 (Duration) yrs. mos. ds.

 Contributory (Secondary)
 (Duration) yrs. mos. ds.
 (Signed) E. J. Vassar M. D.
Jan 28 1913 (Address) Lewiston

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

 At place In the
 of death yrs. mos. ds. State yrs. mos. ds.
 Where was disease contracted,
 If not at place of death?
 Former or
 usual residence.

 19. PLACE OF BURIAL OR REMOVAL DATE OF BURIAL
Lewiston Ida Jan 28 1913
 20. UNDERTAKER ADDRESS
E. J. Vassar Lewiston

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Form V. S. 2 1/2 M. 7-24-11

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics
File No. 1009
Registered No. 18

1. DEATH. Registration District No. 16
County of Lemhi Primary Registration District No. 1009
City of Lewiston (No. 1307, 16th St. St.)

If death occurred in usual residence or place of usual residence called for under special provision.

2. FULL NAME

(Infant) Robt Andrews

If death occurred in a hospital, institution or camp give its NAME instead of street and number.

3. SEX 4. COLOR OR RACE 5. SINGLE, MARRIED, WIDOWED OR DIVORCED.

3. SEX M W 4. COLOR OR RACE (Write the word.) 5. SINGLE, MARRIED, WIDOWED OR DIVORCED.

6. DATE OF BIRTH Jan 27 1913
(Month) (Day) (Year)

7. AGE yrs. mos. ds. IF LESS than 1 day how many hrs. or min?

8. OCCUPATION

(a) Trade, profession or particular kind of work.
(b) General nature of industry business or establishment in which employed (or employer)

none

9. BIRTHPLACE

(State or Country)

Lewiston

10. NAME OF FATHER

Robt Andrews

11. BIRTHPLACE OF FATHER

(State or Country)

Wis

12. MAIDEN NAME OF MOTHER

A. Rubenzer

13. BIRTHPLACE OF MOTHER

(State or Country)

Wis

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

Robt Andrews

(Address)

15.

Filed Feb 20 1913 S. J. Perkins
Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH

Jan 28 1913
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from Jan. 27 1913, to Jan. 28 1913 that I last saw him alive on Jan 27 1913 and that death occurred on the date stated above, at 2 A. M. The CAUSE OF DEATH* was as follows:
Mm. vitality

(Duration) yrs. mos. ds.

Contributory (Secondary)

(Duration) yrs. mos. ds.

(Signed)

Jan 28 1913 (Address) S. J. Perkins M. D.

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place In the
of death yrs. mos. ds. State yrs. mos. ds.
Where was disease contracted,
If not at place of death?
Former or
usual residence.

19. PLACE OF BURIAL OR REMOVAL DATE OF BURIAL

Lewiston Jan 28 1913

20. UNDERTAKER

ADDRESS

C. J. Vassar Lewiston

Form V. S. No. 5. 10M. 6-20-11.

CERTIFICATE

State of Idaho
BOARD OF HEALTH
Bureau of Vital StatisticsFile No. 1057Registered No. 190

If death occurred in a hospital, institution or camp give its NAME instead of street and number.

1. PLACE OF DEATH. Registration District No.
County of Bonner Primary Registration District 36
City of Prust River (No., St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

PERSONAL AND STATISTICAL PARTICULARS

3. SEX Female 4. COLOR OR RACE white 5. SINGLE, MARRIED, WID-
OWED OR DIVORCED. Single
(Write the word.)6. DATE OF BIRTH Unknown 1
(Month) (Day) (Year)7. AGE 7 yrs. 8 mos. ds. IF LESS than 1 day
how many hrs. or
..... min.?

8. OCCUPATION

(a) Trade, profession, or
particular kind of work None(b) General nature of industry
business, or establishment in
which employed (or employer)

9. BIRTHPLACE

(State or Country) Idaho10. NAME OF
FATHER Joseph Saccomanno11. BIRTHPLACE
OF FATHER Italy12. MAIDEN NAME
OF MOTHER Mina Traccarato13. BIRTHPLACE
OF MOTHER Italy

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Joseph Saccomanno(Address) Prust River, Idaho15. Feb 13 1913 M. J. Curran
Filed Feb 13 1913

Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

Feb 13 1913
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from

Feb 13 1913, to 1913that I last saw him alive on Feb 12 1913,and that death occurred on the date stated above, at M.

The CAUSE OF DEATH* was as follows:

Obstetrical Obstruction(Duration) yrs. mos. 2 ds.Contributory
(Secondary)

(Duration) yrs. mos. ds.

(Signed) C. Bussey M. D.Feb 19 1913 (Address) Prust River*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1)
MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.18. LENGTH OF RESIDENCE (For Hospitals, Institutions,
Transients or Recent Residents.)At place In the
of death yrs. mos. ds. State yrs. mos. ds.

Where was Disease contracted,

If not at place of death?

Former or
usual residence.

19. PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

Prust River, Ida Feb 13 1913

20. UNDERTAKER

ADDRESS

None

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Form V. S. No. 5 20M.1-16-12 NO. 106.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics
File No. **4081**

1. PLACE OF DEATH. Registration District No. 8
County of Bonner Primary Registration District No. 203
City of Hopepoint (No. _____, _____ St.)

Registered No. 191

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Ivan D. Fink.

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX Male 4. COLOR OR RACE White 5. SINGLE, MARRIED, WIDOWED OR DIVORCED. Single
(Write the word.)

6. DATE OF BIRTH _____
(Month) (Day) (Year)

7. AGE 25 yrs. 0 mos. 0 ds.
IF LESS than 1 day how many hrs. or mins.?

8. OCCUPATION Laborer
(a) Trade, profession or particular kind of work
(b) General nature of industry business, or establishment in which employed (or employer) Woods

9. BIRTHPLACE (State or Country) Canada

10. NAME OF FATHER Duncan Fink

11. BIRTHPLACE OF FATHER Unknown
(State or Country)

12. MAIDEN NAME OF MOTHER

13. BIRTHPLACE OF MOTHER
(State or Country)

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Clint Blanchard(Address) Hope, Idaho.15. M. M. McArthurFiled Febr, 19, 1913

Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH
February, 17, 1913
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from _____
191____, to _____ 191____,
that I last saw h_____ alive on _____ 191____,
and that death occurred on the date stated above, at _____ M.

The CAUSE OF DEATH* was as follows:

Accident falling of treeFracture of Skull

_____ (Duration) Inst yrs. _____ mos. _____ ds.

Contributory
(Secondary)

_____ (Duration) _____ yrs. _____ mos. _____ ds.
(Signed) W. M. Knapp Knapp M. D.

19. (Address) Hope, Idaho

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death _____ yrs. _____ mos. _____ days. In the State _____ yrs. _____ mos. _____ days.

Where was disease contracted if not at place of death? _____

Former or usual residence _____

19. PLACE OF BURIAL OR REMOVAL DATE OF BURIAL

Charlevoix, Michigan Feb 19 1913

20. UNDERTAKER ADDRESS

E. M. Brown Sandpoint

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Form V. S. No. 5 20M.1-16-12

10. 105. CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH.

Registration District No. _____

County of BonnerPrimary Registration District No. 20.35File No. 4082City of Sandpoint.

(No. _____, _____ St.)

Registered No. 192

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Lewis Olson.

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX

Male

4. COLOR OR RACE

White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED.

Single

(Write the word.)

6. DATE OF BIRTH

December301988

(Month)

(Day)

(Year)

7. AGE

24 yrs.

mos.

ds.

IF LESS than 1 day
how many _____ hrs. or
_____ mins.?

8. OCCUPATION

(a) Trade, profession or particular kind of work common Laborer.

(b) General nature of industry business, or establishment in which employed (or employer) _____

9. BIRTHPLACE

(State or Country)

N. Dak.

10. NAME OF FATHER

Edward Olson.

11. BIRTHPLACE OF FATHER

(State or Country)

Wis.

12. MAIDEN NAME OF MOTHER

Anna Klenkains

13. BIRTHPLACE OF MOTHER

(State or Country)

Germany.

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) J. L. Olson,(Address) Spirit Lake, Idaho.

15.

Filed Feb 18 1913M. McKinnon
Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH

Febr.17th1913

(Month)

(Day)

(Year)

17. I HEREBY CERTIFY, That I attended deceased from

191, to191,that I last saw h. alive on 191,and that death occurred on the date stated above, at M.

The CAUSE OF DEATH* was as follows:

Chronic valvular disease.Died suddenly at night.

(Duration) _____ yrs. _____ mos. _____ ds.

Contributory Rheumatism
(Secondary)

(Duration) _____ yrs. _____ mos. _____ ds.

(Signed) W. M. Knapp M. D.Feb 18 1913 (Address) Hope, Idaho

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death _____ yrs. _____ mos. _____ days. In the State _____ yrs. _____ mos. _____ days.

Where was disease contracted if not at place of death? _____

Former or usual residence _____

19. PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

Spokane, WashFeb 19 1913

20. UNDERTAKER

ADDRESS

Smith & Co.Spokane, "n.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Form V. S. No. 5 20M.1-16-12

No. 108.

CERTIFICATE OF DEATH

 State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH.

Registration District No. 8

County of Bonner

Primary Registration District No. 2035

City of Sandpoint

(No. , Hudon Camp 6 miles north St.)

File No. 4083

Registered No. 194

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME David Alonzo Crozier.

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX

4. COLOR OR RACE

5. SINGLE, MARRIED, WIDOWED OR DIVORCED.

(Write the word.)

6. DATE OF BIRTH

 December 16 1913
(Month) (Day) (Year)

7. AGE

66 yrs. 2 mos. 8 ds.

 IF LESS than 1 day
how many hrs. or
mins.?

8. OCCUPATION

(a) Trade, profession or particular kind of work

Laborer

(b) General nature of industry business, or establishment in which employed (or employer)

Woods

9. BIRTHPLACE

(State or Country)

Illinois

10. NAME OF FATHER

Smith Crozier

11. BIRTHPLACE OF FATHER

(State or Country)

Scotland

12. MAIDEN NAME OF MOTHER

Katherine Shoemaker,

13. BIRTHPLACE OF MOTHER

(State or Country)

Penn

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

A. C. Crozier

(Address)

Sandpoint Idaho

15.

Filed

Febr. 26

1913

Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH

 February 24 1913
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from

191, to 191,

that I last saw h. alive on 191,

and that death occurred on the date stated above, at 5 P.M.

The CAUSE OF DEATH* was as follows:

Supposed heart failure

(Duration) Sudden 1 day ds.

Contributory (Secondary)

(Duration) yrs. mos. ds.

(Signed)

N. M. Knapp, M. D.

19

(Address)

Hager

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death.....yrs.....mos.....days. In the State.....yrs.....mos.....days.

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

Sandpoint

Febr. 27 1913

20. UNDERTAKER

ADDRESS

Sandpoint

A stillbirth must be registered both as a birth and death. The date of death should be the date of delivery and the death certificate should further state, if known, the cause of the stillbirth and the period of utero gestation in months.

STATEMENT OF OCCUPATION.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer, Physician, Stenographer, Compositor, Architect, Locomotive engineer, Civil engineer, Stationary fireman, etc.* But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner*, (b) *Cotton mill*; (a) *Salesman*, (b) *Grocery*; (a) *Foreman*, (b) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification, as *Day laborer, Farm laborer, Laborer—Coal mine, etc.* Women at home, who are engaged in the duties of the household only (not paid *Housekeepers*, who receive a definite salary), may be entered as *Housewife, Housework, or At home*, and children, not gainfully employed, as *At school or At home*. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer (retired, 6 yrs.)* For persons who have no occupation whatever, write *None*.

STATEMENT OF CAUSE OF DEATH.—Name, first the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebro-*

spinal fever (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid Pneumonia") *Lobar pneumonia; Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritoneum, etc., Carcinoma, Sarcoma, etc., of* (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis, etc.* The contributory (secondary or intercurrent affection need not be stated unless important. Example: *Measles* (disease causing death), 29 ds.; *Bronchopneumonia* (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "Asthenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility," ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Haemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uraemia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify as "PUERPERAL, septicemia," "PUERPERAL peritonitis," etc., all diseases resulting from childbirth or miscarriage. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning; Struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid—probably suicide.* The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "Contributory."

2

6

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Form V. S. No. 5 20M.1-16-12

No. 109 CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH.

Registration District No. 8

County of Banner

Primary Registration District No. 2033

City of Kootenai

(No. _____ St.)

File No. 4085

Registered No. 195

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME William Edward Murray

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX 4. COLOR OR RACE 5. SINGLE, MARRIED, WIDOWED OR DIVORCED.

Male White Married

6. DATE OF BIRTH

Aug 3rd 1873
(Month) (Day) (Year)

7. AGE

39 yrs. 6 mos. 22 ds.

IF LESS than 1 day
how many hrs. or
..... mins.?

8. OCCUPATION

(a) Trade, profession or particular kind of work
(b) General nature of industry business, or establishment in which employed (or employer)

Plumber

9. BIRTHPLACE

(State or Country)

Monsie

10. NAME OF FATHER

Francis M. Murray

11. BIRTHPLACE OF FATHER

(State or Country)

Monsie

12. MAIDEN NAME OF MOTHER

Elix Ann Davis

13. BIRTHPLACE OF MOTHER

(State or Country)

Mo.

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

Mrs W E Murray

(Address)

Kootenai Idaho

15.

Filed

Febr. 26

1913

M. McKinnon

Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH

Feb. 25 1913
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from

1913, to Feb 25 - 1913,
that I last saw him alive on Feb 25 1913,
and that death occurred on the date stated above, at 3⁴⁵ P.M.

The CAUSE OF DEATH* was as follows:

Pneumonia

(Duration) 10 yrs. - 10 mos. 10 ds.

Contributory Not fully recovered from
(Secondary) Typhoid Fever

(Duration) _____ yrs. _____ mos. _____ ds.

(Signed) W. E. Smith M. D.

2/25 1913 (Address) Kootenai

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death _____ yrs. _____ mos. _____ days. In the State _____ yrs. _____ mos. _____ days.

Where was disease contracted if not at place of death?

Former or usual residence _____

19. PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

Sandpoint, Idaho

Febr. 28 1913

20. UNDERTAKER

ADDRESS

E. A. Brown

Sandpoint

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Form V. S. No. 5 20M.1-16-12 No. III.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH.

Registration District No. 8

County of Bonner

Primary Registration District No. 2033

City of Sandpoint

(No. , Pine St.)

File No. 1056

Registered No. 196

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME John Henry Ferber.

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX

Male

4. COLOR OR RACE

White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED.

Married
(Write the word.)

6. DATE OF BIRTH

August, 30, 1856
(Month) (Day) (Year)

7. AGE

56 yrs. 5 mos. 27 ds.

IF LESS than 1 day
how many hrs. or mins.?

8. OCCUPATION

(a) Trade, profession or particular kind of work Hotel Keeper,
(b) General nature of industry business, or establishment in which employed (or employer)

9. BIRTHPLACE

(State or Country) Germany

10. NAME OF FATHER

John Henry Ferber,

11. BIRTHPLACE OF FATHER

(State or Country) Germany

12. MAIDEN NAME OF MOTHER

unknown

13. BIRTHPLACE OF MOTHER

(State or Country) Germany

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Mrs. Mary Ferber.

(Address) Sandpoint, Idaho.

15.

Filed Febr. 28th. 1913

M. McKinnon

Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH

Feb 27 1913
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from 1913, to Feb 27 1913, that I last saw him alive on Feb 27 1913, and that death occurred on the date stated above, at 4 P.M.

The CAUSE OF DEATH* was as follows:

Pneumonia following Acute Nephritis with Asthma

(Duration) yrs. mos. 10 ds.
Contributory Nephritis Acute with Asthma
(Secondary)

(Duration) yrs. mos. 10 ds.

(Signed) M. McKinnon M. D.
Feb 27 1913 (Address) Sandpoint Id.

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death. yrs. mos. days. In the State. yrs. mos. days.

Where was disease contracted if not at place of death?

Former or usual residence.

19. PLACE OF BURIAL OR REMOVAL

Sandpoint, Idaho

DATE OF BURIAL

March 2 1913

20. UNDERTAKER

E. M. Brown

ADDRESS

Sandpoint Id.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Form V. S. No. 5 20M.1-16-12

No. 113. CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH.

Registration District No. 5

County of Bonner

Primary Registration District No. 2033

City of Sandpoint

(No. , St.)

File No. 4087

Registered No. 197

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

Florence Ethel Volz.

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX

Female

4. COLOR OR RACE

White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED.

Single

(Write the word.)

6. DATE OF BIRTH

July,

20

1902

(Month)

(Day)

(Year)

7. AGE

10

yrs.

7

mos.

13

ds.

IF LESS than 1 day
how many hrs. or
..... mins.?

8. OCCUPATION

(a) Trade, profession or particular kind of work

Student

(b) General nature of industry, business, or establishment in which employed (or employer)

Public school

9. BIRTHPLACE

(State or Country)

Sandpoint, Idaho

10. NAME OF FATHER

Frank C. Volz.

11. BIRTHPLACE OF FATHER

(State or Country)

Germany

12. MAIDEN NAME OF MOTHER

Amanda De Laittre.

13. BIRTHPLACE OF MOTHER

(State or Country)

Minn.

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

Mrs. Frank C. Volz.

(Address)

Sandpoint, Idaho

15.

Filed March, 4 1913

M. McKinnon
Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

March

3

1913

(Month)

(Day)

(Year)

17. I HEREBY CERTIFY, That I attended deceased from

Jan. 15 1913, to March 3 1913,

that I last saw her alive on March 3 1913,

and that death occurred on the date stated above, at 6 P. M.

The CAUSE OF DEATH* was as follows:

Acute dilatation of heart with
Endocarditis following Rheumatism

(Duration)

yrs. 1 1/2 mos.

ds.

Contributory

Rheumatism - 1st attack

(Secondary)

(Duration)

yrs. 1/4 mos.

ds.

(Signed)

M. McKinnon M. D.

March 4 1913 (Address) Sandpoint, Idaho

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place

of death yrs. mos. days.

In the

State yrs. mos. days.

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

Sandpoint, Idaho.

3-6-13 1913

20. UNDERTAKER

ADDRESS

E. M. Brown

Sandpoint.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Form V. S. No. 5-10M. 6-20-11.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH.

Registration District No. 8

County of Blaine

Primary Registration District No. 2033

City of Sandpoint

(No. , St.)

File No. 10-5

Registered No. 183

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

William J. Dunlop

If death occurred in a hospital, institution or camp give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX

Male

4. COLOR OR RACE

White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED.

Widow
(Write the word.)

6. DATE OF BIRTH

1847
(Month) (Day) (Year)

7. AGE

69 yrs. mos. ds.

IF LESS than 1 day
how many hrs. or min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work
(b) General nature of industry business or establishment in which employed (or employer)

Farmer

9. BIRTHPLACE

(State or Country)

10. NAME OF FATHER

11. BIRTHPLACE OF FATHER

(State or Country)

12. MAIDEN NAME OF MOTHER

13. BIRTHPLACE OF MOTHER

(State or Country)

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

(Address)

15.

Filed

Feb 26 1913

M. McInnis

Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

Feb 25 1913
(Month) (Day) (Year)17. I HEREBY CERTIFY, That I attended deceased from
Nov 1912, to Feb 1913

that I last saw him alive on Feb 15 1913

and that death occurred on the date stated above, at M.

The CAUSE OF DEATH* was as follows:

General Peritonitis

(Duration) yrs. mos. 3 ds.
Contributory Cause of stomach
(Secondary) was operation for neck
tumor
(Duration) yrs. mos. ds.

(Signed) M. McInnis M. D.

Feb 26 1913 (Address) Sandpoint

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted.

If not at place of death?

Former or

usual residence

19. PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

C. E. Smith

Feb 27 1913

20. UNDERTAKER

ADDRESS

C. E. Smith

C. E. Smith

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Form V. S. No. 5 20M.1-16-12

No. 98.

CERTIFICATE OF DEATH

 State of Idaho
 BOARD OF HEALTH
 Bureau of Vital Statistics

1. (1918) PLACE OF DEATH.

Registration District No. 8

County of Bonner

Primary Registration District No. 2033

City of Sandpoint.

(No. , St.)

File No. 4090

Registered No. 1857

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

M. McKinnon.

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX

Male

4. COLOR OR RACE

White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED.

(Write the word.)

6. DATE OF BIRTH

(Month)

(Day)

(Year)

7. AGE

54 yrs.

mos.

ds.

 IF LESS than 1 day
 how many hrs. or
 mins.?

8. OCCUPATION

(a) Trade, profession or particular kind of work

Cook

(b) General nature of industry, business, or establishment in which employed (or employer)

Construction Crew

9. BIRTHPLACE

(State or Country)

10. NAME OF FATHER

11. BIRTHPLACE OF FATHER

(State or Country)

12. MAIDEN NAME OF MOTHER

13. BIRTHPLACE OF MOTHER

(State or Country)

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) M. McKinnon

(Address)

Sandpoint, Idaho.

15.

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH

Jan .

30

3

(Month)

(Day)

(Year)

17. I HEREBY CERTIFY, That I attended deceased from

 Jan 29 1913, to Jan 30 1913,
 that I last saw him alive on Jan 29 1913,

and that death occurred on the date stated above, at M.

The CAUSE OF DEATH* was as follows:

Haemorrhage of Stomach

(Duration)

yrs.

mos.

ds.

Contributory (Chief cause - (Cause))
(Secondary)

(Duration)

yrs.

mos.

ds.

(Signed)

J. H. 1913 (Address) Sandpoint - Idaho

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place

of death yrs. mos. days.

In the

State yrs. mos. days.

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL

Sandpoint, Idaho.

DATE OF BURIAL

Feb 14 1913

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Form V. S. No. 5 20M.1-16-12 NO. 100. CERTIFICATE OF DEATH

1. PLACE OF DEATH. Registration District No. 8
County of Bonner Primary Registration District No. 2033
City of Sandpoint (No. _____, _____ St.)

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics
File No. 4091
Registered No. 186

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Arthur Hall.

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX Male 4. COLOR OR RACE White 5. SINGLE, MARRIED, WIDOWED OR DIVORCED. Single
(Write the word.)

6. DATE OF BIRTH February 6 1890
(Month) (Day) (Year)

7. AGE 22 yrs II mos. 5 ds. IF LESS than 1 day how many _____ hrs. or _____ mins.?

8. OCCUPATION

(a) Trade, profession or particular kind of work Farmer
(b) General nature of industry, business, or establishment in which employed (or employer) Common laborer

9. BIRTHPLACE

(State or Country) Wisconsin

10. NAME OF FATHER

Thomas Hall

11. BIRTHPLACE OF FATHER

(State or Country) Wisconsin

12. MAIDEN NAME OF MOTHER

Emma Hegeman

13. BIRTHPLACE OF MOTHER

(State or Country) Wisconsin

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) J. H. Lancaster
(Address) Sandpoint Idaho.

15.

Filed Feb. 1. 1913M. J. McElm
Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH

Feb. 6 1913
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from Jan 10 1913, to Feb 6 1913, that I last saw him alive on Feb 6 1913, and that death occurred on the date stated above, at 9 P. M.

The CAUSE OF DEATH* was as follows:

Coronary Arteriosclerosis following Sandpoint with Rheumatism

(Duration) _____ yrs. _____ mos. _____ ds.
Contributory Rheumatism 4th all over
(Secondary)

(Duration) _____ yrs. _____ mos. _____ ds.
(Signed) M. J. McElm M. D.
Feb 1 1913 (Address) Sandpoint

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death _____ yrs. _____ mos. _____ days. In the State _____ yrs. _____ mos. _____ days.

Where was disease contracted if not at place of death? _____

Former or usual residence _____

19. PLACE OF BURIAL OR REMOVAL Sandpoint, Idaho DATE OF BURIAL Feb. 3 1913

20. UNDERTAKER [REDACTED] ADDRESS [REDACTED]

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
Every item of information should be carefully supplied. AGE should be stated EXACTLY. F
CIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact
ment of OCCUPATION is very important. See instructions on back of certificate.

PLACE OF DEATH

NO. 101 CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

County of Banner

Registration District No. 8

File No. 4092

City of Kootenai

Primary Registration District No. 2033

Registered No. 187

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Elizabeth Irvin

If death occurred in a hospital, institution or camp, give its name instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX Female 4. COLOR OR RACE White 5. SINGLE, MARRIED, WIDOWED OR DIVORCED. Single (Write the word.)

6. DATE OF BIRTH

(Month) 1 (Day) 1 (Year) 1913

7. AGE

89 yrs. 0 mos. 0 ds.

IF LESS than 1 day
how many hrs. or
..... mins.?

8. OCCUPATION

(a) Trade, profession or particular kind of work
(b) General nature of industry, business, or establishment in which employed (or employer)

Retired

9. BIRTHPLACE

(State or Country)

Ireland

10. NAME OF FATHER

James Irvin

11. BIRTHPLACE OF FATHER

(State or Country)

Not known

12. MAIDEN NAME OF MOTHER

" "

13. BIRTHPLACE OF MOTHER

(State or Country)

Not known

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

James Irvin

(Address)

Kootenai Idaho.

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

Feb 1st
(Month) (Day)

17. I HEREBY CERTIFY, That I attended deceased Jan 30 1913 to Feb 1st 1913

that I last saw her alive on Jan 30 1913

and that death occurred on the date stated above, at 5:30

The CAUSE OF DEATH* was as follows:

La Grippe

(Duration) yrs. 0 mos. 0 ds.

Contributory (Secondary) Auto Intoxication

(Duration) yrs. 0 mos. 0 ds.

(Signed) Will H. Potter

1-1-1913 (Address) Kootenai Idaho.

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death yrs. mos. days. In the State yrs. mos. days.

Where was disease contracted if not at place of death?

Former or usual residence.

19. PLACE OF BURIAL OR REMOVAL

Spokane, Wash.

DATE OF BURIAL

Feb. 1 1913

20. UNDERTAKER

Smith & Co.,

ADDRESS

Spokane, Wash

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Form V. S. No. 5 20M.1-16-12

No. 103.

CERTIFICATE OF DEATH

 State of Idaho
 BOARD OF HEALTH
 Bureau of Vital Statistics

1. PLACE OF DEATH.

Registration District No. 8

County of Bonner

Primary Registration District No. 2033

City of Sandpoint

(No. , St.)

File No. 4093

Registered No. 158

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

Julia Bithell.

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX

Female

4. COLOR OR RACE

White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED.

Single (the word.)

6. DATE OF BIRTH

Febr.

1

1

1913

(Month)

(Day)

(Year)

7. AGE

yrs.

mos.

3

ds.

 IF LESS than 1 day
 how many hrs. or
 mins.?

8. OCCUPATION

(a) Trade, profession or

particular kind of work None

(b) General nature of industry

business, or establishment in

which employed (or employer)

9. BIRTHPLACE

(State or Country)

Kootenai, Idaho.

10. NAME OF FATHER

Joseph Bithell

11. BIRTHPLACE OF FATHER

(State or Country)

England

12. MAIDEN NAME OF MOTHER

Millie McIntyre,

13. BIRTHPLACE OF MOTHER

(State or Country)

Penn.

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

Joseph Bithell.

(Address)

Elk, Wash.

15.

Filed Feb. 5, 1913

 M. McKinnon
 Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH

Febr.

4

1913

(Month)

(Day)

(Year)

17. I HEREBY CERTIFY, That I attended deceased from

191., to

191.,

that I last saw h. alive on 191.,

and that death occurred on the date stated above, at M.

The CAUSE OF DEATH* was as follows:

 Died suddenly don't know
 Cause -

(Duration)

yrs.

mos.

ds.

Contributory

(Secondary)

(Duration)

yrs.

mos.

ds.

(Signed)

 M. McKinnon M. D.
 Febr. 49 13 (Address) Sandpoint Id

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place

of death

yrs. mos. days.

In the

State

yrs. mos. days.

 Where was disease contracted
 if not at place of death?

 Former or
 usual residence

19. PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

Sandpoint, Idaho.

Feb. 5, 1913

20. UNDERTAKER

ADDRESS

E. M. Brown

Sandpoint,

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Form V. S. No. 5 20M.1-

1. PLACE OF DEATH.

Registration District No.

County of Bonner

Primary Registration District No. 2033

City of Sandpoint

(No. _____, _____ St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Ellen Mulloy.

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

File No. 1094

Registered No. 189

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX

4. COLOR OR RACE

5. SINGLE, MARRIED, WIDOWED OR DIVORCED.

Female

white

7
(Write the word.)

6. DATE OF BIRTH

(Month) (Day) (Year)

7. AGE

80 yrs. 0 mos. 0 ds.

IF LESS than 1 day
how many _____ hrs. or
_____ mins.?

8. OCCUPATION

(a) Trade, profession or particular kind of work None

(b) General nature of industry business, or establishment in which employed (or employer)

9. BIRTHPLACE

(State or Country) Ireland.

10. NAME OF FATHER

11. BIRTHPLACE OF FATHER

(State or Country)

12. MAIDEN NAME OF MOTHER

13. BIRTHPLACE OF MOTHER

(State or Country)

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Wm. Bullock.

(Address) Sandpoint, Idaho.

15.

Filed Feb. 4, 1913

M. Mulloy
Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH

Feb. 1 1913
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from

Nov 27 1912, to Feb 1 1913,
that I last saw her alive on Jan 28 1913,
and that death occurred on the date stated above, at 4 P.M.

The CAUSE OF DEATH* was as follows:

Cancer of Stomach

(Duration) _____ yrs. _____ mos. _____ ds.

Contributory
(Secondary)

(Duration) _____ yrs. _____ mos. _____ ds.

(Signed)

Feb 2 1913 (Address) Sandpoint Id

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death _____ yrs. _____ mos. _____ days. In the State _____ yrs. _____ mos. _____ days.

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

Hope, Idaho.

Feb. 5, 1913

20. UNDERTAKER

ADDRESS

E. J. Brown

SP.

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Form V. S. No. 5. 10

ATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics
File No. 4099
Registered No. 172

1. PLACE OF DEATH [Redacted] Registration District No. 8
County of Bonner Primary Registration District No. 2034
City of Bonner Ferry No. [Redacted] St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

W. L. Hulet

If death occurred in a hospital, institution or camp give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX Male 4. COLOR OR RACE White 5. SINGLE, MARRIED, WIDOWED, OR DIVORCED. widower
(Write the word.)

6. DATE OF BIRTH

(Month) (Day) (Year)

7. AGE

58 yrs.

mos. ds.

IF LESS than 1 day
how many hrs. or min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work
(b) General nature of industry business or establishment in which employed (or employer)

Conductor

9. BIRTHPLACE

(State or Country)

10. NAME OF FATHER

11. BIRTHPLACE OF FATHER

(State or Country)

12. MAIDEN NAME OF MOTHER

13. BIRTHPLACE OF MOTHER

(State or Country)

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

(Address)

15.

Filed Feb. 12 1913

E. E. Fry

Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

January 7 1913
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from Jan 2 1912, to Jan 7 1913
that I last saw him alive on Jan 7 1913,
and that death occurred on the date stated above, at 5:30 P.M.

The CAUSE OF DEATH* was as follows:

Pyloric obstruction following
as chronic ulcer near the
pyloric orifice

(Duration) 3 yrs. mos. ds.

Contributory (Secondary)

(Duration) yrs. mos. ds.

(Signed) Leslie J. Stauffer M. D.
Jan 10 1913 (Address) Bonner Ferry, Ida

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death. yrs. 2 mos. ds. State. 10 yrs. mos. ds.

Where was disease contracted.

If not at place of death?

Former or usual residence. About Bonner Ferry.

19. PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

Bonner Ferry Jan 12 1913

20. UNDERTAKER

ADDRESS

John J. Made Bonner Ferry

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Form V. S. No. 5. 10M. 6-20-11.

CERTIFICATE OF

Idaho
HEALTH

1. PLACE OF DEATH.

Registration District No.

Bureau of Vital Statistics

County of *Bonner*

Primary Registration District No. *2034*

File No. *4109*

City of *Bonner Ferry*

(No. _____, _____ St.)

Registered No. *173*

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

If death occurred in a hospital, institution or camp give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX

4. COLOR OR RACE

5. SINGLE, MARRIED, WIDOWED OR DIVORCED.

female

white

Single
(Write the word.)

6. DATE OF BIRTH

Jan. 7th 1913
(Month) (Day) (Year)

7. AGE

____ yrs. ____ mos. *3* ds.

IF LESS than 1 day
how many _____ hrs. or
_____ min.?

8. OCCUPATION

- (a) Trade, profession or particular kind of work _____
(b) General nature of industry business or establishment in which employed (or employer) _____

9. BIRTHPLACE

(State or Country)

Bonner Ferry, Idaho.

10. NAME OF FATHER

Jas. Poston

11. BIRTHPLACE OF FATHER

(State or Country)

Virginia.

12. MAIDEN NAME OF MOTHER

Agnes Lund.

13. BIRTHPLACE OF MOTHER

(State or Country)

Minnesota

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

Miss Agnes Lund

(Address)

Bonner Ferry, Ida.

15.

Filed *Feb. 1-* 191*3*

S. E. Fry

Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

Jan. 10th 1913
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from *Jan. 7th 1913*, to *Jan. 10th 1913*, that I last saw her alive on *Jan. 10th 1913*, and that death occurred on the date stated above, at *11:55 P.M.*

The CAUSE OF DEATH* was as follows:

Prematurity of birth
(7 mos.)

(Duration) ____ yrs. ____ mos. *3* ds.

Contributory (Secondary)

(Duration) ____ yrs. ____ mos. ____ ds.

(Signed)

S. E. Fry, M. D.
Jan. 14 1913 (Address) *Bonner Ferry, Ida.*

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death ____ yrs. ____ mos. ____ ds. State ____ yrs. ____ mos. ____ ds.

Where was disease contracted,

If not at place of death?

Former or

usual residence

19. PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

Bonner Ferry, Ida. *Jan. 11-1913*

20. UNDERTAKER

ADDRESS

None.

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Form V. S. No. [redacted]

1. PLACE OF DEATH. Registration District No. [redacted]
County of Bonner Primary Registration District No. 20 34
City of Bonner Ferry, Idaho (St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Arden Gertude Husted

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics
File No. 1102
Registered No. 173

If death occurred in a hospital, institution or camp give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX Female 4. COLOR OR RACE White 5. SINGLE, MARRIED, WIDOWED OR DIVORCED. married
(Write the word.)

6. DATE OF BIRTH Sept 26
(Month) (Day) (Year)

7. AGE 20 yrs. 4 mos. 20 ds. IF LESS than 1 day how many.....hrs. or min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work Housewife
(b) General nature of industry business or establishment in which employed (or employer)

9. BIRTHPLACE (State or Country) Batavia, N. Y.

10. NAME OF FATHER Fred Wilson Smith

11. BIRTHPLACE OF FATHER (State or Country) Missouri

12. MAIDEN NAME OF MOTHER Griffith

13. BIRTHPLACE OF MOTHER (State or Country) New York

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) J. W. Husted Jr
(Address) Bonner Ferry, Idaho

15. Filed Feb. 1 - 1913 E. E. Smy
Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH January 11 1913
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased ~~from~~ Jan. 11 th 1913, to — 191—, that I last saw her alive on Jan. 11 th 1913, and that death occurred on the date stated above, at 8:30 P. M.

The CAUSE OF DEATH* was as follows:
Haemorrh.

(Duration) yrs. mos. ds.
Contributory Childbirth
(Secondary)

(Duration) yrs. mos. ds.
(Signed) E. E. Smy M. D.
Jan. 12 1913 (Address) Bonner Ferry, Idaho

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death..... yrs. mos. ds. State..... yrs. mos. ds.
Where was disease contracted.
If not at place of death?.....
Former or usual residence.....

19. PLACE OF BURIAL OR REMOVAL <u>Cheney, Wash.</u>	DATE OF BURIAL <u>191</u>
20. UNDERTAKER <u>J. C. Moore</u>	ADDRESS <u>Bonner Ferry</u>

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Form V. S. No. 5 20M.1-16-12

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics
File No. 4103
Registered No. 176

1. PLACE OF DEATH.

Registration District No. 8

County of Bonner

Primary Registration District No. 2034

City of Bonanza Ferry (No. _____ St.)

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

Calvin William Sawyer

PERSONAL AND STATISTICAL PARTICULARS

3. SEX

Male

4. COLOR OR RACE

White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED.

Married
(Write the word.)

6. DATE OF BIRTH

Nov 1 1862
(Month) (Day) (Year)

7. AGE

50 yrs. 2 mos. 29 ds.

IF LESS than 1 day
how many hrs. or mins.?

8. OCCUPATION

(a) Trade, profession or particular kind of work

Engineer

(b) General nature of industry, business, or establishment in which employed (or employer)

9. BIRTHPLACE

(State or Country)

Canada

10. NAME OF FATHER

Benjamin F Sawyer

11. BIRTHPLACE OF FATHER

(State or Country)

New York

12. MAIDEN NAME OF MOTHER

Rose Sullivan

13. BIRTHPLACE OF MOTHER

(State or Country)

Canada

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Mrs J M Sawyer

(Address) Bonner Ferry Ida

15.

Filed Feb 1st 1913

E E Fry
Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH

January 30 1913
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from

Jan. 22nd, 1913, to Jan. 30 - 1913,
that I last saw him alive on Jan. 29 - 1913,
and that death occurred on the date stated above, at 1 A.M.

The CAUSE OF DEATH* was as follows:

Pneumonia

(Duration) yrs. mos. ds.

Contributory (Secondary)

(Duration) yrs. mos. ds.

(Signed)

Feb 1/1913 (Address) Bonner Ferry, Ida.

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death. yrs. mos. days. In the State. yrs. mos. days.

Where was disease contracted if not at place of death?

Former or usual residence.

19. PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

Bonner Ferry

Feb 2 1913

20. UNDERTAKER

ADDRESS

John J. Moore

B. Ferry

Form V. S. No. 5 20M.1-16-12

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH.

Registration District No. 8County of BonnerPrimary Registration District No. 2034City of Bonner Ferry(No. St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

Latty Ellen StrawFile No. 4104Registered No. 177

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX

Female

4. COLOR OR RACE

White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED.

(Write the word.)

6. DATE OF BIRTH

July 29 1912
(Month) (Day) (Year)

7. AGE

6 yrs. 6 mos. 1 ds.IF LESS than 1 day
how many hrs. or mins.?

8. OCCUPATION

(a) Trade, profession or particular kind of work

(b) General nature of industry, business, or establishment in which employed (or employer)

9. BIRTHPLACE

(State or Country)

10. NAME OF FATHER

11. BIRTHPLACE OF FATHER

(State or Country)

12. MAIDEN NAME OF MOTHER

13. BIRTHPLACE OF MOTHER

(State or Country)

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

(Address)

15.

Filed

Feb. 1 st 1913

Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH

January 30 1913
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from

191, to Jan. 30 - 1913that I last saw her alive on Jan. 30 - 1913and that death occurred on the date stated above, at 5 P.M.

The CAUSE OF DEATH* was as follows:

Broncho - Pneumonia

(Duration) yrs. mos. ds.

Contributory
(Secondary)

(Duration) yrs. mos. ds.

(Signed)

Feb. 1 1913 (Address) Bonner Ferry, Ida.

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death.....yrs.....mos.....days. In the State.....yrs.....mos.....days.

Where was disease contracted if not at place of death?

Former or usual residence.....

19. PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

Bonner Ferry Idaho Feb. 1 st 1913

20. UNDERTAKER

ADDRESS

J. T. Moore B. Ferry Idaho

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Form V. S. No. 5. 10M. 6-20-11.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics
File No. 4105
Registered No. 178

1. PLACE OF DEATH.

Registration District No. 8

County of Bonner

Primary Registration District No. 2834

City of Port Hill, Ida.

(No. _____, _____ St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

Frank Cameron

If death occurred in a hospital, institution or camp give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX

4. COLOR OR RACE

5. SINGLE, MARRIED, WIDOWED OR DIVORCED.

male

white

(Write the word.)

6. DATE OF BIRTH

_____. 1. _____
(Month) (Day) (Year)

7. AGE

25 yrs. _____ mos. _____ ds.

IF LESS than 1 day
how many _____ hrs. or
_____ min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work
(b) General nature of industry business, or establishment in which employed (or employer)

"Lumber-jack" - woodman

9. BIRTHPLACE

(State or Country)

10. NAME OF FATHER

FATHER

11. BIRTHPLACE OF FATHER

(State or Country)

12. MAIDEN NAME OF MOTHER

13. BIRTHPLACE OF MOTHER

(State or Country)

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

(Address)

15.

Filed Feb. 13th 1913

E. E. Stru

Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

February - 2nd 1913.
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from

191____, to 191____

that I last saw h. _____ alive on 191____

and that death occurred on the date stated above, at 5:45 P. M.

The CAUSE OF DEATH* was as follows:

Homicide - Bullet wound of skull.

(Duration) _____ yrs. _____ mos. _____ ds.

Contributory

(Secondary)

(Duration) _____ yrs. _____ mos. _____ ds.

(Signed)

Feb. 13 - 1913 (Address) Bonner Ferry, Ida.

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death _____ yrs. _____ mos. _____ ds. State _____ yrs. _____ mos. _____ ds.

Where was disease contracted,

If not at place of death?

Former or

usual residence.

19. PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

Bonner Ferry, Ida. Feb. 13 - 1913.

20. UNDERTAKER

ADDRESS

John Y. Moore Bonner Ferry

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Form V. S. No. 5 20M.1-16-12

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics
File No. **4106**

1. PLACE OF DEATH.

Registration District No. **8**County of **Bonner**Primary Registration District No. **2034**City of **Bonner Ferry, Idaho** (St.)Registered No. **179**

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME **Edgar A. Brown**

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX

Male

4. COLOR OR RACE

White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED.

(Write the word.)

6. DATE OF BIRTH

Jan. 21 st. 1884
(Month) (Day) (Year)

7. AGE

29 yrs. - mos. 10 ds.

IF LESS than 1 day
how many hrs. or
..... mins.?

8. OCCUPATION

(a) Trade, profession or particular kind of work

Customs Broker

(b) General nature of industry, business, or establishment in which employed (or employer)

9. BIRTHPLACE

(State or Country)

Ontario.

10. NAME OF FATHER

Heil J. Brown

11. BIRTHPLACE OF FATHER

(State or Country)

Ontario

12. MAIDEN NAME OF MOTHER

Mary McCallum.

13. BIRTHPLACE OF MOTHER

(State or Country)

Ontario.

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) **Allen Senior**(Address) **Edmonton, Alta.**

15.

Filed **Feb. 13 th. 1913****E. E. Fry**

Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH

February 9 th. 1913
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from

191., to 191.,

that I last saw him alive on **Feb. 9 th. 1913.**and that death occurred on the date stated above, at **4 3/4 M.**

The CAUSE OF DEATH* was as follows:

Hemorrhage from cut jugular vein - suicidal.

(Duration) yrs. mos. ds.

Contributory

(Secondary)

(Duration) yrs. mos. ds.

(Signed)

Feb. 9 1913 (Address) **Bonner Ferry**

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death yrs. mos. days. In the State yrs. mos. days.

Where was disease contracted if not at place of death?

Former or usual residence.

19. PLACE OF BURIAL OR REMOVAL DATE OF BURIAL

Bonner Ferry, Idaho **7 14** 1913

20. UNDERTAKER

ADDRESS

John J. Moore **Bonner Ferry, Idaho**

Form V. S. No. 5 20M.1-16-12

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
 Bureau of Vital Statistics
 File No. 4107
 Registered No. 180

1. PLACE OF DEATH.

Registration District No. 8County of BonnerPrimary Registration District No. 2034City of Bonner Ferry Idaho

St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

Jennie Mary Hill

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX

Female

4. COLOR OR RACE

White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED.

(Write the word.)

6. DATE OF BIRTH

Jan

(Month)

28th

(Day)

1913

(Year)

7. AGE

yrs.

mos.

14

ds.

IF LESS than 1 day
 how many hrs. or
 mins.?

8. OCCUPATION

- (a) Trade, profession or particular kind of work
 (b) General nature of industry, business, or establishment in which employed (or employer)

9. BIRTHPLACE

(State or Country)

Bonner Ferry Idaho

10. NAME OF FATHER

Alfred Joseph Hill

11. BIRTHPLACE OF FATHER

(State or Country)

N. D.

12. MAIDEN NAME OF MOTHER

Jessie A. Olson

13. BIRTHPLACE OF MOTHER

(State or Country)

South Dakota

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

Mrs Jennie Hill

(Address)

Bonner Ferry Idaho

15.

Filed

Feb. 12191 3

Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH

February

(Month)

11th

(Day)

1913

(Year)

17. I HEREBY CERTIFY, That I attended deceased from

Jan. 28th 1913, to Feb. 11th 1913,that I last saw her alive on Feb. 10th 1913,and that death occurred on the date stated above, at 7:30 PM.

The CAUSE OF DEATH* was as follows:

Thrombocle

(Duration)

yrs.

mos.

13

ds.

Contributory
(Secondary)

(Duration)

yrs.

mos.

ds.

(Signed)

Leslie J. Stauffer M. D.Feb 12 1913 (Address) Bonner Ferry Idaho

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death

yrs.

mos.

13

days.

In the State

yrs.

mos.

13

days.

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

Bonner Ferry IdahoFeb 11 1913

20. UNDERTAKER

ADDRESS

John J. MooreBonner Ferry Idaho

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Form V. S. No. 5 20M.1-16-12

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics
File No. **4108**

1. PLACE OF DEATH.

Registration District No. **8**County of **Bonner**Primary Registration District No. **2034**City of **Bonner Ferry, Idaho** (No. **2** St.)Registered No. **181**

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

John Anton Nales

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX

Male

4. COLOR OR RACE

White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED.

married
(Write the word.)

6. DATE OF BIRTH

September 10th 1879
(Month) (Day) (Year)

7. AGE

63 yrs. 5 mos. 7 ds.

IF LESS than 1 day
how many hrs. or
..... mins.?

8. OCCUPATION

(a) Trade, profession or particular kind of work

Carpenter

(b) General nature of industry business, or establishment in which employed (or employer)

9. BIRTHPLACE

(State or Country)

Sweden

10. NAME OF FATHER

11. BIRTHPLACE OF FATHER

(State or Country)

France

12. MAIDEN NAME OF MOTHER

13. BIRTHPLACE OF MOTHER

(State or Country)

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) **Mrs. John A. Nales**(Address) **Bonner Ferry, Idaho**

15.

Filed **Feb 13** 191**3** **Newsperson**

Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH

February 17th 1913
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased ~~from~~
once only on Feb 17 191**3**,
that I last saw him alive on **Feb 15** 191**3**,
and that death occurred on the date stated above, at **1 P.M.**

The CAUSE OF DEATH* was as follows:

Cerebral hemorrhage, apoplexy

(Duration) yrs. mos. ds.

Contributory
(Secondary)**Epilepsy**

(Duration) yrs. mos. ds.

(Signed)

Leslie J. Stauffer M. D.**Feb 27 1913**(Address) **Bonner Ferry, Idaho**

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death yrs. mos. days. In the State yrs. mos. days.

Where was disease contracted if not at place of death?

• Former or usual residence.....

19. PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

Bonner Ferry, Idaho**1913**

20. UNDERTAKER

ADDRESS

John J. Moore**Bonner Ferry, Idaho**

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Form V. S. No. 5 20M.1-16-12

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics
File No. **4109**

1. PLACE OF DEATH

Registration District No. **5**County of **Conmus**Primary Registration District No. **2034**City of **Conmus Ferry, Ida.**

No.

St.)

Registered No. **182**

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME **Edna Arabel Mann**

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX **Female**4. COLOR OR RACE **White**5. SINGLE, MARRIED, WIDOWED OR DIVORCED. **Single**
(Write the word.)

6. DATE OF BIRTH

Sept

(Month)

25th

(Day)

1909

(Year)

7. AGE

3

yrs.

5

mos.

no

ds.

IF LESS than 1 day
how many hrs. or
mins.?

8. OCCUPATION

(a) Trade, profession or particular kind of work

(b) General nature of industry, business, or establishment in which employed (or employer)

9. BIRTHPLACE

(State or Country)

Idaho

10. NAME OF FATHER

Earl D. Mann

11. BIRTHPLACE OF FATHER

(State or Country)

Idaho

12. MAIDEN NAME OF MOTHER

Rosal Gregory

13. BIRTHPLACE OF MOTHER

(State or Country)

Idaho

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

Earl D. Mann

(Address)

Conmus Ferry, Ida.

15.

Filed

Feb. 25th 1913.**E. E. Fry**

Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH

Feb

(Month)

25th

(Day)

1913

(Year)

17. I HEREBY CERTIFY, That I attended deceased from

191

to

191that I last saw him alive on **Feb. 5th 1913.**and that death occurred on the date stated above, at **5 A. M.**

The CAUSE OF DEATH* was as follows:

Pulmonary Tuberculosis.

(Duration)

yrs.

mos.

ds.

Contributory
(Secondary)

(Duration)

yrs.

mos.

ds.

(Signed)

E. E. Fry M. D.**2/25 1913 (Address) Conmus Ferry, Ida.**

* State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death

yrs. mos. days.

In the

State yrs. mos. days.

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

Conmus Ferry, Ida.**Feb 27 1913**

20. UNDERTAKER

ADDRESS

John J. Moon**Conmus Ferry**

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Form V. S. No. 5. 12½ M. 7-24-11

CERTIFICATE OF DEATH

1. PLACE OF DEATH. Registration District No. 32
County of Lewis Primary Registration District No. 2127
City of Nezperce (No. _____, _____ St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

Katie Jacobs

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

File No. 1111Registered No. 3

If death occurred in a hospital, institution or camp give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX Female 4. COLOR OR RACE White 5. SINGLE, MARRIED, WIDOWED OR DIVORCED. Married
(Write the word.)

6. DATE OF BIRTH January 16 1865
(Month) (Day) (Year)

7. AGE 48 yrs. 1 mos. 7 ds. IF LESS than 1 day how many _____ hrs. or _____ min?

8. OCCUPATION

(a) Trade, profession or particular kind of work. Housewife
(b) General nature of industry business or establishment in which employed (or employer)

9. BIRTHPLACE

(State or Country) Minnesota

10. NAME OF FATHER

George Luther

11. BIRTHPLACE OF FATHER

(State or Country) Germany

12. MAIDEN NAME OF MOTHER

Anna Mary Winter

13. BIRTHPLACE OF MOTHER

(State or Country) Germany

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) N. H. Jacobs(Address) Nezperce, Ida.

15.

Filed Feb 24 1913

Ellen B. Rogers
Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH

February 23 1913
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from 1911, to Feb 23 1913

that I last saw him alive on Dec 1912
and that death occurred on the date stated above, at 2 P.M.

The CAUSE OF DEATH* was as follows:

Encephalitic Dile

(Duration) 3 yrs. 4 mos. 0 ds.

Contributory
(Secondary)

(Duration) _____ yrs. _____ mos. _____ ds.

(Signed) O. G. Jeffery M. D.

2-1-1913 (Address) Nezperce

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place _____ yrs. _____ mos. _____ ds. In the _____ yrs. _____ mos. _____ ds.

Where was disease contracted,

If not at place of death?

Former or

usual residence.

19. PLACE OF BURIAL OR REMOVAL DATE OF BURIAL

Nezperce 2-24 1913

20. UNDERTAKER

ADDRESS

P. E. Miller Nezperce

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Form V. S. No. 5. 12½ M. 7-24-11

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH. Registration District No. 32
County of Louis Primary Registration District No. 2127
City of Ilo (No. _____, _____ St.)

File No. 1115
Registered No. 4

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Simon Broker

If death occurred in a hospital, institution or camp give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX Male 4. COLOR OR RACE white 5. SINGLE, MARRIED, WIDOWED OR DIVORCED. married
(Write the word.)

6. DATE OF BIRTH Sept 16 1834
(Month) (Day) (Year)

7. AGE 78 yrs. 5 mos. 7 ds. IF LESS than 1 day how many _____ hrs. or _____ min?

8. OCCUPATION

(a) Trade, profession or particular kind of work Farmer
(b) General nature of industry business or establishment in which employed (or employer)

9. BIRTHPLACE

(State or Country) Germany

10. NAME OF FATHER

not known

11. BIRTHPLACE OF FATHER

(State or Country) Germany

12. MAIDEN NAME OF MOTHER

not known

13. BIRTHPLACE OF MOTHER

(State or Country) Germany

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) R. M. Broker
(Address) Ilo Idaho

15.

Filed 2-26-1913

Elmer P. Rogers
Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH Feb 23 1913
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from Jan 31 1913, to Feb 22 1913 that I last saw him alive on Feb 14 1913 and that death occurred on the date stated above, at 11:30 PM.

The CAUSE OF DEATH* was as follows:

Senile Debility

(Duration) 2 yrs. _____ mos. _____ ds.
Contributory arterial Sclerosis
(Secondary)

(Duration) _____ yrs. _____ mos. _____ ds.
(Signed) J. C. Parrish M. D.
2-24 1913 (Address) Ilo Idaho

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; (2) whether ACCIDENTAL, SUICIDAL OR HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place _____ In the _____
of death _____ yrs. _____ mos. _____ ds. State _____ yrs. _____ mos. _____ ds.
Where was disease contracted,
If not at place of death? _____
Former or
usual residence _____

19. PLACE OF BURIAL OR REMOVAL DATE OF BURIAL

I.O.O.F Cemetery, Ilo 2-26 1913
20. UNDERTAKER ADDRESS

Ilo Idaho & Imp Co. Ilo, Idaho

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Form V. S. No. 5. 10M. 6-20-11.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics
File No. 4113

1. PLACE OF DEATH.

Registration District No. 22

County of Canyon

Primary Registration District No. 2010

City of New Falk

(No. , St.)

Registered No. 71

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Mary Katherine Kessler

If death occurred in a hospital, institution or camp give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX

F

4. COLOR OR RACE 5. SINGLE, MARRIED, WIDOWED OR DIVORCED.

W

married
(Write the word.)

6. DATE OF BIRTH

Jan

12

1894

(Month)

(Day)

(Year)

7. AGE

59

yrs.

0

mos.

16

ds.

IF LESS than 1 day
how many hrs. or min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work

Housewife

(b) General nature of industry business or establishment in which employed (or employer)

9. BIRTHPLACE

(State or Country)

Pennsylvania

10. NAME OF FATHER

Sybramus Smader

11. BIRTHPLACE OF FATHER

(State or Country)

Penn.

12. MAIDEN NAME OF MOTHER

Mary Anne Bickle

13. BIRTHPLACE OF MOTHER

(State or Country)

Penn

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

J. F. Kessler

(Address)

Falk Idaho

15.

Filed

Feb 15 1913

8

Alwoodward

Dep. Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

Jan

28

1913

(Month)

(Day)

(Year)

17. I HEREBY CERTIFY, That I attended deceased from

examined deceased after death 191

that I last saw h alive on 191

and that death occurred on the date stated above, at 4 A. M.

The CAUSE OF DEATH* was as follows:

Acute Cardiac Insufficiency

(Duration) less than 30 minutes

Contributory (Secondary)

Chronic Nephritis & probably

valvular disease

(Duration) 5 yrs. mos. ds.

(Signed) W. T. D. Ryshale M. D.

Jan 28 1913 (Address) New Plymouth Ida

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death yrs. mos. ds. State yrs. mos. ds.

Where was disease contracted,

If not at place of death?

Former or

usual residence.

19. PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

20. UNDERTAKER

ADDRESS

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Form V. S. No. 5. 10M. 6-20-11.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH.

County of Canyon
City of EmmettRegistration District No. 22Primary Registration District No. 2010

(No. _____, St.)

File No. 1114Registered No. 70

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Infant Son of F.E. Daniels

If death occurred in a hospital, institution or camp give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX

male

4. COLOR OR RACE

white

5. SINGLE, MARRIED, WIDOWED OR DIVORCED.

Infant
(Write the word.)

6. DATE OF BIRTH

Jan 1 1913
(Month) (Day) (Year)

7. AGE

7 yrs. 7 mos. 7 ds.IF LESS than 1 day
how many hrs. or
..... min.?

8. OCCUPATION

(a) Trade, profession, or particular kind of work

Infant

(b) General nature of industry, business, or establishment in which employed (or employer)

9. BIRTHPLACE

(State or Country)

Idaho

10. NAME OF FATHER

F.E. Daniels

11. BIRTHPLACE OF FATHER

(State or Country)

Iowa

12. MAIDEN NAME OF MOTHER

Lulu Prosser

13. BIRTHPLACE OF MOTHER

(State or Country)

Minnesota

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

(Address)

Emmett Idaho

15.

Filed Jan 10 1913J. D. Reynolds
Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

January 8 1913
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from

Jan 1 1913, to Jan 1 1913that I last saw him alive on Jan 1 1913,and that death occurred on the date stated above, at 7 P. M.

The CAUSE OF DEATH* was as follows:

Probably atelectasis(Duration) yrs. few hrs. ds.Contributory
(Secondary)

(Duration) yrs. mos. ds.

(Signed) R. N. Bucknum M. D.Jan 1 1913 (Address) Emmett Idaho

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL,

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place

In the

of death yrs. mos. ds. State yrs. mos. ds.

Where was Disease contracted,

If not at place of death?

Former or

usual residence

19. PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

Emmett CemeteryJan 8 1913

20. UNDERTAKER

ADDRESS

C. D. BucknumEmmett

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Form V. S. No. 5. 10M. 6-20-11.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics
File No. 4113

1. PLACE OF DEATH.

Registration District No. 22County of CanyonPrimary Registration District No. 2010City of Emmett

(No. _____, St.)

Registered No. 69

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

Mecoline Peterson

If death occurred in a hospital, institution or camp give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX

female

4. COLOR OR RACE

white

5. SINGLE, MARRIED, WIDOWED OR DIVORCED.

Widow
(Write the word.)

6. DATE OF BIRTH

Apr 2 1836
(Month) (Day) (Year)

7. AGE

76 yrs 9 mos 15 ds

IF LESS than 1 day
how many hrs. or
..... min.?

8. OCCUPATION

(a) Trade, profession, or particular kind of work

housewife

(b) General nature of industry business, or establishment in which employed (or employer)

9. BIRTHPLACE

(State or Country)

Norway

10. NAME OF FATHER

Don't know

11. BIRTHPLACE OF FATHER

(State or Country)

" "

12. MAIDEN NAME OF MOTHER

" "

13. BIRTHPLACE OF MOTHER

(State or Country)

" "

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

Anthony Peterson

(Address)

15.

Filed Feb 15 1913S R. EdwardsDep Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

Jan 17 1913
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from

191 1, to Jan 14 1913
that I last saw her alive on Jan 14 1913,
and that death occurred on the date stated above, at M.

The CAUSE OF DEATH* was as follows:

Senile dementia

(Duration) Several mos. ds.

Contributory (Secondary)

(Duration) 1 1/2 yrs. mos. ds.

(Signed) R. H. Cummings M. D.

1/12 1913 (Address) Emmett Idaho

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL,

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place In the
of death yrs. mos. ds. State yrs. mos. ds.

Where was Disease contracted,

If not at place of death?

Former or

usual residence.

19. PLACE OF BURIAL OR REMOVAL DATE OF BURIAL

Emmett Cemetery Jan 19 1913

20. UNDERTAKER ADDRESS

Emmett Cemetery Emmett

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Form V. S. No. 5. 12½ M. 7-24-11

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics
File No. 4116
Registered No. 67

1. PLACE OF DEATH. Registration District No. 22
County of Canyon. Primary Registration District No. 2009
City of Payette. (No. _____, _____ St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Maudie Elizabeth Stegall.

If death occurred in a hospital, institution or camp give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX Female 4. COLOR OR RACE White 5. SINGLE, MARRIED, WIDOWED OR DIVORCED. Single
(Write the word.)
6. DATE OF BIRTH October 5 1893
(Month) (Day) (Year)

7. AGE 30 yrs. 4 mos. 3 ds. IF LESS than 1 day how many _____ hrs. or _____ min?

8. OCCUPATION
(a) Trade, profession or particular kind of work. Teacher
(b) General nature of industry business or establishment in which employed (or employer)

9. BIRTHPLACE Ill.
(State or Country)

10. NAME OF FATHER Marks Stegall.

11. BIRTHPLACE OF FATHER Ill.
(State or Country)

12. MAIDEN NAME OF MOTHER Eva Slocum.

13. BIRTHPLACE OF MOTHER Michigan.
(State or Country)

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Alice Makinson
(Address) New Plymouth

15. Filed Feb 7 1913 J. R. Woodward
Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH February 6 1913
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from June 1910, to Feb 5 1910
that I last saw her alive on about Jan 28 1913
and that death occurred on the date stated above, at 8:15 P.

The CAUSE OF DEATH* was as follows:

Pulm. Tuberculosis

(Duration) 2 yrs. 6 mos. _____ ds.

Contributory (Secondary)

(Duration) _____ yrs. _____ mos. _____ ds.

(Signed) Wm T Drysdale M. D.
Feb 7 1913 (Address) New Plymouth

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place _____ In the _____
of death _____ yrs. _____ mos. _____ ds. State _____ yrs. _____ mos. _____ ds.

Where was disease contracted,
If not at place of death? _____
Former or
usual residence. _____

19. PLACE OF BURIAL OR REMOVAL DATE OF BURIAL

New Plymouth Feb 8 1913

20. UNDERTAKER ADDRESS

G. C. Landon Payette Idaho

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Form V. S. No. 5 20M.1-16-12

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics
File No. 1111
Registered No. 73

1. PLACE OF DEATH.

Registration District No. 22County of CanyonPrimary Registration District No. 2008City of Payette

(No. _____ St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

William Knox

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX

Male

4. COLOR OR RACE

White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED.

Married
(Write the word.)

6. DATE OF BIRTH

March 14 1858
(Month) (Day) (Year)

7. AGE

54 yrs. 11 mos. 13 ds.IF LESS than 1 day
how many _____ hrs. or
_____ mins.)

8. OCCUPATION

(a) Trade, profession or particular kind of work

Farmer

(b) General nature of industry business, or establishment in which employed (or employer)

Stockman

9. BIRTHPLACE

(State or Country)

Utah

10. NAME OF FATHER

William Knox

11. BIRTHPLACE OF FATHER

(State or Country)

England

12. MAIDEN NAME OF MOTHER

Elizabeth Tweddle

13. BIRTHPLACE OF MOTHER

(State or Country)

England

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

Thomas Knox

(Address)

Payette

15.

Filed 7-6-19135114
Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH

February 27 1913
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from

Feb. 26 1913, to Feb. 26 1913,that I last saw him alive on Feb. 26 1913,and that death occurred on the date stated above, at 2 A.M.

The CAUSE OF DEATH* was as follows:

Double lobar pneumonia(Duration) _____ yrs. _____ mos. 7 ds.Contributory
(Secondary)

(Duration) _____ yrs. _____ mos. _____ ds.

(Signed)

O. H. Avery M. D.Feb. 28 1913. (Address) Payette Idaho

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death _____ yrs. _____ mos. _____ days. In the State _____ yrs. _____ mos. _____ days.

Where was disease contracted if not at place of death?

Former or usual residence _____

19. PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

Cash Valley Utah Mar 1 1913

20. UNDERTAKER

ADDRESS

J. H. ... Payette Ida

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Form V. S. No. 5 20M.1-16-12

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH.

Registration District No. 22

County of Canyon

Primary Registration District No. 2005

City of Payette

(No. _____, _____ St.)

File No. 4118

Registered No. 72

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Harry Asmusen

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX

Male

4. COLOR OR RACE

White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED.

(Write the word.)

6. DATE OF BIRTH

June 28 1895
(Month) (Day) (Year)

7. AGE

17 yrs. 7 mos. 18 ds.

IF LESS than 1 day
how many _____ hrs. or
_____ mins.?

8. OCCUPATION

(a) Trade, profession or particular kind of work

Farmer

(b) General nature of industry business, or establishment in which employed (or employer)

9. BIRTHPLACE

(State or Country)

Idaho

10. NAME OF FATHER

Harry Asmusen

11. BIRTHPLACE OF FATHER

(State or Country)

Germany

12. MAIDEN NAME OF MOTHER

Maria Christiansen

13. BIRTHPLACE OF MOTHER

(State or Country)

Germany

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Mrs. A. F. Wagermann

(Address) Payette Ida.

15.

Filed Feb 17 1913

S. R. Woodward
Seal Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH

Feb 16 1913
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from

Jan 14 1913, to Feb 16 1913,

that I last saw him alive on Feb 16 1913,

and that death occurred on the date stated above, at 1 M.

The CAUSE OF DEATH* was as follows:

Brain Tumor Lasting several years

(Duration) _____ yrs. _____ mos. _____ ds.

Contributory (Secondary)

Epilepsy

(Duration) _____ yrs. _____ mos. _____ ds.

(Signed)

J. E. Crouch M. D.
2-17-13 (Address) Payette Idaho

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death _____ yrs. _____ mos. _____ days. In the State _____ yrs. _____ mos. _____ days.

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

Payette Ida Feb 20 1913

20. UNDERTAKER

ADDRESS

J. H. Adair Payette Ida

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Form V. S. No. 5 20M.1-16-12

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics
File No. 4119
Registered No. 68

1. PLACE OF DEATH. Registration District No. 22
County of anyone Primary Registration District No. 2005
City of Idaho (No. _____ St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME William E. Alberson

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX Male 4. COLOR OR RACE White 5. SINGLE, MARRIED, WIDOWED OR DIVORCED. Married
(Write the word.)

6. DATE OF BIRTH Dec 8 1841
(Month) (Day) (Year)

7. AGE 71 yrs. 1 mos. 29 ds.
IF LESS than 1 day how many hrs. or mins.

8. OCCUPATION
(a) Trade, profession or particular kind of work Carpenter
(b) General nature of industry business, or establishment in which employed (or employer)

9. BIRTHPLACE Missouri
(State or Country)

10. NAME OF FATHER Colman Alberson

11. BIRTHPLACE OF FATHER Sally G. Missouri
(State or Country)

12. MAIDEN NAME OF MOTHER Sally Ann Coy.

13. BIRTHPLACE OF MOTHER Missouri
(State or Country)

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Lewis Marshall
(Address) Payroll's Idaho

15. Filed Feb 7 1913 J. H. Adams Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH Feb 7 1913
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from May 12 1912 to Feb 7 1913, that I last saw him alive on Feb 7 1913, and that death occurred on the date stated above, at 11 A.M.

The CAUSE OF DEATH* was as follows:
Inflammatory Rheumatism

(Duration) 3 yrs. — mos. — ds.
Contributory (Secondary)

(Duration) _____ yrs. _____ mos. _____ ds.
(Signed) J. H. Adams M. D.
2/7 1913 (Address) Payroll's Idaho

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death. _____ yrs. _____ mos. _____ days. In the State. _____ yrs. _____ mos. _____ days.

Where was disease contracted if not at place of death?

Former or usual residence.

19. PLACE OF BURIAL OR REMOVAL Alberson Ore. DATE OF BURIAL Feb 8 1913

20. UNDERTAKER J. H. Adams ADDRESS Payroll's Idaho

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Form V. S. No. 5. 10M. 6-20-11.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH.

County of Bannock
City of PayetteRegistration District No. 22Primary Registration District No. 2008

(No. _____ St.)

File No. 4129Registered No. 66

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

Celton Benjamin Hodge

If death occurred in a hospital, institution or camp give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX

male

4. COLOR OR RACE

white

5. SINGLE, MARRIED, WIDOWED OR DIVORCED.

(Write the word.)

6. DATE OF BIRTH

July 5th 1913
(Month) (Day) (Year)

7. AGE

6 yrs. 30 mos. 30 ds.IF LESS than 1 day
how many hrs. or
..... min.?

8. OCCUPATION

- (a) Trade, profession, or particular kind of work
(b) General nature of industry business, or establishment in which employed (or employer)

9. BIRTHPLACE

(State or Country)

Payette, Ida.

10. NAME OF FATHER

B. F. Hodge

11. BIRTHPLACE OF FATHER

(State or Country)

Virginia

12. MAIDEN NAME OF MOTHER

Emma Ringer

13. BIRTHPLACE OF MOTHER

(State or Country)

Virginia

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

B. F. Hodge

(Address)

Payette Idaho

15.

Filed

Feb 6 1913S. B. Woodward
Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

Feb. 4 1913
(Month) (Day) (Year)17. I HEREBY CERTIFY, That I attended deceased from Jan. 20 1913, to Feb. 4 1913, that I last saw him alive on Feb. 4 1913, and that death occurred on the date stated above, at 5.30 PM.

The CAUSE OF DEATH* was as follows:

Pneumonia(Duration) yrs. mos. 21 ds.Contributory
(Secondary)

(Duration) yrs. mos. ds.

(Signed) H. R. Barton M. D.Feb. 5 1913 (Address) Payette, Ida

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL,

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place In the
of death yrs. mos. ds. State yrs. mos. ds.Where was Disease contracted,
If not at place of death?Former or
usual residence

19. PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

Payette Idaho Feb 6 1913

20. UNDERTAKER

ADDRESS

H. C. Brandon Payette Idaho

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Form V. S. No. 5. 12½ M. 7-24-11

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics
File No. 1122

1. PLACE OF DEATH. Registration District No. 17
County of Clearwater Primary Registration District No. 2078
City of Croftino (No. _____, _____ St.)

Registered No. 9

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

Joseph R. Dunbar

If death occurred in a hospital, institution or camp give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX Male 4. COLOR OR RACE White 5. SINGLE, MARRIED, WIDOWED OR DIVORCED. Married
(Write the word.)

6. DATE OF BIRTH February 4 1913
(Month) (Day) (Year)

7. AGE 63 yrs. _____ mos. _____ ds. IF LESS than 1 day
how many _____ hrs. or _____ min?

8. OCCUPATION

(a) Trade, profession or particular kind of work
(b) General nature of industry business or establishment in which employed (or employer)

Farmer

9. BIRTHPLACE

(State or Country)

America

10. NAME OF FATHER

2

11. BIRTHPLACE OF FATHER

(State or Country)

2

12. MAIDEN NAME OF MOTHER

2

13. BIRTHPLACE OF MOTHER

(State or Country)

2

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

(Address)

John Livers
Croftino, Ida

15.

Filed

Feb 12 1913J. M. Fair
Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH

February 4 1913
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from Dec. 8 1912, to Feb 4 1913

that I last saw him alive on Feb. 2 1913

and that death occurred on the date stated above, at 9 P. M.

The CAUSE OF DEATH* was as follows:

Arterio-Sclerosis

_____ (Duration) 5 yrs. 1 mos. 25 ds.

Contributory (Secondary)

Insanity

_____ (Duration) _____ yrs. _____ mos. _____ ds.

(Signed)

John Livers M. D.
Feb 12 1913 (Address)

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place _____ In the _____
of death _____ yrs. _____ mos. _____ ds. State _____ yrs. _____ mos. _____ ds.

Where was disease contracted,

If not at place of death?

Former or

usual residence.

19. PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

No Idaho Anytime CemeteryFeb 5 1913

20. UNDERTAKER

ADDRESS

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Form V. S. No. 5. 12½ M. 7-24-11

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics
File No. 1123
Registered No. 10

1. PLACE OF DEATH
County of Blaine Registration District No. 17
City of Idaho Primary Registration District No. 2078
(No. _____, St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

James McAvoy

If death occurred in a hospital, institution or camp give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX 4. COLOR OR RACE 5. SINGLE, MARRIED, WIDOWED OR DIVORCED.

Male White Married
(Write the word.)

6. DATE OF BIRTH

1867
(Month) (Day) (Year)

7. AGE

46 yrs. mos. ds.

IF LESS than 1 day
how many hrs. or
..... min?

8. OCCUPATION

(a) Trade, profession or particular kind of work
(b) General nature of industry business or establishment in which employed (or employer)

Farmer

9. BIRTHPLACE

(State or Country)

Mass.

10. NAME OF FATHER

John McAvoy

11. BIRTHPLACE OF FATHER

(State or Country)

Ireland

12. MAIDEN NAME OF MOTHER

Burns

13. BIRTHPLACE OF MOTHER

(State or Country)

Ireland

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

(Address)

Thom. McAvoy
Idaho

15.

Filed

July 18 1913

J. M. Fairley
Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH

February 9 1913
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from

May 1912, to About July 1912
that I last saw him alive on Oct 1912
and that death occurred on the date stated above, at 6 A M.

The CAUSE OF DEATH* was as follows:

Carcinoma of Stomach

(Duration) 2 yrs. mos. ds.

Contributory
(Secondary)

(Duration) yrs. mos. ds.

(Signed) E. H. McAvoy M. D.

Feb 17 1913 (Address) Idaho

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place In the
of death yrs. mos. ds. State yrs. mos. ds.

Where was disease contracted,

If not at place of death?

Former or

usual residence.

19. PLACE OF BURIAL OR REMOVAL DATE OF BURIAL

Idaho Idaho July 11 1913

20. UNDERTAKER

ADDRESS

W. E. Stoddard Gifford

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Form V. S. No. 5. 12½ M. 7-24-11

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics
File No. 1124
Registered No. 11

1. PLACE OF DEATH. Registration District No. 17
County of Clearwater Primary Registration District No. 2078
City of Crosby (No. _____, _____ St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

Annie Parrish

If death occurred in a hospital, institution or camp give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX Female 4. COLOR OR RACE White 5. SINGLE, MARRIED, WIDOWED OR DIVORCED. widow
(Write the word.)

6. DATE OF BIRTH

1850
(Month) (Day) (Year)

7. AGE

64 yrs. _____ mos. _____ ds. IF LESS than 1 day
how many _____ hrs. or _____ min?

8. OCCUPATION

(a) Trade, profession or particular kind of work. House-wife
(b) General nature of industry business or establishment in which employed (or employer)

9. BIRTHPLACE

(State or Country) Ireland

10. NAME OF FATHER

2

11. BIRTHPLACE OF FATHER

(State or Country) 2

12. MAIDEN NAME OF MOTHER

2

13. BIRTHPLACE OF MOTHER

(State or Country) 2

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Geo. H. Shreve

(Address) Crosby, Ida

15.

Filed July 14, 1913 J. M. Fairley
Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH

February 12 1913
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from

Feb. 22, 1910, to Feb. 12, 1913

that I last saw her alive on Feb. 12, 1913

and that death occurred on the date stated above, at 9 A. M.

The CAUSE OF DEATH* was as follows:

Epilepsy

(Duration) 2 yrs. 11 mos. 20 ds.

Contributory (Secondary)

(Duration) _____ yrs. _____ mos. _____ ds.

(Signed) J. M. Fairley M. D.

July 12, 1913 (Address) Crosby, Ida

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place _____ In the _____
of death _____ yrs. _____ mos. _____ ds. State _____ yrs. _____ mos. _____ ds.
Where was disease contracted,
If not at place of death?
Former or
usual residence.

19. PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

Idaho July 14, 1913

20. UNDERTAKER

ADDRESS

W. E. Stoddard Gifford, Ida

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Form V. S. No. 5. 12½ M. 7-24-11

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics
File No. 4125
Registered No. 12

1. PLACE OF DEATH. Registration District No. 17
County of Clearwater Primary Registration District No. 2078
City of Prosser (No. _____, _____ St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

William Gavin

If death occurred in a hospital, institution or camp give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX Male 4. COLOR OR RACE White 5. SINGLE, MARRIED, WIDOWED OR DIVORCED. Widowed
(Write the word.)

6. DATE OF BIRTH 1835
(Month) (Day) (Year)

7. AGE 78 yrs. 0 mos. 0 ds. IF LESS than 1 day
how many hrs. or min?

8. OCCUPATION
(a) Trade, profession or particular kind of work. Farmer
(b) General nature of industry business or establishment in which employed (or employer)

9. BIRTHPLACE
(State or Country) Ireland

10. NAME OF FATHER 2

11. BIRTHPLACE OF FATHER 2
(State or Country)

12. MAIDEN NAME OF MOTHER 2

13. BIRTHPLACE OF MOTHER 2
(State or Country)

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Geo. W. Shreve
(Address) Prosser, Idaho

15. Feb 15 1913
Filed W. E. Shattard
Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH February 13 1913
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from Dec. 11, 1912, to Feb. 13, 1913
that I last saw him alive on Feb. 8, 1913
and that death occurred on the date stated above, at 4 P. M.
The CAUSE OF DEATH* was as follows:

General Debility

(Duration) 2 yrs. 2 mos. 2 ds.
Contributory Insanity
(Secondary)

(Duration) 2 yrs. 2 mos. 2 ds.
(Signed) J. M. Fairly M. D.
Feb 13 1913 (Address) Prosser, Idaho

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place In the
of death 2 yrs. 2 mos. 2 ds. State 2 yrs. 2 mos. 2 ds.
Where was disease contracted,
If not at place of death?
Former or
usual residence.

19. PLACE OF BURIAL OR REMOVAL Moscow, Ida DATE OF BURIAL Feb 16 1913

20. UNDERTAKER W. E. Shattard ADDRESS Prosser, Ida

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Form V. S. No. 5 20M.1-16-12

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics
File No. 4126
Registered No. 13

1. PLACE OF DEATH. Registration District No. 17
County of Cassia Primary Registration District No. 2078
City of Shoshone (No. _____, _____ St.)

If death occurs away from usual residence, give facts called for under special information. 2. FULL NAME None

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX Male 4. COLOR OR RACE White 5. SINGLE, MARRIED, WIDOWED OR DIVORCED. Single
(Write the word.)

6. DATE OF BIRTH Feb 15 1913
(Month) (Day) (Year)

7. AGE _____ yrs. _____ mos. 1 ds.
IF LESS than 1 day how many _____ hrs. or _____ mins.

8. OCCUPATION
(a) Trade, profession or particular kind of work None
(b) General nature of industry business, or establishment in which employed (or employer) _____

9. BIRTHPLACE Idaho
(State or Country)

10. NAME OF FATHER Samuel Hatmaker

11. BIRTHPLACE OF FATHER W. Va.
(State or Country)

12. MAIDEN NAME OF MOTHER Lola M. Smith

13. BIRTHPLACE OF MOTHER Idaho
(State or Country)

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Samuel Hatmaker
(Address) Shoshone, Ida

15. Filed Mar 20 1913 J. W. Smith
Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH Feb 17 1913
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from _____ 191____, to _____ 191____,
that I last saw h_____ alive on _____ 191____,
and that death occurred on the date stated above, at _____ M.
The CAUSE OF DEATH* was as follows:

Unknown

_____. (Duration) _____ yrs. _____ mos. _____ ds.

Contributory _____
(Secondary) _____

_____. (Duration) _____ yrs. _____ mos. _____ ds.

(Signed) J. W. Smith M. D.

2/17 1913 (Address) Shoshone, Ida

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL OR HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death _____ yrs. _____ mos. _____ days. In the State _____ yrs. _____ mos. _____ days.

Where was disease contracted if not at place of death? _____

Former or usual residence _____

19. PLACE OF BURIAL OR REMOVAL DATE OF BURIAL

Cassia Cemetery, Shoshone, Ida Feb 18 1913

20. UNDERTAKER ADDRESS

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Form V. S. No. 5. 12½ M. 7-24-11

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics
File No. 4127
Registered No. 14

1. PLACE OF DEATH.

Registration District No. 17County of ClearwaterPrimary Registration District No. 2078City of Orofino

(No. _____ St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

Thomas H. Caruthers

If death occurred in a hospital, institution or camp give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX

Male

4. COLOR OR RACE

White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED.

Married
(Write the word.)

6. DATE OF BIRTH

Feb 18 1913
(Month) (Day) (Year)

7. AGE

64 yrs. _____ mos. _____ ds.

IF LESS than 1 day
how many _____ hrs. or
_____ min?

8. OCCUPATION

(a) Trade, profession or particular kind of work
(b) General nature of industry business or establishment in which employed (or employer)

Farmer

9. BIRTHPLACE

(State or Country)

Missouri

10. NAME OF FATHER

11. BIRTHPLACE OF FATHER

(State or Country)

12. MAIDEN NAME OF MOTHER

13. BIRTHPLACE OF MOTHER

(State or Country)

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

(Address)

Charles H. Caruthers
Manigville Ida.

15.

Filed

Feb 18 3 J. M. Fairley
1913
Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH

Feb 18 1913
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from

Feb 15 1913, to Feb 18 1913

that I last saw him alive on Feb 17 1913

and that death occurred on the date stated above, at 64 M.

The CAUSE OF DEATH* was as follows:

Asphyxiation following a fracture of right thigh

(Duration) _____ yrs. _____ mos. 3 ds.

Contributory

(Secondary)

(Duration) _____ yrs. _____ mos. _____ ds.

(Signed) E. W. Howell M. D.

Feb 18 1913 (Address) Orofino Ida.

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place _____ In the _____
of death _____ yrs. _____ mos. _____ ds. State _____ yrs. _____ mos. _____ ds.

Where was disease contracted,

If not at place of death?

Former or

usual residence.

19. PLACE OF BURIAL OR REMOVAL DATE OF BURIAL

Grangeville - Ida 2 1913

20. UNDERTAKER

ADDRESS

W. E. Stoddard Bifford

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Form V. S. No. 5 20M.1-16-12

CERTIFICATE OF DEATH

 State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

 1. PLACE OF DEATH. Registration District No. 7
 County of Bonanza Primary Registration District No. 2027
 City of Lincoln (No. _____, St.)

 File No. 4128
 Registered No. 141

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Randolph Woodhouse

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

 3. SEX Male 4. COLOR OR RACE White 5. SINGLE, MARRIED, WIDOWED OR DIVORCED. married
 (Write the word.)

 6. DATE OF BIRTH June 22 1894
 (Month) (Day) (Year)

 7. AGE 19 yrs. 8 mos. 11 ds.
 IF LESS than 1 day how many hrs. or mins.?

 8. OCCUPATION Farming
 (a) Trade, profession or particular kind of work
 (b) General nature of industry, business, or establishment in which employed (or employer)

 9. BIRTHPLACE Lehi Utah
 (State or Country)

 10. NAME OF FATHER Morgan T Woodhouse

 11. BIRTHPLACE OF FATHER Utah
 (State or Country)

 12. MAIDEN NAME OF MOTHER Matilda Howes

 13. BIRTHPLACE OF MOTHER Utah
 (State or Country)

 14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
 (Informant) Morgan T Woodhouse
 (Address)

 15. Filed Nov 6 1913 J. E. Bennett
 Local Registrar

MEDICAL CERTIFICATE OF DEATH.

 16. DATE OF DEATH March 5 1913
 (Month) (Day) (Year)

 17. I HEREBY CERTIFY, That I attended deceased from Jan. 27 1913 to Mar. 5 1913
 that I last saw him alive on Mar. 5 1913
 and that death occurred on the date stated above, at 5:30 P.

The CAUSE OF DEATH* was as follows:

Chronic myocarditis
 (Duration) Indefinite yrs. mos. ds.
 Contributory (Secondary) Nephritis
 (Duration) Indefinite yrs. mos. ds.
 (Signed) John O. McLean M. D.
 19 (Address) Idaho Falls, Idaho

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death.....yrs.....mos.....days. In the State.....yrs.....mos.....days.

 Where was disease contracted if not at place of death?.....
 Former or usual residence.....

 19. PLACE OF BURIAL OR REMOVAL Lehi, Utah DATE OF BURIAL 1913

 20. UNDERTAKER C. E. Remonding ADDRESS Idaho Falls

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Form V. S. No. 5 20M.1-16-12

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics
File No. **4129**
Registered No. **15**

1. PLACE OF DEATH. Registration District No. **7**
County of **Bonerville** Primary Registration District No. **2027**
City of **Idaho Falls** (No. **1** St.)
If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME **Alice Mabel Deugler**

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX **Female** 4. COLOR OR RACE **White** 5. SINGLE, MARRIED, WIDOWED OR DIVORCED. **Child**
(Write the word.)

6. DATE OF BIRTH **Nov. 8 1906**
(Month) (Day) (Year)

7. AGE **6 yrs. 3 mos. 25 ds.**
IF LESS than 1 day how many hrs. or mins.?

8. OCCUPATION **Child**
(a) Trade, profession or particular kind of work
(b) General nature of industry, business, or establishment in which employed (or employer)

9. BIRTHPLACE **Montana**
(State or Country)

10. NAME OF FATHER **Wm L. Deugler**

11. BIRTHPLACE OF FATHER **Idaho**
(State or Country)

12. MAIDEN NAME OF MOTHER **Olive Ritchie**

13. BIRTHPLACE OF MOTHER **Ill.**
(State or Country)

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) **Wm L. Deugler**
(Address) **Monida Montana**

15. Filed **Nov 6 1913** **J. E. Bennett**
Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH **March 5 1913**
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from **March 4 1913**, to **March 4 1913**, that I last saw her alive on **March 4 1913**, and that death occurred on the date stated above, at **19 M.**
The CAUSE OF DEATH* was as follows:

Malnutrition

(Duration) **2** yrs. **2** mos. **25** ds.

Contributory (Secondary)

(Duration) **2** mos. **25** ds.
(Signed) **Wm L. Deugler** M. D.
1913 (Address) **Idaho Falls, Ida.**

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death **2** yrs. **2** mos. **25** days. In the State **2** yrs. **2** mos. **25** days.

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL **Idaho Falls, Ida** DATE OF BURIAL **3/6 1913**

20. UNDERTAKER **B. B. Dimwoody** ADDRESS **Idaho Falls**

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Form V. S. No. 5 20M.1-16-12

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH.

Registration District No. 7

County of Donnerville

Primary Registration District No. 2027

City of Idaho Falls

(No. , St.)

File No. 4139

Registered No. 13

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

I. Mochizuki

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX

male Japan

4. COLOR OR RACE

5. SINGLE, MARRIED, WIDOWED OR DIVORCED.
married
(Write the word.)

6. DATE OF BIRTH

year 1888
(Month) (Day) (Year)

7. AGE

30 yrs. mos. ds.

IF LESS than 1 day
how many hrs. or
 mins.?

8. OCCUPATION

(a) Trade, profession or particular kind of work
(b) General nature of industry, business, or establishment in which employed (or employer)

Farmer

9. BIRTHPLACE

(State or Country)

Japan

10. NAME OF FATHER

11. BIRTHPLACE OF FATHER

(State or Country)

Don't know

12. MAIDEN NAME OF MOTHER

13. BIRTHPLACE OF MOTHER

(State or Country)

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

(Address)

Joe Marley (Coroner)
Idaho Falls

15.

Filed

Feb. 20

1913

H. E. Bennett
Exp Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH

Feb. 19 1913
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from

191, to 191,
that I last saw h. alive on 191,

and that death occurred on the date stated above, at M.

The CAUSE OF DEATH* was as follows:

Gunshot wound inflicted by
a fellow Jap.

(Duration) yrs. mos. ds.

Contributory
(Secondary)

(Duration) yrs. mos. ds.

(Signed)

Feb. 20 1913 (Address) Idaho Falls

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death yrs. mos. days. In the State yrs. mos. days.

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL DATE OF BURIAL

Idaho Falls Feb 20 1913

20. UNDERTAKER ADDRESS

J. H. Hunt Idaho Falls

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH. Registration District No. 7
County of Bonerville Primary Registration District No. 2030
City of Drvin (No. _____ St.)

File No. 4131
Registered No. 18

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Frank nelson

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX male 4. COLOR OR RACE White 5. SINGLE, MARRIED, WID-
OWED OR DIVORCED. Single
(Write the word.)

6. DATE OF BIRTH
(Month) 12 (Day) 8 (Year) 1885

7. AGE 28 yrs. _____ mos. _____ ds.
IF LESS than 1 day
how many _____ hrs. or
_____ mins.?

8. OCCUPATION Farm hand
(a) Trade, profession or particular kind of work
(b) General nature of industry, business, or establishment in which employed (or employer)

9. BIRTHPLACE United States
(State or Country)

10. NAME OF FATHER H^m R. Nelson

11. BIRTHPLACE OF FATHER U.S.
(State or Country)

12. MAIDEN NAME OF MOTHER ?

13. BIRTHPLACE OF MOTHER U.S.
(State or Country)

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Paul Gitlan
(Address) Drvin Ida

15. Filed Feb. 13 19113 J. E. Bennett
Dep Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH Feb 8 19113
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from _____ 191____, to _____ 191____,
that I last saw h. _____ alive on _____ 191____,
and that death occurred on the date stated above, at _____ M.
The CAUSE OF DEATH* was as follows:

Found dead -
Coroner's Inquest verdict -
"Frash Exhaustion".
(Duration) _____ yrs. _____ mos. _____ ds.
Contributory _____
(Secondary) _____
(Duration) _____ yrs. _____ mos. _____ ds.
(Signed) W. J. ... M. D.
19 _____ (Address) Drvin

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death _____ yrs. _____ mos. _____ days. In the State _____ yrs. _____ mos. _____ days.
Where was disease contracted if not at place of death? _____

Former or usual residence _____

19. PLACE OF BURIAL OR REMOVAL Drvin DATE OF BURIAL 2/15 19113

20. UNDERTAKER G. E. Dinwoody ADDRESS Ida Falls

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Form V. S. No. 5 20M.1-16-12

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH.

County of *Bonnerville*
City of *Idaho Falls*

Registration District No. *7*

Primary Registration District No. *2027*

(No. _____ St.)

File No. *4133*

Registered No. *10*

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME *Mary Metzger*

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX

Female

4. COLOR OR RACE

White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED.

Married
(Write the word.)

6. DATE OF BIRTH

Sept. 10 1913
(Month) (Day) (Year)

7. AGE

68 yrs. *26* mos. *26* ds.

IF LESS than 1 day
how many _____ hrs. or
_____ mins.?

8. OCCUPATION

(a) Trade, profession or particular kind of work
(b) General nature of industry, business, or establishment in which employed (or employer)

Farmer's Wife

9. BIRTHPLACE

(State or Country)

Switzerland

10. NAME OF FATHER

Hubert Quen

11. BIRTHPLACE OF FATHER

(State or Country)

Switzerland

12. MAIDEN NAME OF MOTHER

Elizabeth Rothman

13. BIRTHPLACE OF MOTHER

(State or Country)

Switzerland

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) *Jacob Metzger Sr.*
(Address) *Lathrop Idaho*

15.

Filed *Feb 7* 1913 *W. H. Hunt*
Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH

Feb. 6 1913
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from

Jan 20 1913, to *Feb 6 1913*
that I last saw her alive on *Feb 5 1913*

and that death occurred on the date stated above, at *2 P. M.*

The CAUSE OF DEATH* was as follows:

Acute Nephritis

(Duration) _____ yrs. _____ mos. _____ ds.

Contributory
(Secondary)

(Duration) _____ yrs. _____ mos. _____ ds.

(Signed)

Ed. S. Fuller M. D.
Feb 7 1913 (Address) *Idaho Falls Ida*

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death _____ yrs. _____ mos. _____ days. In the State _____ yrs. _____ mos. _____ days.

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

Coltman Idaho *Feb. 9 1913*
20. UNDERTAKER *G. H. Hunt* ADDRESS *Idaho Falls*

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Form V. S. No. 5 20M.1-16-12

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH.

County of Bonner
City of Idaho Falls

Registration District No. 7

Primary Registration District No. 2027

(No. _____ St.)

If death occurs away from usual residence, give facts known for under special information.

2. FULL NAME Milton Roder

File No. 4134

Registered No. 9

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX Male 4. COLOR OR RACE White 5. SINGLE, MARRIED, WIDOWED OR DIVORCED. Widower
(Write the word.)

6. DATE OF BIRTH Feb. 14 1913
(Month) (Day) (Year)

7. AGE 80 yrs. 11 mos. 19 ds. IF LESS than 1 day how many _____ hrs. or _____ mins.?

8. OCCUPATION (a) Trade, profession or particular kind of work Retired
(b) General nature of industry, business, or establishment in which employed (or employer)

9. BIRTHPLACE Ohio
(State or Country)

10. NAME OF FATHER Milton Roder

11. BIRTHPLACE OF FATHER Ohio
(State or Country)

12. MAIDEN NAME OF MOTHER Unknown

13. BIRTHPLACE OF MOTHER ✓
(State or Country)

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE (Informant) H. M. Ayers
(Address) Idaho Falls

15. Filed Feb 5 1913 H. M. Ayers Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH Feb. 4 1913
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from Jan 25 1913, to Feb 3 1913 that I last saw him alive on Feb 3 1913 and that death occurred on the date stated above, at 12 M. The CAUSE OF DEATH* was as follows:

Cerebral Hemorrhage

(Duration) _____ yrs. _____ mos. 6 ds.
Contributory Arterio sclerosis
(Secondary)

(Duration) _____ yrs. _____ mos. _____ ds.
(Signed) H. M. Ayers M. D.
2/5 1913 (Address) Idaho Falls

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death.....yrs.....mos.....days. In the State.....yrs.....mos.....days.
Where was disease contracted if not at place of death?.....
Former or usual residence.....

19. PLACE OF BURIAL OR REMOVAL Idaho Falls DATE OF BURIAL Feb 5 1913
20. UNDERTAKER G. H. Hunt ADDRESS Idaho Falls

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Form V. S. No. 5 20M.1-16-12

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH.

Registration District No.

County of *Bonneville*
City of *Idaho Falls*

Primary Registration District No.

(No. St.)

File No.

Registered No.

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

Infant Lorah

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX *Female* 4. COLOR OR RACE *White* 5. SINGLE, MARRIED, WIDOWED OR DIVORCED.

(Write the word.)

6. DATE OF BIRTH

(Month) (Day) (Year)

7. AGE

Still Born

IF LESS than 1 day
how many hrs. or
..... mins.

8. OCCUPATION

(a) Trade, profession or particular kind of work
(b) General nature of industry business, or establishment in which employed (or employer)

none

9. BIRTHPLACE

(State or Country)

Idaho

10. NAME OF FATHER

Jessie Lorah

11. BIRTHPLACE OF FATHER

(State or Country)

Idaho

12. MAIDEN NAME OF MOTHER

Nellie Elze

13. BIRTHPLACE OF MOTHER

(State or Country)

Idaho

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

J. L. Loran

(Address)

Idaho Falls

15.

Filed

Feb 4

1913

M. M. Munn

Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH

Feb

4

1913

(Month)

(Day)

(Year)

17. I HEREBY CERTIFY, That I attended deceased from

Feb 4

1913, to

Feb 4

1913,

that I last saw him ~~live on~~ *Feb 4* 1913

and that death occurred on the date stated above, at *P. M.*

The CAUSE OF DEATH* was as follows:

Still Born

(Duration) yrs. mos. ds.

Contributory
(Secondary)

(Duration) yrs. mos. ds.

(Signed)

W. C. Hollister

M. D.

Feb 4 1913 (Address) *Idaho Falls, Ida.*

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death yrs. mos. days. In the State yrs. mos. days.

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

Idaho Falls

Feb 4

1913

20. UNDERTAKER

ADDRESS

G. H. Hunt

Idaho Falls

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Form V. S. No. 5 20M.1-16-12

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics
File No. **4136**

1. PLACE OF DEATH. Registration District No. **7**
County of **Bannock** Primary Registration District No. **2127**
City of **Idaho Falls** (No. _____ St.)

Registered No. **7**
If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME **(Baby) Fred & Indgrid Carlson**

PERSONAL AND STATISTICAL PARTICULARS

3. SEX **male** 4. COLOR OR RACE **White** 5. SINGLE, MARRIED, WIDOWED OR DIVORCED. **Child**
(Write the words.)

6. DATE OF BIRTH **Nov 23 1912**
(Month) (Day) (Year)

7. AGE **2 yrs. 8 mos.** IF LESS than 1 day how many hrs. or mins.?

8. OCCUPATION
(a) Trade, profession or particular kind of work
(b) General nature of industry business, or establishment in which employed (or employer)

9. BIRTHPLACE **Idaho Falls**
(State or Country)

10. NAME OF FATHER **Fred Carlson**

11. BIRTHPLACE OF FATHER **Sweden**
(State or Country)

12. MAIDEN NAME OF MOTHER **Indgrid Peterson**

13. BIRTHPLACE OF MOTHER **Sweden**
(State or Country)

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) **Fred Carlson**
(Address) **Medicine Lodge, Mont.**

15. Filed **Feb 1 1913** Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH **Feb 1 1913**
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from **Jan 23 1913**, to **Feb 1 1913**
that I last saw him alive on **Jan 31 1913**
and that death occurred on the date stated above, at **7 A.M.**
The CAUSE OF DEATH* was as follows: **Pneumonia**

(Duration) yrs. mos. **1** ds.

Contributory (Secondary)

(Duration) yrs. mos. ds.

(Signed) **E. B. Miller M.D.**
19 **1913** (Address) **Idaho Falls, Idaho**

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death yrs. mos. days. In the State yrs. mos. days.

Where was disease contracted if not at place of death?

Former or usual residence.

19. PLACE OF BURIAL OR REMOVAL **Dillon, Mont.** DATE OF BURIAL **Feb 1 1913**

20. UNDERTAKER **E. B. Dinwoody** ADDRESS **Idaho Falls**

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
N. B.—Every item of information should be carefully supplied. AGE should be state EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Form V. S. No. 5. 10M. 6-20-11.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics
File No. 4138
Registered No. 22

1. PLACE OF DEATH Cassia Registration District No. 31
County of Idaho Primary Registration District No. 212
City of Jackson (No. _____, _____ St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Geo H Shubert

If death occurred in a hospital, institution or camp give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX male 4. COLOR OR RACE White 5. SINGLE, MARRIED, WIDOWED OR DIVORCED. Single
(Write the word.)

6. DATE OF BIRTH

Jan 6 1897
(Month) (Day) (Year)

7. AGE

16 yrs. 1 mos. 10 ds. IF LESS than 1 day how many _____ hrs. or _____ min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work

Farmer

(b) General nature of industry business or establishment in which employed (or employer)

9. BIRTHPLACE

(State or Country)

Arkansas

10. NAME OF FATHER

O L Shubert

11. BIRTHPLACE OF FATHER

(State or Country)

Ill.

12. MAIDEN NAME OF MOTHER

Lena Boss

13. BIRTHPLACE OF MOTHER

(State or Country)

Missouri

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

O L Shubert

(Address)

Jackson Ida

15.

Filed

May 10

A B Storch

Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

Febr 16 1913
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from

Aug 1912, to Febr 15 1913

that I last saw him alive on Febr 15 1913,

and that death occurred on the date stated above, at 3 A.M.

The CAUSE OF DEATH* was as follows:

nephritis

(Duration) _____ yrs. 8 mos. _____ ds.

Contributory (Secondary)

(Duration) _____ yrs. _____ mos. _____ ds.

(Signed) J B Kanagy M. D.

Febr 16 1913 (Address) P. O. Shubert

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death _____ yrs. _____ mos. _____ ds. State _____ yrs. _____ mos. _____ ds.

Where was disease contracted,

If not at place of death? _____

Former or

usual residence _____

19. PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

Jackson Ida

Feb 17 1913

20. UNDERTAKER

ADDRESS

H A Goodman

Rupert

Please get signature of undertaker

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Form V. S. No. 5. 12½ M. 7-24-11

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics
File No. 1139
Registered No. 7

1. PLACE OF DEATH. Registration District No. 29
County of Lincoln Primary Registration District No. 2015
City of Heyburn (No. _____, _____ St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

Baby Borders

If death occurred in a hospital, institution or camp give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX Female 4. COLOR OR RACE white 5. SINGLE, MARRIED, WIDOWED OR DIVORCED. Single
(Write the word.)

6. DATE OF BIRTH Feb. 12 1913
(Month) (Day) (Year)

7. AGE _____ yrs. _____ mos. _____ ds. IF LESS than 1 day how many 3 hrs. or _____ min?

8. OCCUPATION

(a) Trade, profession or particular kind of work. none
(b) General nature of industry business or establishment in which employed (or employer)

9. BIRTHPLACE

(State or Country)

Heyburn, Lincoln Co.

10. NAME OF FATHER

J. F. Borders.

11. BIRTHPLACE OF FATHER

(State or Country)

Washington Co. Arkansas

12. MAIDEN NAME OF MOTHER

Gertrude E. Swagerty

13. BIRTHPLACE OF MOTHER

(State or Country)

Wash. Co. Arkansas

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

(Address)

J. F. BordersHeyburn Ida.

15.

Filed

Mar 10 1913J. P. Killeen
Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH

Feb. 12 1913
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from Feb 12 1913, to Feb 12 1913

that I last saw him alive on Feb 12 1913 and that death occurred on the date stated above, at 3 a.m.

The CAUSE OF DEATH* was as follows:

Premature Birth

(Duration) _____ yrs. _____ mos. _____ ds.

Contributory
(Secondary)

(Duration) _____ yrs. _____ mos. _____ ds.

(Signed) J. C. Patterson M. D.

Feb 12 1913 (Address) Burley Idaho

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place _____ In the _____
of death _____ yrs. _____ mos. _____ ds. State _____ yrs. _____ mos. _____ ds.

Where was disease contracted,

If not at place of death?

Former or

usual residence.

19. PLACE OF BURIAL OR REMOVAL DATE OF BURIAL

Heyburn Ida. Feb 12 1913

20. UNDERTAKER

ADDRESS

L. B. Gallagher Burley Ida.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Form V. S. No. 5 20M.1-16-12

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH.

Registration District No. 29County of MinnehahaPrimary Registration District No. 2015City of Rupert

(No. _____, St.)

Registered No. 6

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

Margaret M. Wilson

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX

F

4. COLOR OR RACE

White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED.

Married

6. DATE OF BIRTH

May 15 1913
(Month) (Day) (Year)

7. AGE

22 yrs. 8 mos. 23 ds.IF LESS than 1 day
how many _____ hrs. or
_____ mins.?

8. OCCUPATION

(a) Trade, profession or particular kind of work

House Wife

(b) General nature of industry, business, or establishment in which employed (or employer)

9. BIRTHPLACE

(State or Country)

Samaria Idaho

10. NAME OF FATHER

Joseph Morse

11. BIRTHPLACE OF FATHER

(State or Country)

South Wales

12. MAIDEN NAME OF MOTHER

Ester Jenkins

13. BIRTHPLACE OF MOTHER

(State or Country)

S Wales

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

Joseph Morse

(Address)

Samaria Idaho

15.

Filed

Mar. 10 1913V. P. Kilbuck

Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH

Feb 8 1913
(Month) (Day) (Year)17. I HEREBY CERTIFY, That I attended deceased from Feb 7 1913 to Feb 8 1913 that I last saw her alive on Feb 7 1913and that death occurred on the date stated above, at 1 A. M.

The CAUSE OF DEATH* was as follows:

apoplexy(Duration) _____ yrs. _____ mos. 1/2 ds.Contributory
(Secondary)

(Duration) _____ yrs. _____ mos. _____ ds.

(Signed)

Feb 8 1913 (Address) Rupert Id.

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death _____ yrs. _____ mos. _____ days. In the State _____ yrs. _____ mos. _____ days.

Where was disease contracted if not at place of death? _____

Former or usual residence _____

19. PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

Samaria IdahoFeb 10 1913

20. UNDERTAKER

ADDRESS

W. G. GoodmanRupert

A stillbirth must be registered both as a birth and death. The date of death should be the date of delivery and the death certificate should further state, if known, the cause of the stillbirth and the period of utero gestation in months.

STATEMENT OF OCCUPATION.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer, Physician, Stenographer, Composer, Architect, Locomotive engineer, Civil engineer, Stationary fireman, etc.* But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner*, (b) *Cotton mill*; (a) *Salesman*, (b) *Grocery*; (a) *Foreman*, (b) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification, as *Day laborer, Farm laborer, Laborer—Coal mine, etc.* Women at home, who are engaged in the duties of the household only (not paid *Housekeepers*, who receive a definite salary), may be entered as *Housewife, Housework, or At home*, and children, not gainfully employed, as *At school* or *At home*. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer (retired, 6 yrs.)* For persons who have no occupation whatever, write *None*.

STATEMENT OF CAUSE OF DEATH.—Name, first the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebro-*

spinal fever (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid Pneumonia") *Lobar pneumonia*; *Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritoneum, etc., Carcinoma, Sarcoma, etc., of* (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis, etc.* The contributory (secondary or intercurrent affection need not be stated unless important. Example: *Measles* (disease causing death), 29 ds.; *Bronchopneumonia* (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "Asthenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility," ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Haemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uraemia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify as "PUERPERAL, septicemia", "PUERPERAL peritonitis," etc., all diseases resulting from childbirth or miscarriage. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning; Struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid—probably suicide.* The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "Contributory."

2
#6

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Form V. S. No. 5. 12½ M. 7-24-11

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics
File No. 1111
Registered No. 19

1. PLACE OF DEATH. Registration District No. 16
County of Pay Puce Primary Registration District No. 1009
City of Lewiston (No. _____ St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

Thomas Taylor

If death occurred in a hospital, institution or camp give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX Male 4. COLOR OR RACE White 5. SINGLE, MARRIED, WIDOWED OR DIVORCED.
Widower
(Write the word.)

6. DATE OF BIRTH Oct 11 1845
(Month) (Day) (Year)

7. AGE 68 yrs. 3 mos. 20 ds. IF LESS than 1 day
how many hrs. or min?

8. OCCUPATION
(a) Trade, profession or particular kind of work. Engineer Mechanical
(b) General nature of industry business or establishment in which employed (or employer)

9. BIRTHPLACE
(State or Country) California

10. NAME OF FATHER John Taylor

11. BIRTHPLACE OF FATHER
(State or Country) England

12. MAIDEN NAME OF MOTHER Margaret Ward

13. BIRTHPLACE OF MOTHER
(State or Country) England

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) C. T. Stranahan
(Address) Lewiston Idaho

15. Filed Mar. 10 1913 L. J. Perkins
Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH Feb 1 1913
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from Aug 17 1908, to Feb 1 1913
that I last saw him alive on Jan 31 1913
and that death occurred on the date stated above, at _____ M.

The CAUSE OF DEATH* was as follows:

Paralysis of the digestive organs

(Duration) _____ yrs. _____ mos. _____ ds.
Contributory (Secondary) Partial Paralysis of the whole body

(Duration) _____ yrs. _____ mos. _____ ds.
(Signed) C. T. Stranahan
19 _____ (Address) Supr County Hospital

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place four years In the
of death _____ yrs. _____ mos. _____ ds. State _____ yrs. _____ mos. _____ ds.
Where was disease contracted,
If not at place of death?
Former or usual residence Leland Idaho

19. PLACE OF BURIAL OR REMOVAL Lewiston Idaho DATE OF BURIAL Feb 1 1913

20. UNDERTAKER C. J. Vassar ADDRESS Lewiston

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIAN should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact state of OCCUPATION is very important. See instructions on back of certificate.

Form V. S. No. 5. 12½ M. 7-24-11

1. PLACE OF DEATH.

County of LewisCity of Lewiston

Registration District No. _____

Primary Registration District No. 1089(No. Hospital St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

Thos LiguillBOARD OF HEALTH
Bureau of Vital StatisticsFile No. 1112Registered No. 20

If death occurred in a hospital, institution or camp give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX

M.

4. COLOR OR RACE

W

5. SINGLE, MARRIED, WIDOWED OR DIVORCED.

Widower
(Write the word.)

6. DATE OF BIRTH

Jan 23 1883
(Month) (Day) (Year)

7. AGE

38 yrs. 12 mos. ds.IF LESS than 1 day
how many.....hrs. or
.....min?

8. OCCUPATION

(a) Trade, profession or particular kind of work.....
(b) General nature of industry, business or establishment in which employed (or employer).....farmer

9. BIRTHPLACE

(State or Country)

not known

10. NAME OF FATHER

11. BIRTHPLACE OF FATHER

(State or Country)

12. MAIDEN NAME OF MOTHER

13. BIRTHPLACE OF MOTHER

(State or Country)

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Signature)

(Address)

Lewis
LewistonMar. 10 1913L. J. Perkins

Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH

Feb 3 1913
(Month) (Day) (Year)17. I HEREBY CERTIFY, That I attended deceased from Feb 27th 1913, to Feb 8th 1913 that I last saw him alive on Feb 2nd 1913 and that death occurred on the date stated above, at.....M.

The CAUSE OF DEATH* was as follows:

Expansion from fracture of
hip & old age(Duration) yrs. about 20 mos. ds.
Contributory Weak condition & development
(Secondary) of large blood vessels on back
(Duration) yrs. about 11 mos. ds.(Signed) L. J. Perkins M. D.
Feb 5th 1913 (Address) Lewiston Ida

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place In the
of death.....yrs.....mos.....ds. State.....yrs.....mos.....ds.
Where was disease contracted,
If not at place of death?
Former or
usual residence.....

19. PLACE OF BURIAL OR REMOVAL DATE OF BURIAL

LewistonFeb 4 1913

20. UNDERTAKER

ADDRESS

C. J. VansurLewiston

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Form V. S. No. 5. 12½ M. 7-24-11

CERTIFICATE OF DEATH

1. PLACE OF DEATH.

County of Perce

City of Leboston

Registration District No. 16

Primary Registration District No. 1009

(No. _____, St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

Fred Chipman Smith

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics
File No. 1143
Registered No. 21

If death occurred in a hospital, institution or camp give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX

Male

4. COLOR OR RACE

White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED.

Married
(Write the word.)

6. DATE OF BIRTH

Jan 5 1874
(Month) (Day) (Year)

7. AGE

39 yrs. 1 mos. 2 ds.

IF LESS than 1 day
how many _____ hrs. or
_____ min?

8. OCCUPATION

(a) Trade, profession or particular kind of work.
(b) General nature of industry business or establishment in which employed (or employer)

Gardner

9. BIRTHPLACE

(State or Country)

Wisconsin

10. NAME OF FATHER

Chipman Smith

11. BIRTHPLACE OF FATHER

(State or Country)

Canada

12. MAIDEN NAME OF MOTHER

Ellen Harkine Smith

13. BIRTHPLACE OF MOTHER

(State or Country)

Illinois

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

Mrs Fred C Smith

(Address)

Clarkston Wash

15.

Filed Mar. 10 1913

L. J. Perkins

Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH

Feb 7 1913
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from

Jan 31 1913, to Feb 7 1913

that I last saw him alive on Feb 6 1913

and that death occurred on the date stated above, at 5 A. M.

The CAUSE OF DEATH* was as follows:

Intussusception of the ileum

..... (Duration) yrs. mos. 7 ds.

Contributory Operation & resection of bowel
(Secondary)

..... (Duration) yrs. mos. 2 ds.

(Signed) Paul W. Johnson M. D.

Feb 7 1913 (Address) Clarkston Wash

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place In the
of death yrs. mos. 4 ds. State yrs. mos. 4 ds.

Where was disease contracted, Clarkston Washington
If not at place of death?

Former or usual residence Clarkston Washington

19. PLACE OF BURIAL OR REMOVAL DATE OF BURIAL

Clarkston Wash Feb 9 1913

20. UNDERTAKER ADDRESS

H R Merchant Asotin Wash

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Form V. S. No. 5. 12½ M. 7-24-11

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics
File No. 1114
Registered No. 22

1. PLACE OF DEATH. Registration District No. 16
County of Nez Perce Primary Registration District No. 1069
City of Lewiston (No. 236, 24th St St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Kenneth Lerman

If death occurred in a hospital, institution or camp give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX Male 4. COLOR OR RACE White 5. SINGLE, MARRIED, WIDOWED OR DIVORCED. Single
(Write the word.)

6. DATE OF BIRTH
(Month) (Day) (Year)

7. AGE 5 yrs. - mos. - ds. IF LESS than 1 day how many hrs. or min?

8. OCCUPATION
(a) Trade, profession or particular kind of work. X
(b) General nature of industry business or establishment in which employed (or employer)

9. BIRTHPLACE
(State or Country) Lewiston Idaho

10. NAME OF FATHER Philip Lerman (Deceased.)

11. BIRTHPLACE OF FATHER
(State or Country) not known.

12. MAIDEN NAME OF MOTHER Myrtle Home

13. BIRTHPLACE OF MOTHER
(State or Country) not known.

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) L. J. Perkins
(Address) Lewiston

15. Filed Mar. 10 1913 L. J. Perkins
Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH
Feb 1913
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from Feb. 9 1913, to Feb. 10 1913 that I last saw him alive on Feb. 10 1913 and that death occurred on the date stated above, at 12 M.

The CAUSE OF DEATH* was as follows:
Laryngeal Diphtheria.

(Duration) yrs. mos. 4 ds.
Contributory renal failure or paralysis
(Secondary)

(Duration) yrs. mos. 1 ds.
(Signed) L. J. Perkins M. D.
Feb. 10 1913 (Address) Lewiston Idaho

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place In the
of death yrs. mos. ds. State yrs. mos. ds.
Where was disease contracted,
If not at place of death?
Former or
usual residence.

19. PLACE OF BURIAL OR REMOVAL DATE OF BURIAL
Lewiston Feb. 10 1913

20. UNDERTAKER ADDRESS
O. J. Vassar Lewiston

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Form V. S. No. 5. 12½ M. 7-24-11

CERTIFICATE OF DEATH

1. PLACE OF DEATH. Registration District No. 16
County of Logan Primary Registration District No. 1009
City of Lewiston (No. _____, St.)

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics
File No. 4145
Registered No. 23

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Mr. E. S. Wooster

If death occurred in a hospital, institution or camp give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX M 4. COLOR OR RACE W 5. SINGLE, MARRIED, WIDOWED OR DIVORCED. married
(Write the word.)

6. DATE OF BIRTH Oct 18 1 99
(Month) (Day) (Year)

7. AGE 34 yrs. 3 mos. 23 ds. IF LESS than 1 day how many _____ hrs. or _____ min?

8. OCCUPATION
(a) Trade, profession or particular kind of work. Housewife
(b) General nature of industry business or establishment in which employed (or employer)

9. BIRTHPLACE
(State or Country)

10. NAME OF FATHER Henry H. Farnham

11. BIRTHPLACE OF FATHER N.Y.
(State or Country)

12. MAIDEN NAME OF MOTHER Ellen C. Clark

13. BIRTHPLACE OF MOTHER N.Y.
(State or Country)

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Earl S. Wooster
(Address)

15. Filed Mar. 10 1913 S. J. Weathers
Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH Feb 11 1913
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from Feb 4 1913, to Feb 11 1913, that I last saw her alive on Feb 10 1913, and that death occurred on the date stated above, at 12:45 M.

The CAUSE OF DEATH* was as follows:

Diabetes mellitus
I understand. About
(Duration) five yrs. _____ mos. _____ ds.

Contributory (Secondary) _____ (Duration) _____ yrs. _____ mos. _____ ds.

(Signed) J. B. Morris M. D.
Feb 12 1913 (Address) Lewiston

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place _____ In the _____
of death _____ yrs. _____ mos. _____ ds. State _____ yrs. _____ mos. _____ ds.
Where was disease contracted, _____
If not at place of death? _____
Former or _____
usual residence _____

19. PLACE OF BURIAL OR REMOVAL Carmelus R. F. DATE OF BURIAL Feb 1913

20. UNDERTAKER C. J. Vassar ADDRESS Lewiston

WRITE PLAINLY, WITH UNFADING INK--THIS IS A PERMANENT RECORD.
N. B.--Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Form V. S. No. 5. 12½ M. 7-24-11

CERTIFICATE OF DEATH

State of Idaho

BOARD OF HEALTH
Bureau of Vital Statistics

File No. 1146

Registered No. 24

1. PLACE OF DEATH.
County of *Nez Perce*
City of *Lewiston*

Registration District No. *16*
Primary Registration District No. *1009*
(No. *411*, *5th St* St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

Mary Scully

If death occurred in a hospital, institution or camp give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX *Female* 4. COLOR OR RACE *W* 5. SINGLE, MARRIED, WIDOWED OR DIVORCED.
married
(Write the word.)

6. DATE OF BIRTH *Feb 14* 1913
(Month) (Day) (Year)

7. AGE *69* yrs. *10* mos. *13* ds. IF LESS than 1 day
how many.....hrs. or
.....min?

8. OCCUPATION
(a) Trade, profession or particular kind of work *Housewife*
(b) General nature of industry business or establishment in which employed (or employer)

9. BIRTHPLACE
(State or Country) *Canada*

10. NAME OF FATHER *Dunnigan*

11. BIRTHPLACE OF FATHER
(State or Country) *Ireland*

12. MAIDEN NAME OF MOTHER *Mary Butler*

13. BIRTHPLACE OF MOTHER
(State or Country) *Ireland*

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) *Alice Scully*
(Address)

15. Filed *Mar 10* 1913 *S. J. Perkins*
Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH *Feb 14* 1913
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from *Feb 1* 1913, to *Feb 13* 1913, that I last saw her alive on *Feb 13* 1913, and that death occurred on the date stated above, at *2406*.

The CAUSE OF DEATH was as follows:

Myocardial disease of heart

(Duration) *3* yrs. mos. ds.

Contributory (Secondary) *asthma*

(Duration) *6* yrs. mos. ds.

(Signed) *E. W. Shaff* M. D.
Feb 15 1913 (Address) *E. W. Shaff*

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place In the
of death..... yrs. mos. ds. State..... yrs. mos. ds.
Where was disease contracted,
If not at place of death?
Former or
usual residence.

19. PLACE OF BURIAL OR REMOVAL DATE OF BURIAL

Lewiston *Feb 17* 1913

20. UNDERTAKER ADDRESS

C. J. Vassar *Lewiston*

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Form V. S. No. 5. 12½M. 7-24-11

CERTIFICATE OF DEATH

1913
73
40

State of Idaho

BOARD OF HEALTH
Bureau of Vital Statistics

4147

1. PLACE OF DEATH.
County of *Myer*
City of *Caldesac*

Registration District No. *16*
Primary Registration District No. *2073*
(No. _____, _____ St.)

File No. _____
Registered No. *25*

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

Rebecca Stratton

If death occurred in a hospital, institution or camp give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX *Female* 4. COLOR OR RACE *White* 5. SINGLE, MARRIED, WIDOWED OR DIVORCED. *married*
(Write the word.)

6. DATE OF BIRTH *June 15th 1913*
(Month) (Day) (Year)

7. AGE *73* yrs. *8* mos. *4* ds. IF LESS than 1 day how many hrs. or min?

8. OCCUPATION

(a) Trade, profession or particular kind of work
(b) General nature of industry business or establishment in which employed (or employer)

Retired

9. BIRTHPLACE
(State or Country)

Ireland

10. NAME OF FATHER

John. Parkhill

11. BIRTHPLACE OF FATHER
(State or Country)

Ireland

12. MAIDEN NAME OF MOTHER

Sarah Melham

13. BIRTHPLACE OF MOTHER
(State or Country)

Ireland

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

A. E. Finch

(Address)

Caldesac Ida.

15.

Filed

*Feb 20 1913**L. G. Pagsdale*

Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH *Feb 19 1913*
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from *Feb 19 1913*, to *1913*

that I last saw her alive on *Feb 19 1913* and that death occurred on the date stated above, at *9:45 P.M.*

The CAUSE OF DEATH* was as follows:

Edema of lungs as complication of diabetes

(Duration) yrs. *few hours* mos. ds.

Contributory (Secondary)

Diabetes

(Duration) *28* yrs. mos. ds.

(Signed)

L. G. Pagsdale

M. D.

7:30 1913 (Address) *Caldesac Ida.*

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted,

If not at place of death?

Former or

usual residence.

19. PLACE OF BURIAL OR REMOVAL DATE OF BURIAL

*Menlo, Washington**1913*

20. UNDERTAKER

ADDRESS

*W. E. Stoddard**Gifford Ida.*

A stillbirth must be registered both as a birth and death. The date of death should be the date of delivery and the death certificate should further state, if known, the cause of the stillbirth and the period of utero gestation in months.

STATEMENT OF OCCUPATION.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer, Physician, Stenographer, Compositor, Architect, Locomotive engineer, Civil engineer, Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner*, (b) *Cotton mill*; (a) *Salesman*, (b) *Grocery*; (a) *Foreman*, (b) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification, as *Day laborer, Farm laborer, Laborer—Coal mine*, etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers*, who receive a definite salary), may be entered as *Housewife, Housework*, or *At home*, and children, not gainfully employed, as *At school* or *At home*. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer (retired, 6 yrs.)*. For persons who have no occupation whatever, write *None*.

STATEMENT OF CAUSE OF DEATH.—Name, first the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebro-*

spinal fever (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid Pneumonia") *Lobar pneumonia; Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritoneum*, etc., *Carcinoma, Sarcoma*, etc., of (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent affection need not be stated unless important. Example: *Measles* (disease causing death), *29 ds.*; *Bronchopneumonia* (secondary), *10 ds.* Never report mere symptoms or terminal conditions, such as "Asthenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility, (Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Haemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uraemia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify as "PUERPERAL, *septicemia*", "PUERPERAL *peritonitis*," etc., all diseases resulting from childbirth or miscarriage. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning; Struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "Contributory."

2

6

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
N. B.—Every item of information should be carefully supplied. AGE must be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Form V. S.

ATH

1. PLACE OF DEATH. Registration District No. 16
County of Lewiston Primary Registration District No. 1009
City of Lewiston (No. 1936, 7 Ave. St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Frank E. Parkyn

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics
File No. 1149
Registered No. 27

If death occurred in a hospital, institution or camp give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX M 4. COLOR OR RACE W 5. SINGLE, MARRIED, WIDOWED OR DIVORCED. Married
(Write the word.)

6. DATE OF BIRTH Feb 7 1900
(Month) (Day) (Year)

7. AGE 52 yrs. 11 mos. 6 ds. IF LESS than 1 day
how many hrs. or min?

8. OCCUPATION
(a) Trade, profession or particular kind of work Lumberman
(b) General nature of industry business or establishment in which employed (or employer)

9. BIRTHPLACE (State or Country) Irish

10. NAME OF FATHER John Parkyn

11. BIRTHPLACE OF FATHER (State or Country) England

12. MAIDEN NAME OF MOTHER Sophia Pickett

13. BIRTHPLACE OF MOTHER (State or Country) not known

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Mrs Frank Parkyn
(Address) Lewiston Idaho

15.

Filed Mar 10 1913 L. J. G. G. G.
Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH Jan 31 1913
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from Jan 1913, to Jan 31 1913
that I last saw him alive on Jan 31 1913
and that death occurred on the date stated above, at 11 P.M.

The CAUSE OF DEATH* was as follows:

Subphrenic abscess involv
ing lung

(Duration) 3 yrs. 3 mos. — ds.

Contributory Abscess of Lung
(Secondary)

(Duration) 2 1/2 yrs. — mos. — ds.

(Signed) L. J. G. G. G. M. D.
Feb 1st 1913 (Address) L. J. G. G. G.

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place In the
of death — yrs. — mos. — ds. State — yrs. — mos. — ds.
Where was disease contracted,
If not at place of death?
Former or
usual residence

19. PLACE OF BURIAL OR REMOVAL DATE OF BURIAL

Lewiston Feb 2 1913

20. UNDERTAKER ADDRESS

C. J. Vassar Lewiston

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. PHYSICIANS—Every item of information should be carefully supplied. AGE should be stated EXACTLY. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Form V. S. No. 5. 10M. 6-20-11.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH.

Registration District No. 71County of BlainePrimary Registration District No. 7022City of Hailey

(No. _____ St.)

File No. 4151Registered No. 3

If death occurs away from usual residence, give facts called for under special information.

If death occurred in a hospital, institution or camp give its NAME instead of street and number.

2. FULL NAME

Roberto Burns

PERSONAL AND STATISTICAL PARTICULARS

3. SEX

Male

4. COLOR OR RACE 5. SINGLE, MARRIED, WIDOWED OR DIVORCED.

W

(Write the word.)

6. DATE OF BIRTH

(Month) (Day) (Year)

7. AGE

____ yrs. ____ mos. ____ ds.

IF LESS than 1 day
how many ____ hrs. or
____ min.?

8. OCCUPATION

- (a) Trade, profession or particular kind of work
(b) General nature of industry business or establishment in which employed (or employer)

Laborer

9. BIRTHPLACE

(State or Country)

10. NAME OF FATHER

11. BIRTHPLACE OF FATHER

(State or Country)

12. MAIDEN NAME OF MOTHER

13. BIRTHPLACE OF MOTHER

(State or Country)

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

(Address)

15.

Filed

Feb 20 1913

Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

Jan 7 1913
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from

____ 191____, to ____ 191____

that I last saw h____ alive on ____ 191____,

and that death occurred on the date stated above, at ____ M.

The CAUSE OF DEATH* was as follows:

Alcoholism

(Duration) ____ yrs. ____ mos. ____ ds.

Contributory
(Secondary)

(Duration) ____ yrs. ____ mos. ____ ds.

(Signed) ____ M. D.

____ 19____ (Address)

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death ____ yrs. ____ mos. ____ ds. State ____ yrs. ____ mos. ____ ds.

Where was disease contracted,

If not at place of death?

Former or usual residence.

19. PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

Hailey Ida1913

20. UNDERTAKER

ADDRESS

Ralph D. HarrisHailey, Ida

Form V. S. No. 5. 10M. 6-20-11.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH.

Registration District No. 21

County of Blaine

Primary Registration District 2022

City of Hailey

(No. , St.)

File No. 4152

Registered No. 4

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

Erich A White

If death occurred in a hospital, institution or camp give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX

Male

4. COLOR OR RACE

Wht

5. SINGLE, MARRIED, WIDOWED OR DIVORCED.

Married
(Write the word.)

6. DATE OF BIRTH

Sept. 16, 1836
(Month) (Day) (Year)

7. AGE

76 yrs. 3 mos. 22 ds.

IF LESS than 1 how many min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work

Cabinet maker & Builder

(b) General nature of industry business or establishment in which employed (or employer)

9. BIRTHPLACE

(State or Country)

Ohio

10. NAME OF FATHER

11. BIRTHPLACE OF FATHER

(State or Country)

12. MAIDEN NAME OF MOTHER

13. BIRTHPLACE OF MOTHER

(State or Country)

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Mrs. E. A. White

(Address)

Hailey

15.

Filed

Feb 20 1913

Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

Jan. 8, 1913
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from

Dec 29 1912, to Jan 8 1913

that I last saw him alive on Jan 8 1913

and that death occurred on the date stated above, at 9 P.M.

The CAUSE OF DEATH* was as follows:

Pneumonia

(Duration) yrs. mos. 10 ds.

Contributory (Secondary)

(Duration) yrs. mos. ds.

(Signed)

13 Feb 1913 J. H. Rimmer M. D.
(Address) Hailey Ida

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death yrs. mos. ds. State yrs. mos. ds.

Where was disease contracted.

If not at place of death?

Former or usual residence.

19. PLACE OF BURIAL OR REMOVAL

Hailey Ida

DATE OF BURIAL

Jan 10 1913

20. UNDERTAKER

Ralph Harris

ADDRESS

Hailey Ida

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Form V. S. No. 5. 10M. 6-20-11.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics
File No. 41-3
Registered No. 5

1. PLACE OF DEATH.

Registration District No. 21County of BlainePrimary Registration District No. 2024City of Howe

(No. _____, _____ St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

Leonard Drucabee

If death occurred in a hospital, institution or camp give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX

M

4. COLOR OR RACE

W

5. SINGLE, MARRIED, WIDOWED OR DIVORCED.

Single
(Write the word.)

6. DATE OF BIRTH

May
(Month)22
(Day)1911
(Year)

7. AGE

1 yrs. 8 mos. 29 ds.

IF LESS than 1 day
how many _____ hrs. or
min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work
(b) General nature of industry business or establishment in which employed (or employer)

None

9. BIRTHPLACE

(State or Country)

Oklahoma

10. NAME OF FATHER

Ida Clare Drucabee

11. BIRTHPLACE OF FATHER

(State or Country)

Kentucky

12. MAIDEN NAME OF MOTHER

Emma Lindeman

13. BIRTHPLACE OF MOTHER

(State or Country)

Iowa

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

J. C. Drucabee, Jr. Dr.

(Address)

Howe Ida

15.

Filed

Feb 30 19113

Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

Feb
(Month)21
(Day)1913
(Year)

17. I HEREBY CERTIFY, That I attended deceased from

Feb 141913to Feb 201913that I last saw him alive on Feb 20 1913and that death occurred on the date stated above, at 11 P. M.

The CAUSE OF DEATH* was as follows:

Lobar Pneumonia(Duration) _____ yrs. _____ mos. 8 ds.

Contributory (Secondary)

(Duration) _____ yrs. _____ mos. _____ ds.

(Signed) Edmond H. H. H. M. D.Feb 21 19113 (Address) Howe Ida

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place

In the

of death, _____ yrs. _____ mos. _____ ds. State _____ yrs. _____ mos. _____ ds.

Where was disease contracted,

If not at place of death?

Former or

usual residence

19. PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

Howe IdaFeb 22 19113

20. UNDERTAKER

ADDRESS

Miss MayoHowe Ida

Form V. S. No. 5. 10M. 6-20-11.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH.

Registration District No. 21County of BlainePrimary Registration District No. 2024City of Arco

(No. _____, _____ St.)

File No. 4154Registered No. 6

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

Jonas Daniel Samworth

If death occurred in a hospital, institution or camp give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX

M

4. COLOR OR RACE 5. SINGLE, MARRIED, WIDOWED OR DIVORCED.

Wmarried
(Write the word.)

6. DATE OF BIRTH

April141866

(Month)

(Day)

(Year)

7. AGE

46 yrs.9 mos.28 ds.IF LESS than 1 day
how many hrs. or
..... min.?

8. OCCUPATION

- (a) Trade, profession or particular kind of work
-
- (b) General nature of industry business, or establishment in which employed (or employer)

Farmer

9. BIRTHPLACE

(State or Country)

Colorado

10. NAME OF FATHER

Joseph Samworth

11. BIRTHPLACE OF FATHER

(State or Country)

England

12. MAIDEN NAME OF MOTHER

Mary A. Walter

13. BIRTHPLACE OF MOTHER

(State or Country)

Ohio

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

Oliver Lars

(Address)

Arco, Ida

15.

Filed

Feb 30 1913

Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

Feb121913

(Month)

(Day)

(Year)

17. I HEREBY CERTIFY, That I attended deceased from

Jan 151913

to

Feb 121913that I last saw him alive on Feb 4 1913and that death occurred on the date stated above, at 9:40 P.

The CAUSE OF DEATH* was as follows:

General edema caused by chronic mitral insufficiency(Duration) 12 yrs. mos. ds.Contributory
(Secondary)Rheumatism(Duration) 12 yrs. mos. ds.(Signed) D. W. Matheson M. D.Feb 14 1913 (Address) Arco, Ida

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death yrs. mos. ds. State yrs. mos. ds.

Where was disease contracted, _____

If not at place of death? _____

Former or usual residence. _____

19. PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

Arco, IdaFeb 15, 1913

20. UNDERTAKER

ADDRESS

L. K. BakerArco

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Form V. S. No. 5. 10M. 6-20-11.

CERTIFICATE OF DEATH

1. PLACE OF DEATH.

County of BlaineCity of Ketchum

If death occurs away from usual residence, give facts called for under special information.

Registration District No. 21Primary Registration District No. 7022

(No. _____, _____ St.)

2. FULL NAME Mary Katherine Baxter

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics
File No. 4155

Registered No. 7

If death occurred in a hospital, institution or camp give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX

Female

4. COLOR OR RACE

White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED.

Married
(Write the word.)

6. DATE OF BIRTH

June 24 - 1839
(Month) (Day) (Year)

7. AGE

73 yrs. 8 mos. 3 ds.
IF LESS than 1 day
how many _____ hrs. or
_____ min.

8. OCCUPATION

(a) Trade, profession or particular kind of work House wife
(b) General nature of industry business or establishment in which employed (or employer)

9. BIRTHPLACE

(State or Country)

Tennessee

10. NAME OF FATHER

11. BIRTHPLACE OF FATHER

(State or Country)

12. MAIDEN NAME OF MOTHER

13. BIRTHPLACE OF MOTHER

(State or Country)

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

Paul P. Baxter

(Address)

Ketchum Idaho

15.

Filed

Feb 30 1913Robert S. Taylor

Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

Feb 27th 1913
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from

Jan 1st 1913, to Feb 27th 1913
that I last saw him alive on Feb 27th 1913,
and that death occurred on the date stated above, at 1:30 P.M.

The CAUSE OF DEATH* was as follows:

Disposing blood
Acute nephritis

(Duration) _____ yrs. 9 mos. _____ ds.

Contributory (Secondary)

(Duration) _____ yrs. _____ mos. _____ ds.

(Signed) R. S. Taylor M. D.Feb 25 1913 (Address) 7 S. 1st St.

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death _____ yrs. _____ mos. _____ ds. State _____ yrs. _____ mos. _____ ds.

Where was disease contracted,

If not at place of death?

Former or

usual residence

19. PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

Quincy, Mass.1913

20. UNDERTAKER

ADDRESS

Ralph D. Harris

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Form V. S. No. 5. 10M. 6-20-11.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH.

Registration District No. 21County of BlainePrimary Registration District No. 7075File No. 4150City of Cary

(No. _____) St. _____

Registered No. 8

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Ethel May Weyland

If death occurred in a hospital, institution or camp give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX

Female

4. COLOR OR RACE

White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED.

Married
(Write the word.)

6. DATE OF BIRTH

June 1888
(Month) (Day) (Year)6th
(Month) (Day) (Year)1888
(Month) (Day) (Year)

7. AGE

24 yrs. 6 mos. 26 ds.IF LESS than 1 day
how many _____ hrs. or
_____ min.

8. OCCUPATION

(a) Trade, profession or particular kind of work
(b) General nature of industry business or establishment in which employed (or employer)Housewife

9. BIRTHPLACE

(State or Country)

Wyoming

10. NAME OF FATHER

J. W. Pitzer

11. BIRTHPLACE OF FATHER

(State or Country)

not known

12. MAIDEN NAME OF MOTHER

Mellie Lash

13. BIRTHPLACE OF MOTHER

(State or Country)

not known

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

(Address)

Michael B. Weyland
Cary - Blaine Co. Idaho

15.

Filed

Feb 20 1913

Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

Feb - 10th
(Month) (Day) (Year)1913

17. I HEREBY CERTIFY, That I attended deceased from

Jan 28 1913 to Feb 10 1913that I last saw him alive on Feb 10 1913and that death occurred on the date stated above, at 9 A.M.

The CAUSE OF DEATH* was as follows:

Pneumonia(Duration) _____ yrs. _____ mos. 10 ds.

Contributory (Secondary)

(Duration) _____ yrs. _____ mos. _____ ds.

(Signed)

E. W. Fox

M. D.

2/12/13 (Address) Cary, Idaho

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death _____ yrs. _____ mos. _____ ds. In the State _____ yrs. _____ mos. _____ ds.

Where was disease contracted.

If not at place of death?

Former or usual residence.

19. PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

Cary - IdahoFeb 21 1913

20. UNDERTAKER

ADDRESS

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Form V. S. No. 5. 10M. 6-20-11.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics
File No. 4157
Registered No. 9

1. PLACE OF DEATH.

Registration District No. 21County of BlainePrimary Registration District No. 7075City of Carney

(No. _____ St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Mrs Lottie Elizabeth Ostrander

If death occurred in a hospital, institution or camp give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX

Female

4. COLOR OR RACE

White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED.

Married
(Write the word.)

6. DATE OF BIRTH

February 7th

(Month)

(Day)

1890
(Year)

7. AGE

22 yrs. 11 mos. 26 ds.

IF LESS than 1 day
how many.....hrs.or
.....min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work.....

Housewife

(b) General nature of industry business or establishment in which employed (or employer).....

9. BIRTHPLACE

(State or Country)

Canton, Missouri

10. NAME OF FATHER

FATHER

Henry Talbot

11. BIRTHPLACE OF FATHER

(State or Country)

not known

12. MAIDEN NAME OF MOTHER

OF MOTHER

Harkins

13. BIRTHPLACE OF MOTHER

(State or Country)

Illinois

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Linda B. Ostrander(Address) Carney - Idaho

15.

Filed Feb 20 1913

Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

January 3rd

(Month)

(Day)

1913
(Year)

17. I HEREBY CERTIFY, That I attended deceased

Dec 28 1912, Jan 28 1913that I last saw him alive on Jan 28 1913and that death occurred on the date stated above, at — M.

The CAUSE OF DEATH* was as follows:

Chronic valvular Heart disease— (Duration) — yrs. — mos. — ds.

Contributory

(Secondary)

Chronic rheumatism— (Duration) — yrs. — mos. — ds.(Signed) Geo. Fox M. D.2/3 1913 (Address) Carney, Idaho

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death.....yrs.....mos.....ds. State.....yrs.....mos.....ds.

Where was disease contracted,
If not at place of death?.....

Former or usual residence.....

19. PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

Carney - IdahoFeb 3 1913

20. UNDERTAKER

ADDRESS

John AdamsonCarney - Idaho

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Form V. S. No. 5. 10M. 6-20-11.

CERTIFICATE OF DEATH

1. PLACE OF DEATH.

County of Blaine
City of Bellefour

Registration District No. 21Primary Registration District No. 7077

(No. _____, _____ St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

Edward Bellinger

PERSONAL AND STATISTICAL PARTICULARS

3. SEX

Male

4. COLOR OR RACE

white

5. SINGLE, MARRIED, WIDOWED OR DIVORCED.

married
(Write the word.)

6. DATE OF BIRTH

April6th1835

(Month)

(Day)

(Year)

7. AGE

77yrs. 9mos. 29

ds.

IF LESS than 1 day
how many hrs. or
..... min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work

Farmer

(b) General nature of industry business or establishment in which employed (or employer)

9. BIRTHPLACE

(State or Country)

Canada

10. NAME OF FATHER

Honical Bellinger

11. BIRTHPLACE OF FATHER

(State or Country)

Germany

12. MAIDEN NAME OF MOTHER

13. BIRTHPLACE OF MOTHER

(State or Country)

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

Merion Bellinger

(Address)

Bellefour

15.

Filed

Feb 17 1913Robert Bellinger
Local Registrar

MEDICAL CERTIFICATE

DEATH

16. DATE OF DEATH

Feb

(Month)

5th

(Day)

1913

(Year)

17. I HEREBY CERTIFY, T

tended deceased from

Jan 3019135th1913that I last saw h. u alive on5th1913

and that death occurred on the date

above, at 12³⁰ M.

The CAUSE OF DEATH* was as

Pneumonia

(Duration)

mos. 6

ds.

Contributory
(Secondary)

(Duration)

mos. _____

ds.

(Signed)

O. J. AllenM. D.

19

(Address)

Bellefour

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place

In the

of death

yrs. _____

mos. _____

ds. State

yrs. _____

mos. _____

ds.

Where was disease contracted,

If not at place of death?

Former or

usual residence.

19. PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

Ralph D HarrisFeb 7th1913

20. UNDERTAKER

ADDRESS

Bellefour

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Form V. S. No. 5. 10M. 6-20-11.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics
No. 4159

1. PLACE OF DEATH.

Registration District No. 71

County of Blaine

Primary Registration District No. 7072

City of Belleuve

(No. _____, St.)

Registered No. 11

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

Samuel Glenn Bellinguer

If death occurred in a hospital, institution or camp give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX

Male

4. COLOR OR RACE

White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED.

(Write the word.)

6. DATE OF BIRTH

January 30th 1913
(Month) (Day) (Year)

7. AGE

12 yrs. 12 mos. 12 ds.

IF LESS than 1 day
how many _____ hrs. or
_____ min.

8. OCCUPATION

- (a) Trade, profession or particular kind of work
(b) General nature of industry business, or establishment in which employed (or employer)

9. BIRTHPLACE

(State or Country) Belleuve

10. NAME OF FATHER

Marion Bellinguer

11. BIRTHPLACE OF FATHER

(State or Country) Oregon

12. MAIDEN NAME OF MOTHER

Lily Stitt

13. BIRTHPLACE OF MOTHER

(State or Country) Virginia

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

Marion Bellinguer

(Address)

Belleuve

15.

Filed

Feb 13 1913

John H. Wright

Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

Feb 11 1913
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from

Feb 7th 1913 to Feb 9th 1913

that I last saw him alive on Feb 7th 1913

and that death occurred on the date stated above, at _____ M.

The CAUSE OF DEATH* was as follows:

Acute Bronchitis

(Duration) _____ yrs. _____ mos. 4 ds.

Contributory (Secondary)

(Duration) _____ yrs. _____ mos. _____ ds.

(Signed) Robert H. Wright M. D.

2/11 1913 (Address) Hailey Ida

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death _____ yrs. _____ mos. _____ ds. State _____ yrs. _____ mos. _____ ds.

Where was disease contracted,

If not at place of death?

Former or

usual residence

19. PLACE OF BURIAL OR REMOVAL

Belleuve Ida

DATE OF BURIAL

Feb 13 1913

20. UNDERTAKER

Ralph D. Harris

ADDRESS

Hailey Ida

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Form V. S. No. 5. 10M. 6-20-11.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH.
County of Boise
City of _____

Registration District No. 6
Primary Registration District No. 2026
(No. _____ St.)

File No. 4162
Registered No. 30

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

Baby Echnodt

If death occurred in a hospital, institution or camp give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX F 4. COLOR OR RACE white 5. SINGLE, MARRIED, WIDOWED OR DIVORCED. Single
(Write the word.)

6. DATE OF BIRTH July 29 1913
(Month) (Day) (Year)

7. AGE _____ yrs. _____ mos. _____ ds. IF LESS than 1 day how many _____ hrs. or _____ min.

8. OCCUPATION

(a) Trade, profession, or particular kind of work
(b) General nature of industry business, or establishment in which employed (or employer)

Child

9. BIRTHPLACE
(State or Country)

Boise Co.

10. NAME OF FATHER

Jessie Echnodt

11. BIRTHPLACE OF FATHER
(State or Country)

Arkansas Iowa

12. MAIDEN NAME OF MOTHER

Bell Hill

13. BIRTHPLACE OF MOTHER
(State or Country)

Henrietta Texas

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

A. Skippen

(Address)

Sweet

15.

Filed

Mar 12 1913

A. G. Boyd

Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH Feb 1st 1913
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from Jan 25 1913, to Feb 1 1913, that I last saw her alive on Feb 1 1913, and that death occurred on the date stated above, at 7 P M.

The CAUSE OF DEATH* was as follows:

Erysipelas

(Duration) _____ yrs. 6 mos. 3 ds.
Contributory (Secondary)

(Duration) _____ yrs. _____ mos. _____ ds.
(Signed) Alfred Skippen M. D.
Feb 20 1913 (Address) Sweet

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL,

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place _____ In the _____
of death _____ yrs. _____ mos. _____ ds. State _____ yrs. _____ mos. _____ ds.
Where was Disease contracted,
If not at place of death?
Former or
usual residence.

19. PLACE OF BURIAL OR REMOVAL Brownlee Graryard DATE OF BURIAL Feb 2 1913

20. UNDERTAKER Gilbert Talley ADDRESS Sweet

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Form V. S. No. 5 20M.1-16-12

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH.

Registration District No.

County of Bonne

Primary Registration District No.

City of (No., St.)

File No. 4163
Registered No.

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Jack Jameson

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX | 4. COLOR OR RACE | 5. SINGLE, MARRIED, WIDOWED OR DIVORCED.

Male | White | Married
(Write the word.)

6. DATE OF BIRTH

.....
(Month) (Day) (Year) 1/83

7. AGE

76 yrs. mos. ds.

IF LESS than 1 day
how many hrs. or
..... mins.?

8. OCCUPATION

(a) Trade, profession or particular kind of work

(b) General nature of industry business, or establishment in which employed (or employer)

farmer

9. BIRTHPLACE

(State or Country)

Idaho

10. NAME OF FATHER

not given

11. BIRTHPLACE OF FATHER

(State or Country)

12. MAIDEN NAME OF MOTHER

13. BIRTHPLACE OF MOTHER

(State or Country)

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

(Address)

15.

Filed Mar 17 1913

Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH

.....
(Month) (Day) (Year) 1 6 1913

17. I HEREBY CERTIFY, That I attended deceased from

11-20 1912, to 1-6 1913,
that I last saw him alive on Jan 5 1913,
and that death occurred on the date stated above, at 6 P.M.

The CAUSE OF DEATH* was as follows:

Incident to old age

..... (Duration) yrs. mos. ds.

Contributory (Secondary)

worn out

..... (Duration) yrs. mos. ds.

(Signed)

G. E. Hoyle M. D.

19

(Address)

Vanwoyok

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL OR HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death 12 yrs. mos. days. In the State 12 yrs. mos. days.

Where was disease contracted if not at place of death?

Former or usual residence

none

19. PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

Vanwoyok

1-7 1913

20. UNDERTAKER

ADDRESS

none

none

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Form V. S. No. 5 20M.1-16-12

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH.

Registration District No. 1

County of Ada

Primary Registration District No. 2004

File No. 4164

City of

(No. 1 1/4 miles South Fairfield School)

Registered No. 14

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

Stanton Lee Permenter

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX

Male

4. COLOR OR RACE

white
Am.

5. SINGLE, MARRIED, WIDOWED OR DIVORCED.

Single
(Write the word.)

6. DATE OF BIRTH

Jan 18 1913

(Month)

(Day)

(Year)

7. AGE

— yrs. — mos. 21 ds.

IF LESS than 1 day
how many hrs. or mins.?

8. OCCUPATION

(a) Trade, profession or particular kind of work

none Infant.

(b) General nature of industry, business, or establishment in which employed (or employer)

9. BIRTHPLACE

(State or Country)

Boise

10. NAME OF FATHER

H. L. Permenter

11. BIRTHPLACE OF FATHER

(State or Country)

Mo.

12. MAIDEN NAME OF MOTHER

Emma Carr

13. BIRTHPLACE OF MOTHER

(State or Country)

Mo.

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

(Address)

15.

Filed Feb 8 1913

J. M. Taylor
Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH

Feb 7 1913

(Month)

(Day)

(Year)

17. I HEREBY CERTIFY, That I attended deceased from

Birth Jan 8 1913, to Feb 7 1913

that I last saw her alive on Feb 11 1913

and that death occurred on the date stated above, at 3 P.M.

The CAUSE OF DEATH* was as follows:

Suffocation from
Asphyxia

(Duration) yrs. mos. ds.

Contributory (Secondary) Contracted cold

(Duration) yrs. mos. ds.

(Signed) John B. Boyd M. D.

Feb 8 1913 (Address) Boise Ida

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death yrs. mos. days. In the State yrs. mos. days.

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

Morris Hill Cemetery

Feb 9 1913

20. UNDERTAKER

ADDRESS

Fry & Summers

Boise Ida

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Form V. S. No. 5 20M.1-16-12

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics
File No. **4165**

1. PLACE OF DEATH.

Registration District No. 1

County of Ada

Primary Registration District No. 2004

City of Boise

(No. Soldiers Home St.)

Registered No. 17

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Simoneo Desno

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX

Male

4. COLOR OR RACE

white American

5. SINGLE, MARRIED, WIDOWED OR DIVORCED.

Married
(Write the word.)

6. DATE OF BIRTH

not obtainable

(Month) (Day) (Year)

7. AGE

70 yrs. — mos. — ds.

IF LESS than 1 day
how many hrs. or
mins.?

8. OCCUPATION

(a) Trade, profession or particular kind of work

Civil War Vet.

(b) General nature of industry business, or establishment in which employed (or employer)

9. BIRTHPLACE

(State or Country)

not obtainable

10. NAME OF FATHER

11. BIRTHPLACE OF FATHER

(State or Country)

12. MAIDEN NAME OF MOTHER

13. BIRTHPLACE OF MOTHER

(State or Country)

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

E. G. Burnett

(Address)

Soldiers Home

15.

Filed

Feb 22 1913

J. M. Taylor

Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

2 20 1913
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from

Jan 15 1913, to Feb 2 1913,

that I last saw him alive on Feb 20 1913

and that death occurred on the date stated above, at 7 P. M.

The CAUSE OF DEATH was as follows:

Chronic Parenchymatous nephritis

(Duration) yrs. mos. ds.

Contributory (Secondary)

Cardiac hypertrophy

(Duration) yrs. mos. ds.

(Signed)

Jed A. Pilling M. D.

Apr 2 1913 (Address) Talk Blk 9

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death yrs. mos. days. In the State yrs. mos. days.

Where was disease contracted if not at place of death?

Former or usual residence.

19. PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

Morris Hill Cem

Feb 22 1913

20. UNDERTAKER

ADDRESS

E. J. Summers

Boise Ida

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Form V. S. No. 5 20M.1-16-12

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH.

Registration District No. 1County of AdaPrimary Registration District No. 2004City of Boise(No. Soldiers Home St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

Chauncy J. PhilmotFile No. 4166Registered No. 18

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX

Male

4. COLOR OR RACE

white American

5. SINGLE, MARRIED, WIDOWED OR DIVORCED.

Married
(Write the word.)

6. DATE OF BIRTH

not obtainable

(Month) (Day) (Year)

7. AGE

72 yrs. — mos. — ds.IF LESS than 1 day
how many hrs. or
..... mins.?

8. OCCUPATION

(a) Trade, profession or particular kind of work

Civil War Vet.

(b) General nature of industry business, or establishment in which employed (or employer)

9. BIRTHPLACE

(State or Country)

not obtainable

10. NAME OF FATHER

11. BIRTHPLACE OF FATHER

(State or Country)

12. MAIDEN NAME OF MOTHER

13. BIRTHPLACE OF MOTHER

(State or Country)

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

E. G. Burnett

(Address)

Soldiers Home

15.

Filed

Feb 23rd1912J. M. Taylor

Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH

2 22 1913
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from

Feb. 10 1913 to Feb 22 1913that I last saw him alive on Feb 21 1913and that death occurred on the date stated above, at 39 M.

The CAUSE OF DEATH* was as follows:

Cardiac Dilatation

(Duration) yrs. mos. ds.

Contributory
(Secondary)

(Duration) yrs. mos. ds.

(Signed)

Freddie Gilling M. D.7/2 1913 (Address) Lake Bldg.

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death yrs. mos. days. In the State yrs. mos. days.

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

Morris Hill CemFeb 23 1913

20. UNDERTAKER

ADDRESS

Fry & SummersBoise Ida.

MARGIN RESERVED FOR BINDING
WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Form V. S. No. 5. 10M. 6-20-11.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

File No. 4169

Registered No. 21

If death occurred in a hospital, institution or camp give its NAME instead of street and number.

1. PLACE OF DEATH.

Registration District No. 1

County of Ada

Primary Registration District No. 2002

City of Green Meadows Gulch

(No. _____, _____ St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

PERSONAL AND STATISTICAL PARTICULARS

3. SEX

4. COLOR OR RACE

5. SINGLE, MARRIED, WIDOWED OR DIVORCED.

Male

W

(Write the word.)

6. DATE OF BIRTH

2 — 24 — 1913
(Month) (Day) (Year)

7. AGE

23 hours
yrs. mos. ds.

IF LESS than 1 day
how many 23 hrs. or
min.

8. OCCUPATION

- (a) Trade, profession, or particular kind of work
(b) General nature of industry, business, or establishment in which employed (or employer)

9. BIRTHPLACE

(State or Country)

Ida.

10. NAME OF FATHER

Jno W. Wheeler

11. BIRTHPLACE OF FATHER

(State or Country)

Indiana

12. MAIDEN NAME OF MOTHER

Ethyl Budden

13. BIRTHPLACE OF MOTHER

(State or Country)

Idaho

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

(Address)

J. E. Froom
Boise Ida

15.

Filed Mar 7 1913

J. M. Taylor
Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

2-25- 1913
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from

2-24- 1913, to 2-25- 1913

that I last saw him alive on 2-24- 1913,

and that death occurred on the date stated above, at 7 A M.

The CAUSE OF DEATH* was as follows:

Non closure of foramen of Ovale

(Duration) yrs. mos. ds.

Contributory (Secondary)

Premature birth

(Duration) yrs. mos. ds.

(Signed) J. E. Froom M. D.

3-7-1913 (Address) Boise, Ida

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL,

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death.....yrs.....mos.....ds. State.....yrs.....mos.....ds.

Where was Disease contracted,

If not at place of death?

Former or

usual residence.

19. PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

at home

1913

20. UNDERTAKER

ADDRESS

none

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Form V. S. No. 5 20M.1-16-12

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics
File No. 1177

1. PLACE OF DEATH.

Registration District No. 1

County of Ada

Primary Registration District No. 2004

City of Boise

(No. _____, St.)

Registered No. 22

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Samuel Warren R. Johnson

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX

Male

4. COLOR OR RACE

White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED.

single
(Write the word.)

6. DATE OF BIRTH

Jan 30 1913
Month Day Year

7. AGE

2 yrs. 1 mos. 17 ds.

IF LESS than 1 day
how many _____ hrs. or
_____ mins.?

8. OCCUPATION

(a) Trade, profession or particular kind of work

none

(b) General nature of industry business, or establishment in which employed (or employer)

9. BIRTHPLACE

(State or Country)

near Boise

10. NAME OF FATHER

Samuel W. Johnson

11. BIRTHPLACE OF FATHER

(State or Country)

Idaho

12. MAIDEN NAME OF MOTHER

Adie Hazel Carlton

13. BIRTHPLACE OF MOTHER

(State or Country)

Idaho

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

S. H. Johnson

(Address)

Boise

15.

Filed Feb 10 1913

J. M. Taylor
Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH

March 7 1913
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from
dead 1913 to saw March 7 1913
that I last saw alive on 1913

and that death occurred on the date stated above, at 10 PM

The CAUSE OF DEATH* was as follows:

Accidental drowning
in south fork of 5 Mile
creek Ada County
(Duration) _____ yrs. _____ mos. _____ ds.

Contributory
(Secondary)

(Duration) _____ yrs. _____ mos. _____ ds.

(Signed)

Adolph Schickel M.D.

March 8 1913 (Address) Boise, Idaho

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death _____ yrs. _____ mos. _____ days. In the State _____ yrs. _____ mos. _____ days.

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

Morris Hill Cemetery March 9 1913

20. UNDERTAKER

ADDRESS

Schickel & Schickel Boise

1. PLACE OF BIRTH. Registration District 18
County of Boise Primary Registrar District No. 2119
City of Boise (No. _____, _____ St.)

File No. 4173
Registered No. 25

If death occurs away from usual residence, give facts called for under special information.

If death occurred in a hospital, institution or camp give its NAME instead of street and number.

2. FULL NAME

Charles J. Spangberg

PERSONAL AND STATISTICAL PARTICULARS

3. SEX Male 4. COLOR OR RACE White 5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.)

6. DATE OF BIRTH

4 29 1920
(Month) (Day) (Year)

7. AGE

87 yrs. 9 mos. 1 ds.

IF LESS than 1 day
how many hrs. or
..... min?

8. OCCUPATION

(a) Trade, profession or particular kind of work Black Smith
(b) General nature of industry business or establishment in which employed (or employer)

9. BIRTHPLACE

(State or Country)

Sweden Denmark

10. NAME OF FATHER

Spangberg

11. BIRTHPLACE OF FATHER

(State or Country)

Sweden Denmark

12. MAIDEN NAME OF MOTHER

Not Known

13. BIRTHPLACE OF MOTHER

(State or Country)

Sweden Denmark

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

Charles J. Spangberg Jr.

(Address)

Boise Idaho

15.

Filed Feb 2 1913

13

Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH

Jan 2 1913
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from

Dec 30 1912, to Jan

that I last saw him alive on Jan

and that death occurred on the date stated above

The CAUSE OF DEATH* was as follows:

Pneumonia

(Duration) yrs. 5 mos. 5 ds.

Contributory (Secondary)

Old age

(Duration) yrs. 1 mos. 4 ds.

(Signed)

Allen R. Curtis M. D.

1/4 1913 (Address) Boise Idaho

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place In the

of death yrs. mos. ds. State yrs. mos. ds.

Where was disease contracted,

If not at place of death?

Former or

usual residence.

19. PLACE OF BURIAL OR REMOVAL DATE OF BURIAL

Boise Idaho

Jan 6 1913

20. UNDERTAKER

ADDRESS

O. Hansen

Boise Idaho

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIAN should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Form V. S. No. 5, 12-14 M. 7-24-11

CERTIFICATE OF DEATH

1. PLACE OF DEATH *Clifton* Registration District *18*
County of *Isabella* Primary Registration District No. *2119*
City of *Clifton* (No. _____ St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME *Paul E. Knibbs*

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics
File No. *1174*
Registered No. *26*

If death occurred in a hospital, institution or camp give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX *Male* 4. COLOR OR RACE *White* 5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.)

6. DATE OF BIRTH *Sept 6 1912*
(Month) (Day) (Year)

7. AGE *4 yrs. 4 mos. 15 ds.* IF LESS than 1 day how many _____ hrs. or _____ min?

8. OCCUPATION

- (a) Trade, profession or particular kind of work
(b) General nature of industry business or establishment in which employed (or employer)

9. BIRTHPLACE (State or Country) *Banida Ida*

10. NAME OF FATHER *Wilbert Knibbs*

11. BIRTHPLACE OF FATHER (State or Country) *Idaho*

12. MAIDEN NAME OF MOTHER *Irma Vignett*

13. BIRTHPLACE OF MOTHER (State or Country) *Idaho*

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) *W. J. Knibbs*
(Address) *Banida Ida*

15. *Clifton*
Filed *Feb 8 1915*
Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH *Jan. 21-1913*
(Month) *14* (Day) *15* (Year)

17. I HEREBY CERTIFY, That I attended deceased from *Jan. 15 1913*, to *Jan. 21-1913* that I last saw her alive on *Jan. 21-1913*

and that death occurred on the date stated above, at *9:15 P.M.*

The CAUSE OF DEATH* was as follows:

Was called to attend this baby Jan. 15th 1913 to Jan. 21-1913
Pneumonia

(Duration) *6* yrs. _____ mos. _____ ds. 8

Contributory (Secondary) *1st cold*

(Duration) _____ yrs. _____ mos. _____ ds. 8

(Signed) *J. D. Mole M. D.*
Jan 22 1913 (Address) *Clifton Idaho*

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place _____ In the _____
of death _____ yrs. _____ mos. _____ ds. State _____ yrs. _____ mos. _____ ds.

Where was disease contracted,
If not at place of death?
Former or
usual residence _____

19. PLACE OF BURIAL OR REMOVAL DATE OF BURIAL

Banida Ida *21* 1913

20. UNDERTAKER ADDRESS

P. E. Herman *Clifton*

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Form V. S. No. 5. 12½ M. 1913

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics
File No. **4175**
Registered No. **27**

1. PLACE OF DEATH. Registration District No. **18**
County of **Quade** Primary Registration District No. **2119**
City of **Preston** (No. _____ St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME **Sibson Condie**

If death occurred in a hospital, institution or camp give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX **Male** 4. COLOR OR RACE **White** 5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.)

6. DATE OF BIRTH **3 25 1835**
(Month) (Day) (Year)

7. AGE **77** yrs. **10** mos. **ds.** IF LESS than 1 day how many _____ hrs. or _____ min?

8. OCCUPATION

(a) Trade, profession or particular kind of work. **Farmer**
(b) General nature of industry business or establishment in which employed (or employer)

9. BIRTHPLACE

(State or Country)

Clackmannan Scotland

10. NAME OF FATHER

Thomas Condie

11. BIRTHPLACE OF FATHER

(State or Country)

Scotland

12. MAIDEN NAME OF MOTHER

Helen Sharp

13. BIRTHPLACE OF MOTHER

(State or Country)

Scotland

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

J. W. Condie

(Address)

Preston, Idaho

15.

Filed **Feb 6 1913**
Mar 10 1913

Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH

1 (Month) **25** (Day) **1913** (Year)

17. I HEREBY CERTIFY, That I attended deceased from **Jan. 19** 1913, to **Jan 25** 1913 that I last saw him alive on **Jan 19** 1913 and that death occurred on the date stated above, at **3:30 P.**

The CAUSE OF DEATH* was as follows:

Defective heart and kidney accompanied with dropsy

(Duration) **2** yrs. **3** mos. **—** ds.

Contributory (Secondary)

Senile decay(Duration) **—** yrs. **—** mos. **—** ds.

(Signed)

Allen R. Curtis M. D.**19** (Address) **Preston Idaho**

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place _____ In the _____
of death _____ yrs. _____ mos. _____ ds. State _____ yrs. _____ mos. _____ ds.
Where was disease contracted,
If not at place of death? _____
Former or
usual residence. _____

19. PLACE OF BURIAL OR REMOVAL DATE OF BURIAL

Craydin Ida **Jan 28** 1913

20. UNDERTAKER

ADDRESS

P. J. Hansen**Preston**

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Form V. S. No. 5 20M.1-16-12

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics
File No. 4176
Registered No. 28

1. PLACE OF DEATH Idaho Registration District No. 18
County of Franklin Primary Registration District No. 2119
City of Dayton (No. _____, St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Edw. Davis

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX Female 4. COLOR OR RACE White 5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.)

6. DATE OF BIRTH 12 10 1899
(Month) (Day) (Year)

7. AGE 10 yrs. 7 mos. 2 ds. IF LESS than 1 day how many _____ hrs. or _____ mins.?

8. OCCUPATION
(a) Trade, profession or particular kind of work
(b) General nature of industry business, or establishment in which employed (or employer)

9. BIRTHPLACE (State or Country) Dayton

10. NAME OF FATHER John T. Davis

11. BIRTHPLACE OF FATHER (State or Country) Idaho

12. MAIDEN NAME OF MOTHER St. David

13. BIRTHPLACE OF MOTHER (State or Country) England

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) John T. Davis
(Address) Dayton Idaho

15. Filed Feb 5 1913 McGowan
Adm 10 1913 Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH Feb. 2nd 1913
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from Jan. 31st 1913, to Feb 2nd 1913, that I last saw her alive on Feb 2nd 1913, and that death occurred on the date stated above, at 10 A.M.

The CAUSE OF DEATH* was as follows:

Pneumonia Complicated by Mitral Insufficiency

(Duration) _____ yrs. _____ mos. 3 Weeks

Contributory (Secondary)

(Duration) 9 yrs. _____ mos. _____ ds.
(Signed) G. J. Parkerson M. D.
3 1913 (Address) Oreston Idaho

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death _____ yrs. _____ mos. _____ days. In the State _____ yrs. _____ mos. _____ days.

Where was disease contracted if not at place of death?

Former or usual residence.

19. PLACE OF BURIAL OR REMOVAL Dayton Ida DATE OF BURIAL 7/4 1913

20. UNDERTAKER G. J. Parkerson ADDRESS Oreston

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Form V. S. No. 5 20M.1-16-12

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH. Registration District No. 18
County of Teton Primary Registration District No. 2119
City of Whitney (No. _____, St.)

File No. 4177

Registered No. 29

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Selma Fendler

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX Female 4. COLOR OR RACE White 5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.)

6. DATE OF BIRTH 6 20 1911
(Month) (Day) (Year)

7. AGE 6 yrs. 9 mos. 9 ds.
IF LESS than 1 day how many _____ hrs. or _____ mins.

8. OCCUPATION
(a) Trade, profession or particular kind of work
(b) General nature of industry, business, or establishment in which employed (or employer)

9. BIRTHPLACE (State or Country) Whitney

10. NAME OF FATHER Osba Fendler

11. BIRTHPLACE OF FATHER (State or Country) Switzerland

12. MAIDEN NAME OF MOTHER Christen

13. BIRTHPLACE OF MOTHER (State or Country) Switzerland

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Ida Fendler
(Address) Whitney Ida

15. Filed Feb 6 1913 Ida Fendler Local Registrar
Feb 10 1913 Ida Fendler

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH Feb 4 1913
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from 2/3 — 1913, to 2/4 1913, that I last saw her alive on 2/4 1913, and that death occurred on the date stated above, at 4 P. M.

The CAUSE OF DEATH* was as follows:

Bronchial Pneumonia

(Duration) _____ yrs. _____ mos. 3 ds.

Contributory (Secondary)

(Duration) _____ yrs. _____ mos. _____ ds.

(Signed) A. R. Cullen M. D.

Feb 1913 (Address) Princeton Idaho

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death _____ yrs. _____ mos. _____ days. In the State _____ yrs. _____ mos. _____ days.

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL DATE OF BURIAL

Whitney Ida Feb 6 1913

20. UNDERTAKER ADDRESS

Ida Fendler Princeton

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Form V. S. No. 5 20M.1-16-12

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics
File No. 1178
Registered No. 20

1. PLACE OF DEATH.

Registration District No. 18County of FranklinPrimary Registration District No. 214City of Glendale

(No. _____)

St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Oleiv Veal Mortensen

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX

Male

4. COLOR OR RACE

White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED.

Single
(Write the word.)

6. DATE OF BIRTH

Sept25th1912

(Month)

(Day)

(Year)

7. AGE

4 yrs. 12 mos. 12 ds.IF LESS than 1 day
how many hrs. or
..... mins.?

8. OCCUPATION

(a) Trade, profession or particular kind of work

(b) General nature of industry business, or establishment in which employed (or employer)

9. BIRTHPLACE

(State or Country) Glendale Ida.

10. NAME OF FATHER

Andrew Mortensen

11. BIRTHPLACE OF FATHER

(State or Country) Utah

12. MAIDEN NAME OF MOTHER

Christema Snagerson

13. BIRTHPLACE OF MOTHER

(State or Country) Denmark

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Christine Mortensen(Address) Glendale Ida.

15.

Filed

Feb 16
1913

1913

G. H. Gray
Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH

February Seventh

1913

(Month)

(Day)

(Year)

17. I HEREBY CERTIFY, That I attended deceased from

2/6

1913, to

2/7

1913,

that I last saw him alive on Sixth 1913,and that death occurred on the date stated above, at 6 PM.

The CAUSE OF DEATH was as follows:

Broncho pneumonia(Duration) yrs. mos. 6 ds.Contributory
(Secondary)

(Duration) yrs. mos. ds.

(Signed) H. C. Parkinson M. D.1913 (Address) Preston Ida.

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death yrs. mos. days. In the State yrs. mos. days.

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

Preston IdaFeb 9 1913

20. UNDERTAKER

ADDRESS

None

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Form V. S. No. 5 20M.1-16-12

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH.

Registration District No. 18County of FranklinPrimary Registration District No. 2117City of Preston

(No. _____)

St.)

File No. 1119Registered No. 31

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Simon T. Gurne

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX

4. COLOR OR RACE

5. SINGLE, MARRIED, WIDOWED OR DIVORCED.

MaleWhite

(Write the word.)

6. DATE OF BIRTH

July . 21 1913
(Month) (Day) (Year)

7. AGE

7 yrs. 7 mos. 7 ds.IF LESS than 1 day
how many hrs. or
..... mins.?

8. OCCUPATION

- (a) Trade, profession or particular kind of work
(b) General nature of industry business, or establishment in which employed (or employer)

9. BIRTHPLACE

(State or Country) Preston Ida10. NAME OF FATHER William D. Gurne

11. BIRTHPLACE OF FATHER

(State or Country) Idaho12. MAIDEN NAME OF MOTHER Talman

13. BIRTHPLACE OF MOTHER

(State or Country) Idaho

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) W. D. Gurne(Address) Preston Ida

15.

Filed Feb. 16 1913W. D. Gurne
Mar 10 1913 Shay Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH

February 14 1913
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from

Febr 6 1913, to Febr 14 1913that I last saw him alive on Febr 14 1913and that death occurred on the date stated above, at 11 P. M.

The CAUSE OF DEATH* was as follows:

Bronchitis Pneumonia(Duration) X yrs. X mos. 8 ds.Contributory
(Secondary)(Duration) 1 yrs. 0 mos. 0 ds.

(Signed)

Feb 16 1913 (Address) Preston Idaho

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death yrs. mos. days. In the State yrs. mos. days.

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

Preston Ida Feb 16 1913

20. UNDERTAKER

ADDRESS

J. F. Hannan Preston

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Form V. S. No. 5 20M.1-16-12

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH.

Registration District No. 18

County of Franklin

Primary Registration District No. 2119

City of Burton

(No. _____, _____ St.)

File No. 1184

Registered No. 32

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

Emanuel Johnson

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX

4. COLOR OR RACE

5. SINGLE, MARRIED, WIDOWED OR DIVORCED.

Male

White

(Write the word.)

6. DATE OF BIRTH

Jun
(Month)

8
(Day)

1913
(Year)

7. AGE

1 yrs. 8 mos. 8 ds.

IF LESS than 1 day
how many _____ hrs. or
_____ mins.

8. OCCUPATION

(a) Trade, profession or particular kind of work
(b) General nature of industry business, or establishment in which employed (or employer)

9. BIRTHPLACE

(State or Country)

Burton Ida

10. NAME OF FATHER

Emanuel Johnson

11. BIRTHPLACE OF FATHER

(State or Country)

Burton Ida

12. MAIDEN NAME OF MOTHER

Parker

13. BIRTHPLACE OF MOTHER

(State or Country)

Franklin Ida

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

Albert E. Johnson

(Address)

Burton Idaho

15.

Filed

July 18

1913

W. H. Ray

Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH

2

14

1913

(Month)

(Day)

(Year)

17. I HEREBY CERTIFY, That I attended deceased from

2/15 1913, to 2/16 1913,

that I last saw him alive on 2/16 1913,

and that death occurred on the date stated above, at 3:15 M.

The CAUSE OF DEATH* was as follows:

Bronchial Pneumonia

(Duration)

_____ yrs.

_____ mos.

One ds.

Contributory

(Secondary)

(Duration)

_____ yrs.

_____ mos.

_____ ds.

(Signed)

A. R. Bailey

M. D.

717 1913 (Address) Burton

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place

of death

_____ yrs.

_____ mos.

_____ days.

In the

State

_____ yrs.

_____ mos.

_____ days.

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

Burton Ida

2-17 1913

20. UNDERTAKER

ADDRESS

W. H. Ray

Burton

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Form V. S. No. 5 20M.1-16-12

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH.

Registration District No. 78

County of Franklin

Primary Registration District No. 2119

City of Preston

(No. _____ St.)

File No. 111

Registered No. 33

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Anna Roper

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX

4. COLOR OR RACE

5. SINGLE, MARRIED, WIDOWED OR DIVORCED.

Female White (Write the word.)

6. DATE OF BIRTH

1 6 1913
(Month) (Day) (Year)

7. AGE

1 yrs. 14 mos. 14 ds.

IF LESS than 1 day
how many _____ hrs. or
_____ mins.?

8. OCCUPATION

- (a) Trade, profession or particular kind of work
(b) General nature of industry business, or establishment in which employed (or employer)

9. BIRTHPLACE

(State or Country) Whitish Ida

10. NAME OF FATHER

Orin Roper

11. BIRTHPLACE OF FATHER

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Form V. S. No. 5 20M.1-16-12

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH. Registration District No. 18
County of Freemblem Primary Registration District No. 2119
City of Preston (No. _____ St.)

File No. 1183
Registered No. 34

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Roxie E. Hobbs

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX Female 4. COLOR OR RACE White 5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.)

6. DATE OF BIRTH Nov 20 1912
(Month) (Day) (Year)

7. AGE 4 yrs. 4 mos. 4 ds.
IF LESS than 1 day how many _____ hrs. or _____ mins.?

8. OCCUPATION
(a) Trade, profession or particular kind of work _____
(b) General nature of industry business, or establishment in which employed (or employer) _____

9. BIRTHPLACE (State or Country) Preston Ida

10. NAME OF FATHER Samuel Hobbs

11. BIRTHPLACE OF FATHER (State or Country) Preston Ida

12. MAIDEN NAME OF MOTHER Abbie

13. BIRTHPLACE OF MOTHER (State or Country) Wyoming

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) C. R. Hobbs

(Address) Preston Idaho

15. Filed Feb 28 1913 G. E. Gentry Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH February 26 1913
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from Feb 23 1913 to Feb 26 1913, that I last saw her alive on Feb 26 1913 and that death occurred on the date stated above, at 10 A.M.

The CAUSE OF DEATH* was as follows:

Bronchitis Pneumonia
(Duration) 2 yrs. 2 mos. 3 ds.

Contributory Otitis
(Secondary)

(Duration) 4 yrs. 7 mos. 7 ds.
(Signed) G. W. Hales M. D.

Feb 24 1913 (Address) Preston Idaho

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death. _____ yrs. _____ mos. _____ days. In the State. _____ yrs. _____ mos. _____ days.

Where was disease contracted if not at place of death? _____

Former or usual residence. _____

19. PLACE OF BURIAL OR REMOVAL Freemblem Ida DATE OF BURIAL Feb 28 1913

20. UNDERTAKER C. J. Hansen ADDRESS Preston

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Form V. S. No. 5 20M.1-16-12

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics
File No. 4183
Registered No. 35

1. PLACE OF DEATH.

Registration District No. 18

County of Oneida

Primary Registration District No. 2069

City of Samaria

(No. _____ St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

Delora Hughes

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX

fe

4. COLOR OR RACE

white

5. SINGLE, MARRIED, WIDOWED OR DIVORCED.

(Write the word.)

6. DATE OF BIRTH

June 11 1912
(Month) (Day) (Year)

7. AGE

7 yrs. 2 mos. 2 ds.

IF LESS than 1 day
how many hrs. or
..... mins.?

8. OCCUPATION

(a) Trade, profession or particular kind of work
(b) General nature of industry, business, or establishment in which employed (or employer)

9. BIRTHPLACE

(State or Country)

Idaho

10. NAME OF FATHER

David Hughes

11. BIRTHPLACE OF FATHER

(State or Country)

Idaho

12. MAIDEN NAME OF MOTHER

Elizabeth Thomas

13. BIRTHPLACE OF MOTHER

(State or Country)

Idaho

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

David Hughes

(Address)

Samaria Idaho

15.

Filed

1-14

191

3

W. E. Ray
Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH

July 13 1913
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from

191... to 191...

that I last saw h... alive on 191...

and that death occurred on the date stated above, at 8:45 M.

The CAUSE OF DEATH* was as follows:

Inanition

(Duration) 70 yrs. 0 mos. 0 ds.

Contributory
(Secondary)

(Duration) no physician attendance yrs. 0 mos. 0 ds.

(Signed) _____ M. D.

19. (Address)

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death... yrs... mos... days. In the State... yrs... mos... days.

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL

Samaria

DATE OF BURIAL

1-14 1913

20. UNDERTAKER

D. E. Johnson

ADDRESS

Malad

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Form V. S. No. 5 20M.1-16-12

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH.

Registration District No. 18

County of Oneida

Primary Registration District No. 2069

City of Malad

(No.)

St.)

File No. 4184

Registered No. 36

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Mary Jones Williams

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX

4. COLOR OR RACE

5. SINGLE, MARRIED, WIDOWED OR DIVORCED.

FemaleWhiteWidowed (Write the word.)

6. DATE OF BIRTH

Feb121913

(Month)

(Day)

(Year)

7. AGE

76 yrs. 1 mos. 1 ds.

IF LESS than 1 day
how many hrs. or
..... mins.?

8. OCCUPATION

(a) Trade, profession or particular kind of work

(b) General nature of industry, business, or establishment in which employed (or employer)

House wife

9. BIRTHPLACE

(State or Country)

Wales

10. NAME OF FATHER

Thomas Jones

11. BIRTHPLACE OF FATHER

(State or Country)

Wales

12. MAIDEN NAME OF MOTHER

Ruth Thomas

13. BIRTHPLACE OF MOTHER

(State or Country)

Wales

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

J. B. Davis

(Address)

Malad

15.

Filed 3-1191 3O. C. Ray

Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH

Feb27191 3

(Month)

(Day)

(Year)

17. I HEREBY CERTIFY, That I attended deceased from

2-18191 3to 2-27191 3that I last saw her alive on 2-27 191 3and that death occurred on the date stated above, at 7¹⁵ A.M.

The CAUSE OF DEATH* was as follows:

Acute Bronchitis(Duration) yrs. mos. 12 ds.

Contributory

(Secondary)

(Duration) yrs. mos. ds.

(Signed)

O. C. Ray

M. D.

228 No 13(Address) Malad City

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death.....yrs.....mos.....days. In the State.....yrs.....mos.....days.

Where was disease contracted if not at place of death?.....

Former or usual residence.....

19. PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

St. JohnMar 3 191 3

20. UNDERTAKER

ADDRESS

W. S. JohnsonMalad

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Form V. S. No. 5. 12½ M. 7-24-11

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics
File No. 4186
Registered No. 10

1. PLACE OF DEATH. Registration District No. 26
County of Washington Primary Registration District No. 1010
City of Ida (No. _____ St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

Lee Erickson

If death occurred in a hospital, institution or camp give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX Male 4. COLOR OR RACE wht 5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.)

6. DATE OF BIRTH

(Month) _____ (Day) _____ (Year) _____

7. AGE

22 yrs. — mos. — ds.

IF LESS than 1 day how many _____ hrs. or _____ min?

8. OCCUPATION

(a) Trade, profession or particular kind of work. Hotel Clerk
(b) General nature of industry business or establishment in which employed (or employer)

9. BIRTHPLACE

(State or Country) Don't know

10. NAME OF FATHER

W

11. BIRTHPLACE OF FATHER

(State or Country) _____

12. MAIDEN NAME OF MOTHER

13. BIRTHPLACE OF MOTHER

(State or Country) _____

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) _____

(Address) _____

15.

Filed Jan 21st 1913

W. A. Lawrence
Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

Jan 30 1913
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from

Jan 29 1913, to Jan 30 1913.
That I last saw him alive on Jan 31 1913
and that death occurred on the date stated above, at 9:25 A.M.

The CAUSE OF DEATH* was as follows:

Pneumonia Lobor.

(Duration) _____ yrs. _____ mos. 10 ds.

Contributory (Secondary)

(Duration) _____ yrs. _____ mos. _____ ds.

(Signed) C. C. Conant M. D.

Jan 30th 1913. (Address) Weiser Ida
State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; (2) whether ACCIDENTAL, SUICIDAL OR HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place _____ In the _____
of death _____ yrs. _____ mos. _____ ds. State _____ yrs. _____ mos. _____ ds.

Where was disease contracted,

If not at place of death?

Former or

usual residence.

19. PLACE OF BURIAL OR REMOVAL DATE OF BURIAL

Montpelier Ida 1913

20. UNDERTAKER

L. C. Northam Weiser

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

37

Form V. S. No. 5 20M.1-16-12

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH

Registration District No.

County of

Primary Registration District No.

City of

(No.

St.)

File No.

Registered No.

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX

4. COLOR OR RACE

5. SINGLE, MARRIED, WIDOWED OR DIVORCED.

6. DATE OF BIRTH

7. AGE

IF LESS than 1 day
how many hrs. or
mins.?

8. OCCUPATION

(a) Trade, profession or particular kind of work

(b) General nature of industry business, or establishment in which employed (or employer)

9. BIRTHPLACE

(State or Country)

10. NAME OF FATHER

11. BIRTHPLACE OF FATHER

(State or Country)

12. MAIDEN NAME OF MOTHER

13. BIRTHPLACE OF MOTHER

(State or Country)

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

(Address)

15.

Filed

1913

Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

17. I HEREBY CERTIFY, That I attended deceased from

Feb 3 hour 1913, to Feb 3 - 1:30 PM 1913,

that I last saw her alive on Feb 3 1913,

and that death occurred on the date stated above, at 1:30 PM.

The CAUSE OF DEATH* was as follows:

Salpingitis suppurativa
deftia with
Peritonitis General.

(Duration) yrs. mos. 4 ds.

Contributory Peritonitis general
(Secondary)

(Duration) yrs. mos. 3 ds.

(Signed) Ernest O. Finney M. D.

Feb 4 1913 (Address) Weiser Ida.

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death... yrs... mos... days. In the State... yrs... mos... days.

Where was disease contracted if not at place of death? Council Idaho

Former or usual residence. Council, Idaho

19. PLACE OF BURIAL OR REMOVAL DATE OF BURIAL

Weiser; Idaho Feb 1913

20. UNDERTAKER ADDRESS

A. J. Cordick Weiser, Ida.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Form V. S. No. 5. 12½ M. 7-24-11

CERTIFICATE OF DEATH

1. PLACE OF DEATH. Registration District No. 26
County of Washington Primary Registration District No. 2112
City of Wenatchee (No. _____ St.)

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics
File No. 4188
Registered No. 12

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

Melissa C. Brigidine

If death occurred in a hospital, institution or camp give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX Female 4. COLOR OR RACE white 5. SINGLE, MARRIED, WIDOWED OR DIVORCED. Married
(Write the word.)

6. DATE OF BIRTH Oct 12 1895
(Month) (Day) (Year)

7. AGE 77 yrs 2 mos 22 ds. IF LESS than 1 day how many _____ hrs. or _____ min?

8. OCCUPATION

(a) Trade, profession or particular kind of work.
(b) General nature of industry business or establishment in which employed (or employer)

Housewife

9. BIRTHPLACE
(State or Country)

Kentucky

10. NAME OF FATHER

Greenham Boston

11. BIRTHPLACE OF FATHER
(State or Country)

12. MAIDEN NAME OF MOTHER

Barbarra Graham

13. BIRTHPLACE OF MOTHER
(State or Country)

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

Ella Lassiter

(Address)

Wenatchee Ida

15.

Filed

Feb 5th 19131913D. R. Hainich

Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH

Feb 4 1913
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from Jan 26 1913, to Feb 4 1913

that I last saw him alive on Feb 4 1913

and that death occurred on the date stated above, at 4 P. M.

The CAUSE OF DEATH* was as follows:

Pneumonia

(Duration) _____ yrs. _____ mos. _____ ds.

Contributory (Secondary)

Influenza

(Duration) _____ yrs. _____ mos. _____ ds.

(Signed)

W. M. Mitchell M. D.

Feb 5 1913 (Address) Wenatchee Ida

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place _____ In the _____
of death _____ yrs. _____ mos. _____ ds. State _____ yrs. _____ mos. _____ ds.

Where was disease contracted,

If not at place of death?

Former or

usual residence.

19. PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

Wenatchee IdaFeb 6 1913

20. UNDERTAKER

ADDRESS

L. P. NorthrupWenatchee Ida

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Form V. S. No. 5. 12 1/2

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics1. PLACE OF DEATH
County of Washington
City of WenatcheeRegistration District No. 2Primary Registration District No. 2

(No. _____ St.)

File No. 4189Registered No. 3

If death occurs away from usual residence, give facts called for under special information.

FULL NAME

Nathaniel Tyler Carter

If death occurred in a hospital, institution or camp give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX

4. COLOR OR RACE

5. SINGLE, MARRIED, WIDOWED OR DIVORCED.
Widower
(Write the word.)

6. DATE OF BIRTH

Aug 29 1882
(Month) (Day) (Year)

7. AGE

80 yrs. 5 mos. 14 ds.IF LESS than 1 day
how many _____ hrs. or
_____ min?

8. OCCUPATION

(a) Trade, profession or particular kind of work.
(b) General nature of industry business or establishment in which employed (or employer)Farmer

9. BIRTHPLACE

(State or Country)

New York

10. NAME OF FATHER

Abraham Carter

11. BIRTHPLACE OF FATHER

(State or Country)

12. MAIDEN NAME OF MOTHER

13. BIRTHPLACE OF MOTHER

(State or Country)

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

A. F. Carter

(Address)

Wenatchee, Ida.

15.

Filed Feb 14 1913W. R. Hume

Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH

Feb 13 1913
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from

Feb 8 1913, to Feb 8 1913that I last saw him alive on Feb 8 1913and that death occurred on the date stated above, at 49 M.

The CAUSE OF DEATH* was as follows:

Seriously

(Duration) _____ yrs. _____ mos. _____ ds.

Contributory
(Secondary)

(Duration) _____ yrs. _____ mos. _____ ds.

(Signed) Camp C. Goyant M. D.2/14/13 19 (Address) Wenatchee, Ida.

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place _____ In the _____
of death _____ yrs. _____ mos. _____ ds. State _____ yrs. _____ mos. _____ ds.

Where was disease contracted,

If not at place of death?

Former or
usual residence.

19. PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

Wenatchee IdaFeb 14 1913

20. UNDERTAKER

ADDRESS

L. C. NorthamWenatchee Ida

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Form V. S. No. 5. 12½M.7-24-11

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics
File No. 4194
Registered No. 14

1. PLACE OF DEATH. Registration District No. 26
County of Was. Co. Primary Registration District No. 1010
City of Weiser (No. _____ St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Ellis Saling

If death occurred in a hospital, institution or camp give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX Male 4. COLOR OR RACE White 5. SINGLE, MARRIED, WIDOWED OR DIVORCED. Married
(Write the word.)

6. DATE OF BIRTH June 13 1860
(Month) (Day) (Year)

7. AGE 52 yrs. 8 mos. 4 ds. IF LESS than 1 day
how many _____ hrs. or _____ min?

8. OCCUPATION Furnace Man
(a) Trade, profession or particular kind of work.
(b) General nature of industry business or establishment in which employed (or employer)

9. BIRTHPLACE Neb.
(State or Country)

10. NAME OF FATHER Rungy Saling

11. BIRTHPLACE OF FATHER unknown
(State or Country)

12. MAIDEN NAME OF MOTHER Ester Sitley

13. BIRTHPLACE OF MOTHER unknown
(State or Country)

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) C. J. Anderson MD
(Address) Weiser

15. Filed Feb 18 1913 M. R. Hanch
Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH Feb 17 1913
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from Feb 2nd 1913, to Feb 17 1913
that I last saw him alive on " 17 1913
and that death occurred on the date stated above, at 10:10 P.M.

The CAUSE OF DEATH* was as follows:

Uremia Superimposed on
Chronic interstitial Nephritis
+ Arteriosclerosis

(Duration) _____ yrs. _____ mos. 14 ds.

Contributory (Secondary) _____

(Duration) 2 yrs. _____ mos. _____ ds.

(Signed) C. J. Anderson M. D.

19 (Address)

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place _____ In the _____
of death _____ yrs. _____ mos. _____ ds. State _____ yrs. _____ mos. _____ ds.

Where was disease contracted,
If not at place of death? _____
Former or
usual residence. _____

19. PLACE OF BURIAL OR REMOVAL DATE OF BURIAL

Weiser 2-19 1913

20. UNDERTAKER ADDRESS

L. C. Northman Weiser

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Form V. S. No. 5 20M.1-16-12

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics
File No. 4191

1. PLACE OF DEATH. Registration District No. 26
County of Washington Primary Registration District No. 2112
City of Weiser (No. 1 St.)

Registered No. 15
If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME William Stacy

PERSONAL AND STATISTICAL PARTICULARS

3. SEX Male 4. COLOR OR RACE White 5. SINGLE, MARRIED, WIDOWED OR DIVORCED. Widower
(Write the word.)

6. DATE OF BIRTH August - 13 - 1827
(Month) (Day) (Year)

7. AGE 85 yrs. 6 mos. 6 ds. IF LESS than 1 day how many hrs. or mins.?

8. OCCUPATION
(a) Trade, profession or particular kind of work Retired Mill Man.
(b) General nature of industry business, or establishment in which employed (or employer)

9. BIRTHPLACE Devanshire; England. G.B.
(State or Country)

10. NAME OF FATHER Wm. Stacy

11. BIRTHPLACE OF FATHER England. G.B.
(State or Country)

12. MAIDEN NAME OF MOTHER Johanna Moore

13. BIRTHPLACE OF MOTHER England G.B.
(State or Country)

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Mrs. J. B. Crakley
(Address) Weiser; Idaho

15. Filed Feb 20th 1913 W. R. Hamilton
Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH Feb. - 19 - 1913
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from Feb. 18 1913, to Feb 19 1913 that I last saw him alive on Feb 18 1913 and that death occurred on the date stated above, at 6:38 M.
The CAUSE OF DEATH* was as follows:

Apoplexy
(Duration) yrs. mos. 1 ds.
Contributory (Secondary)
(Duration) yrs. mos. ds.
(Signed) A. M. Hutchins M. D. X
19. (Address)

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death yrs. mos. days. In the State yrs. mos. days.
Where was disease contracted if not at place of death?
Former or usual residence

19. PLACE OF BURIAL OR REMOVAL Weiser Ida DATE OF BURIAL Feb. 21 1913

20. UNDERTAKER R. H. Bowen ADDRESS Weiser, Ida.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Form V, S. No. 5. 12½ M. 7-24-11

CERTIFICATE OF DEATH

State of Idaho

BOARD OF HEALTH
Bureau of Vital Statistics

File No. 4192

Registered No. 16

If death occurred in a hospital, institution or camp give its NAME instead of street and number.

1. PLACE OF DEATH. Registration District No. 26
County of Washington Primary Registration District No. 2113
City of Manass (No. _____, St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

Christina Ross

PERSONAL AND STATISTICAL PARTICULARS

3. SEX 4. COLOR OR RACE 5. SINGLE, MARRIED, WIDOWED OR DIVORCED.

Female white married (Write the word.)

6. DATE OF BIRTH

June 20 1880
(Month) (Day) (Year)

7. AGE

32 yrs. 8 mos. 8 ds.

IF LESS than 1 day
how many _____ hrs. or
min?

8. OCCUPATION

(a) Trade, profession or particular kind of work.
(b) General nature of industry business or establishment in which employed (or employer)

House Wife

9. BIRTHPLACE

(State or Country)

Russia

10. NAME OF FATHER

Geo Hell

11. BIRTHPLACE OF FATHER

(State or Country)

Russia

12. MAIDEN NAME OF MOTHER

Loise Albrach

13. BIRTHPLACE OF MOTHER

(State or Country)

Russia

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

John H. Ross

(Address)

15.

Filed Mar 5 1913

Faschnig
Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH

Feb 26 1913
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from

Feb 9 1913, to Feb 26 1913

that I last saw her alive on Feb 26 1913

and that death occurred on the date stated above, at 10 PM.

The CAUSE OF DEATH* was as follows:

Mitral regurgitation

(Duration) _____ yrs. _____ mos. _____ ds.

Contributory
(Secondary)

(Duration) _____ yrs. _____ mos. _____ ds.

(Signed) F. Faschnig M. D.

Mar 3 1913 (Address) Medvale

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place In the
of death _____ yrs. _____ mos. _____ ds. State _____ yrs. _____ mos. _____ ds.

Where was disease contracted,

If not at place of death?

Former or

usual residence.

19. PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

Medvale

Mar 5 1913

20. UNDERTAKER

ADDRESS

L. Y. Ray

Medvale

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
N. B.—Every item of information should be carefully supplied. AGE should be state EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Form V. S. No. 5. 10M. 6-20-11.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics
File No. 4195
Registered No. 8

1. PLACE OF DEATH.

Registration District No. 28County of ShoshonePrimary Registration District No. 1411City of Wallace

(No. _____, St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

Jos. A. Kingaley

If death occurred in a hospital, institution or camp give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX

male

4. COLOR OR RACE

white

5. SINGLE, MARRIED, WIDOWED OR DIVORCED.

married
(Write the word.)

6. DATE OF BIRTH

(Month) _____ (Day) _____ (Year) 1

7. AGE

23

yrs. — mos. — ds.

IF LESS than 1 day
how many hrs. or
..... min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work

stationary engineer

(b) General nature of industry business or establishment in which employed (or employer)

9. BIRTHPLACE

(State or Country)

Tenn.

10. NAME OF FATHER

H. R. Kingaley

11. BIRTHPLACE OF FATHER

(State or Country)

unknown

12. MAIDEN NAME OF MOTHER

unknown

13. BIRTHPLACE OF MOTHER

(State or Country)

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

R. H. Killian

(Address)

Marion, Ida.

15.

Filed

Feb 41913H. Leo Quinley

Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

Febr21913

(Month)

(Day)

(Year)

17. I HEREBY CERTIFY, That I attended deceased from

Febr 21913Febr 21913that I last saw him alive on Febr 21913and that death occurred on the date stated above, at 4:30 M.

The CAUSE OF DEATH* was as follows:

Shock & Hemorrhage due to crush injury arm & leg.(Duration) _____ yrs. 3 hrs ds.

Contributory (Secondary)

(Duration) _____ mos. _____ ds.

Signed) Feb 5 1913 Dr. Mowbray M. D. Wallace, Ida.

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place

In the

of death yrs. mos. ds. State yrs. mos. ds.

Where was disease contracted,

If not at place of death?

Former or

usual residence.

19. PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

Miller Mo.1913

20. UNDERTAKER

ADDRESS

Hardy Undertaking Co. Wallace, Ida.

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Form V. S. No. 5. 12½ M. 7-24-11

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics
File No. 1194
Registered No. 9

1. PLACE OF DEATH.
County of Shoshone
City of Wallace

Registration District No. 28
Primary Registration District No. 1011-
(No. Wallace Hospital St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME John Anderson

If death occurred in a hospital, institution or camp give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX Male 4. COLOR OR RACE White 5. SINGLE, MARRIED, WIDOWED OR DIVORCED. single
(Write the word.)

6. DATE OF BIRTH
(Month) (Day) (Year)
1

7. AGE 58 yrs. — mos. — d. IF LESS than 1 day how many..... hrs. or min?

8. OCCUPATION
(a) Trade, profession or particular kind of work. mineral
(b) General nature of industry business or establishment in which employed (or employer)

9. BIRTHPLACE
(State or Country) not given

10. NAME OF FATHER

11. BIRTHPLACE OF FATHER
(State or Country)

12. MAIDEN NAME OF MOTHER

13. BIRTHPLACE OF MOTHER
(State or Country)

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) J. E. St. John
(Address) Wallace, Ida

15. Filed Feb 6, 1913 H. Leo Zuehlke
Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH
Feb 1 1913
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from Dec - 1913, to Feb 1 1913
that I last saw him alive on Feb 1 1913
and that death occurred on the date stated above, at 8:30 P. M.

The CAUSE OF DEATH* was as follows:
Chronic Nephritis
(Duration) yrs. mos. ds.
Contributory Paralysis - alcoholism
(Secondary)
(Duration) yrs. mos. ds.
(Signed) Chas. C. Dethman M. D.
19 (Address) Beurke, Ida,

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place In the
of death..... yrs..... mos..... ds. State..... yrs..... mos..... ds.
Where was disease contracted,
If not at place of death?
Former or
usual residence.....

19. PLACE OF BURIAL OR REMOVAL DATE OF BURIAL
Wallace, Idaho Feb 6, 1913
20. UNDERTAKER ADDRESS
Bruce G. Norstue Wallace

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
N. B.—Every item of information should be carefully supplied. AGE should be state EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Form V. S. No. 5. 10M. 6-20-11.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics
File No. 4195
Registered No. 18

1. PLACE OF DEATH.
County of Shoshone
City of Wallace

Registration District No. 28
Primary Registration District No. 1011-
(No. _____, _____ St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

Lorenz Bersano

If death occurred in a hospital, institution or camp give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX male 4. COLOR OR RACE white 5. SINGLE, MARRIED, WIDOWED OR DIVORCED. single
(Write the word.)

6. DATE OF BIRTH

(Month) _____ (Day) _____ (Year) 1

7. AGE

47 yrs. _____ mos. _____ ds. IF LESS than 1 day how many _____ hrs. or _____ min.

8. OCCUPATION

(a) Trade, profession or particular kind of work
(b) General nature of industry business or establishment in which employed (or employer)

cook

9. BIRTHPLACE

(State or Country)

Italy

10. NAME OF FATHER

Giovanni Bersano

11. BIRTHPLACE OF FATHER

(State or Country)

Italy

12. MAIDEN NAME OF MOTHER

Anna Pomicino

13. BIRTHPLACE OF MOTHER

(State or Country)

Italy

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

Joe Bersano

(Address)

15.

Filed 3/11913F. L. Quigley

Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

Feb 27 1913
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from _____ 191____, to _____ 191____

that I last saw h_____ alive on _____ 191____, and that death occurred on the date stated above, at _____ M.

The CAUSE OF DEATH was as follows:

Apoplexy Cerebrum

(Duration) _____ yrs. few mos. _____ ds.

Contributory (Secondary)

(Duration) _____ mos. _____ ds.

(Signed)

Mar 1 1913 (Address) Wallace

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and 2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place _____ In the _____ of death _____ yrs. _____ mos. _____ ds. State _____ yrs. _____ mos. _____ ds.

Where was disease contracted,

If not at place of death?

Former or

usual residence.

19. PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

WallaceMar 12 1913

20. UNDERTAKER

ADDRESS

Ward's Undertaking Co Wallace

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Form V. S. No. 5 20M.1-16-12

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH.

Registration District No. 28

County of Shoshone

Primary Registration District No. 1011

City of Wallace

(No. 425, Cedar Street St.)

File No. 4196

Registered No. 17

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Diana Moore

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX

female

4. COLOR OR RACE

white

5. SINGLE, MARRIED, WIDOWED OR DIVORCED.

widowed
(Write the word.)

6. DATE OF BIRTH

10 8 1886
(Month) (Day) (Year)

7. AGE

86 yrs. 4 mos. 17 ds.

IF LESS than 1 day
how many hrs. or mins.?

8. OCCUPATION

(a) Trade, profession or particular kind of work none
(b) General nature of industry, business, or establishment in which employed (or employer)

9. BIRTHPLACE

(State or Country) Ohio

10. NAME OF FATHER

Martin

11. BIRTHPLACE OF FATHER

not given

12. MAIDEN NAME OF MOTHER

" "

13. BIRTHPLACE OF MOTHER

" "

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Mrs D M Redding

(Address) Wallace, Idaho.

15.

Filed Feb 26, 1913

H. L. Smith
Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

2 25 1913
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from Jan 26 1913, to Feb 25 1913, that I last saw her alive on Feb 24 1913 and that death occurred on the date stated above, at 10 P. M.

The CAUSE OF DEATH* was as follows:

Myocarditis

(Duration) 20 yrs. mos. ds.

Contributory Lobar Pneumonia
(Secondary)

(Duration) yrs. mos. ds.

(Signed) Dr. Thowry D.

2-28-13. (Address) Wallace, Ida.

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death yrs. mos. days. In the State yrs. mos. days.

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL DATE OF BURIAL

Wallace, Idaho.

2/27- 1913

20. UNDERTAKER

Bruce G Norton Wallace.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Form V. S. No. 5 20M.1-16-12

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital StatisticsFile No. **4197**Registered No. **16**

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

1. PLACE OF DEATH

Registration District No. **28**County of **Shoshone**Primary Registration District No. **111**City of **Wallace**(No **Providence Hospital** St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME **Ehregott Brabandt**

PERSONAL AND STATISTICAL PARTICULARS

3. SEX

male

4. COLOR OR RACE

white

5. SINGLE, MARRIED, WIDOWED OR DIVORCED.

widower
(Write the word.)

6. DATE OF BIRTH

May 1839
(Month) (Day) (Year)

7. AGE

73 yrs. 9 mos. ds.

IF LESS than 1 day
how many hrs. or
mins.?

8. OCCUPATION

(a) Trade, profession or particular kind of work **Paloksmith**

(b) General nature of industry business, or establishment in which employed (or employer)

9. BIRTHPLACE

(State or Country) **Saxony, Germany.**

10. NAME OF FATHER

not given

11. BIRTHPLACE OF FATHER

" "

(State or Country)

12. MAIDEN NAME OF MOTHER

" "

13. BIRTHPLACE OF MOTHER

" "

(State or Country)

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

(Address)

15.

Filed

Feb 24

1913

F. Leo Jurek

Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

Feb. 24 1913
(Month) (Day) (Year)17. I HEREBY CERTIFY, That I attended deceased from **Feb 12** 1913, to **Feb 24** 1913that I last saw him alive on **Feb 23** 1913and that death occurred on the date stated above, at **8:00 PM**

The CAUSE OF DEATH* was as follows:

Septicemia(Duration) yrs. mos. ds.
Contributory **Shock & Traumatism**
(Secondary)(Duration) yrs. mos. ds.
(Signed) **D. H. Mowbray** M. D.2/24/1913. (Address) **Wallace, Idaho.**

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place **Providence Hosp** in the
of death yrs. mos. days. State yrs. mos. days.Where was disease contracted
if not at place of death?Former or
usual residence **Wallace, Idaho**

19. PLACE OF BURIAL OR REMOVAL

Wallace, Idaho

DATE OF BURIAL

Feb. 25 1913.

20. UNDERTAKER

ADDRESS

Bruce E. Mowbray **Wallace**

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
N. B.—Every item of information should be carefully supplied. AGE should be state EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Form V. S. No. 5. 10M. 6-20-11.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics
File No. **4198**
Registered No. **15**

1. PLACE OF DEATH.
County of **Shoshone**
City of **Wallace**

Registration District No. **28**
Primary Registration District No. **1011**
(No. _____, _____ St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

Lemora Byers

If death occurred in a hospital, institution or camp give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX **Female** 4. COLOR OR RACE **white** 5. SINGLE, MARRIED, WIDOWED OR DIVORCED. **single**

(Write the word)

6. DATE OF BIRTH

July 9 1913
(Month) (Day) (Year)

7. AGE

7 yrs. **7** mos. **—** ds. IF LESS than 1 day how many hrs. or min.?

8. OCCUPATION

- (a) Trade, profession or particular kind of work
(b) General nature of industry business or establishment in which employed (or employer)

9. BIRTHPLACE

(State or Country)

Idaho

10. NAME OF FATHER

Thomas Byers

11. BIRTHPLACE OF FATHER

(State or Country)

Mich

12. MAIDEN NAME OF MOTHER

Rose M. Deritt

13. BIRTHPLACE OF MOTHER

(State or Country)

Ireland

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

(Address)

15.

Filed **2/24** **1913**

1913

Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

Feb 22 1913
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from **Feb 20 1913** to **Feb 22 1913**

that I last saw **her** alive on **Feb 22 1913**

and that death occurred on the date stated above, at **10 P. M.**

The CAUSE OF DEATH* was as follows:

acute lobar pneumonia

(Duration) yrs. mos. ds.

Contributory (Secondary)

exposure

(Duration) yrs. mos. ds.

(Signed)

Feb 23 1913 (Address) **Wallace Ida**

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted.

If not at place of death?

Former or

usual residence.

19. PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

Wallace Ida

Feb 24 1913

20. UNDERTAKER

ADDRESS

Hard Undertaking Co Wallace Ida

A stillbirth must be registered both as a birth and death. The date of death should be the date of delivery and the death certificate should further state, if known, the cause of the stillbirth and the period of utero gestation in months.

STATEMENT OF OCCUPATION.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer, Physician, Stenographer, Composer, Architect, Locomotive engineer, Civil engineer, Stationary firemen*, etc. But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner*, (b) *Cotton mill*; (a) *Salesman*, (b) *Grocery*; (a) *Foreman*, (b) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification, as *Day laborer, Farm laborer, Laborer—Coal mine*, etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers*, who receive a definite salary), may be entered as *Housewife, Housework*, or *At home*, and children, not gainfully employed, as *At school* or *At home*. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer (retired, 6 yrs.)*. For persons who have no occupation whatever, write *None*.

STATEMENT OF CAUSE OF DEATH.—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebro-*

spinal fever (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid Pneumonia"); *Lobar pneumonia; Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritoneum*, etc., *Carcinoma, Sarcoma*, etc., of (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent affection need not be stated unless important. Example: *Measles* (disease causing death), 29 ds.; *Bronchopneumonia* (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "Asthenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility, (Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Haemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uraemia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify as "PUERPERAL septicemia", "PUERPERAL peritonitis," etc., all diseases resulting from childbirth or miscarriage. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning; Struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "Contributory."

2

6

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. N. B.—Every item of information should be carefully supplied. AGE should be state EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Form V. S. No. 6-20-11.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH.

Registration District No. 28

County of Shoshone

Primary Registration District No. 1

City of Wallace

(No. 1 Hope Hospital St.)

File No. 4199

Registered No. 17

If death occurs away from usual residence, give facts called for under special information.

If death occurred in a hospital, institution or camp give its NAME instead of street and number.

2. FULL NAME

Angelo Piva

PERSONAL AND STATISTICAL PARTICULARS

3. SEX

male

4. COLOR OR RACE

white

5. SINGLE, MARRIED, WIDOWED OR DIVORCED.

married
(Write the word.)

6. DATE OF BIRTH

(Month) (Day) (Year)

7. AGE

41 yrs. — mos. — ds.

IF LESS than 1 day
how many hrs. or
..... min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work

miner

(b) General nature of industry business or establishment in which employed (or employer)

9. BIRTHPLACE

(State or Country)

Italy

10. NAME OF FATHER

Giovanni Piva

11. BIRTHPLACE OF FATHER

(State or Country)

Italy

12. MAIDEN NAME OF MOTHER

La Via Marina

13. BIRTHPLACE OF MOTHER

(State or Country)

Italy

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Giachino Piva

(Address) Mullane Ida

15.

Filed Feb 19 1913

F. Lo Zuy ley

Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

Feb
(Month)17th
(Day)1913
(Year)

17. I HEREBY CERTIFY, That I attended deceased from

Feb 12 1913, to Feb 17 1913

that I last saw him alive on Feb 17 1913

and that death occurred on the date stated above, at 2:30 P.M.

The CAUSE OF DEATH* was as follows:

Bilateral Lobar Pneumonia

(Duration) yrs. mos. ds.

Contributory (Secondary)

(Duration) yrs. mos. ds.

(Signed) W. J. Smith M. D.

Feb 19 1913 (Address) Wallace, Ida

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death yrs. mos. ds. State yrs. mos. ds.

Where was disease contracted, If not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

Wallace

2/20 1913

20. UNDERTAKER

ADDRESS

Harris Undertaking Wallace, Ida

Form V. S. No. 5. 10M. 6-20-11.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH.

Registration District No. 28County of ShoshonePrimary Registration District No. 1211City of Wallace

(No. _____ St.)

File No. 4209Registered No. 121

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

Sophia Anderson

If death occurred in a hospital, institution or camp give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX

4. COLOR OR RACE 5. SINGLE, MARRIED, WIDOWED OR DIVORCED.

Femalewhite

(Write the word.)

6. DATE OF BIRTH

Feb.111849

(Month)

(Day)

(Year)

7. AGE

64

yrs.

mos.

ds.

IF LESS than 1 day
how many _____ hrs. or
_____ min.

8. OCCUPATION

- (a) Trade, profession or particular kind of work
(b) General nature of industry business or establishment in which employed (or employer)

Housewife

9. BIRTHPLACE

(State or Country)

Finland

10. NAME OF FATHER

Gabriel Asprinas

11. BIRTHPLACE OF FATHER

(State or Country)

Finland

12. MAIDEN NAME OF MOTHER

unknown

13. BIRTHPLACE OF MOTHER

(State or Country)

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

Victor Fredrickson

(Address)

Germ. Idaho

15.

Filed

Feb 131913T. L. Lempert

Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

Feb101913

(Month)

(Day)

(Year)

I HEREBY CERTIFY, That I attended deceased from

Feb 12 1912, to Feb 10 1913that I last saw her alive on Jan 15 1913and that death occurred on the date stated above, at 39 M.

The CAUSE OF DEATH* was as follows:

Carcinoma liver & stomach(Duration) _____ yrs. 6 mos. _____ ds.Contributory
(Secondary)

(Duration) _____ yrs. _____ mos. _____ ds.

(Signed)

Feb 121913

(Address)

Dr. Mowery M.D. Wallace Id.

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death _____ yrs. _____ mos. _____ ds. In the State _____ yrs. _____ mos. _____ ds.

Where was disease contracted.

If not at place of death?

Former or

usual residence.

19. PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

WallaceIdahoFeb 131913

20. UNDERTAKER

ADDRESS

Ward Undertaking Co. Wallace Id.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
N. B.—Every item of information should be carefully supplied. AGE should be state EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Form V. S. No. 5. 10M. 6-20-11.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics
File No. 1201
Registered No. 11
If death occurred in a hospital, institution or camp give its NAME instead of street and number.

1. PLACE OF DEATH.

Registration District No. 28

County of Shoshone

Primary Registration District No. 1011

City of Wallace

(No. 1 Hospital St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

Fanny Baker

PERSONAL AND STATISTICAL PARTICULARS

3. SEX

4. COLOR OR RACE 5. SINGLE, MARRIED, WIDOWED OR DIVORCED.

(Write the word.)

6. DATE OF BIRTH

16 Dec 1913
(Month) (Day) (Year)

7. AGE

34 yrs. — mos. — ds. IF LESS than 1 day how many.....hrs. or min.

8. OCCUPATION

- (a) Trade, profession or particular kind of work
(b) General nature of industry business or establishment in which employed (or employer)

Homestead

9. BIRTHPLACE

(State or Country)

Kansas

10. NAME OF FATHER

Samuel Baker

11. BIRTHPLACE OF FATHER

(State or Country)

unknown

12. MAIDEN NAME OF MOTHER

unknown

13. BIRTHPLACE OF MOTHER

(State or Country)

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

(Address)

Peter E. Gyle
Kellogg, Idaho

15.

Filed

Feb 10, 1913 F. L. Loewig

Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

Feb 8 1913
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from

Jan 24 1913, to Feb 8 1913
that I last saw her alive on Feb 8 1913

and that death occurred on the date stated above, at 9:30 P.M.

The CAUSE OF DEATH* was as follows:

Pulmonary Tuberculosis

(Duration) Not known mos.

Contributory (Secondary)

(Duration) yrs. — mos. — ds.

(Signed) M. D.

Feb 10 1913 (Address) Wallace, Ida

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death.....yrs.....mos.....ds. State.....yrs.....mos.....ds.

Where was disease contracted.

If not at place of death?

Former or usual residence.

19. PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

C. Rathbun Feb 13 1913

20. UNDERTAKER

ADDRESS

Sumner Beck Council Bluffs city

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Form V. S. No. 5 20M.1-16-12

CERTIFICATE OF DEATH

1. PLACE OF DEATH

Registration District No. 28

County of Shoshone

Primary Registration District No. 1011

City of Wallace

(No. Providence Hospital St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Nicholas Cunningham,

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

File No. 4202

Registered No. 12

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX

male

4. COLOR OR RACE

white

5. SINGLE, MARRIED, WIDOWED OR DIVORCED.

widowed

(Write the word.)

6. DATE OF BIRTH

8 12 1855
(Month) (Day) (Year)

7. AGE

57 yrs. 5 mos. 25 ds.

IF LESS than 1 day
how many hrs. or mins.?

8. OCCUPATION

(a) Trade, profession or particular kind of work Blacksmith
(b) General nature of industry, business, or establishment in which employed (or employer)

9. BIRTHPLACE

(State or Country) Ovid, New York

10. NAME OF FATHER

Michael Cunningham

11. BIRTHPLACE OF FATHER

(State or Country) Ireland

12. MAIDEN NAME OF MOTHER

Catherine Murray

13. BIRTHPLACE OF MOTHER

(State or Country) Ireland

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Mrs. O. L. Bourne

(Address) Amarillo, Texas

15.

Filed Feb. 10, 1915 Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

2 7 1913
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from

Sept 2, 1912 to Feb 7, 1913

that I last saw him alive on Feb 7, 1913

and that death occurred on the date stated above, at 1 P. M.

The CAUSE OF DEATH* was as follows:

Sepsis Prostrate gland
(Duration) yrs. 6 mos. ds.

Contributory (Secondary)

(Duration) yrs. mos. ds.

(Signed) Dr. M. M. M. D.

2/8 1913. (Address) Wallace, Idaho.

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions,

Transients or Recent Residents.)

Providence Hospital

At place of death. yrs. mos. days. In the State. yrs. mos. days.

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL DATE OF BURIAL

Wallace, Idaho 2 / 10 1913

20. UNDERTAKER ADDRESS

Bruce E. Norstee Wallace

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Form V. S. No. 5 20M.1-16-12

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics
File No. **4203**

1. PLACE OF DEATH

Registration District No. **28**

County of **Shoshone**

Primary Registration District No. **1011-**

City of **Wallace**

(No. _____, _____ St.)

Registered No. **13**

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME **F. J. Matchette**

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX

male

4. COLOR OR RACE

white

5. SINGLE, MARRIED, WIDOWED OR DIVORCED.

single
(Write the word.)

6. DATE OF BIRTH

3 (Month) **10** (Day) **1882** (Year)

7. AGE

30 yrs. **10** mos. **2** ds.

IF LESS than 1 day
how many _____ hrs. or
_____ mins.?

8. OCCUPATION

(a) Trade, profession or particular kind of work **Clerk or Salesman**

(b) General nature of industry business, or establishment in which employed (or employer) **Correspondence School**

9. BIRTHPLACE

(State or Country) **Illinois**

10. NAME OF FATHER

John Matchette

11. BIRTHPLACE OF FATHER

Ireland

(State or Country)

12. MAIDEN NAME OF MOTHER

Sarah Regan

13. BIRTHPLACE OF MOTHER

Wisconsin

(State or Country)

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) **Mrs. John Matchette**

(Address) **Spokane Wash.**

15.

Filed **Feb. 13**, 191**3**

F. L. Quigley
Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

2 (Month) **12** (Day) **1913** (Year)

17. I HEREBY CERTIFY, That I attended deceased from **Jan 20**, 191**3**, to **Feb 12**, 191**3**, that I last saw him alive on **Feb 12**, 191**3**, and that death occurred on the date stated above, at **6 P. M.**

The CAUSE OF DEATH* was as follows:

Peritonitis
Perforation bowel due to typhoid fever
(Duration) _____ yrs. _____ mos. _____ ds.
Contributory (Secondary) _____
(Duration) _____ yrs. _____ mos. _____ ds.

(Signed) **Dr. Mowery** M. D.
Feb 13 1913 (Address) **Wallace, Idaho.**

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death **Providence Hospital**
0 yrs. **0** mos. **12** days. State _____ yrs. _____ mos. _____ days.

Where was disease contracted if not at place of death?

Former or usual residence **Wallace, Idaho.**

19. PLACE OF BURIAL OR REMOVAL

Spokane, Wash.

DATE OF BURIAL

3/14, 191**3**

20. UNDERTAKER

Bruce S. Masters **Wallace, Idaho**

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Form V. S. No. 5. 12½ M. 7-24-11

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics
File No. 4204
Registered No. 15

1. PLACE OF DEATH. Registration District No. 24
County of Bear Lake Primary Registration District No. 2695
City of Montpelier (No. St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

Laura Nelson

If death occurred in a hospital, institution or camp give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX 4. COLOR OR RACE 5. SINGLE, MARRIED, WIDOWED OR DIVORCED.

Girl White (Write the word.)

6. DATE OF BIRTH September 13 1912
(Month) (Day) (Year)

7. AGE IF LESS than 1 day
yrs. mos. 5 ds. 9 how many hrs. or min?

8. OCCUPATION

- (a) Trade, profession or particular kind of work.
(b) General nature of industry business or establishment in which employed (or employer)

9. BIRTHPLACE

(State or Country) Harmon Bear Lake, Id.

10. NAME OF FATHER

Heik Nelson

11. BIRTHPLACE OF FATHER

(State or Country) Montpelier

12. MAIDEN NAME OF MOTHER

Beane Jensen

13. BIRTHPLACE OF MOTHER

(State or Country) Denmark

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) L. E. Jensen
(Address) Montpelier

15.

Filed 3-4-1913 J. W. Humphreys
Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH Feb 22 1913
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from Feb 22 1913, to Feb 22 1913 that I last saw her alive on Feb 22 1913 and that death occurred on the date stated above, at 6 P. M.
The CAUSE OF DEATH* was as follows:
Pneumonia

(Duration) yrs. mos. ds.

Contributory (Secondary)

(Duration) yrs. mos. ds.
(Signed) C. H. Anderson M. D.
Feb 23 1913 (Address) Montpelier

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place In the
of death yrs. mos. ds. State yrs. mos. ds.
Where was disease contracted,
If not at place of death?
Former or
usual residence.

19. PLACE OF BURIAL OR REMOVAL DATE OF BURIAL

Harmon 2-24-1913
20. UNDERTAKER ADDRESS

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. PHYSICIANS should be carefully supplied. AGE should be stated EXACTLY. Exact state-
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. Exact state-
CIANS could state CAUSE OF DEATH in plain terms, so that it may be properly classified. ment of OCCUPATION is very important. See instructions on back of certificate.

Form V. S. No. 5. 12½ 7-24-11

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics
File No. **4205**
Registered No. **10**

1. PLACE OF DEATH. Registration District No. **24**
County of **Bear River** Primary Registration District No. **2098**
City of **Montpelier** (No. _____, St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

John Hillman Barnes

If death occurred in a hospital, institution or camp give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX **Male** 4. COLOR OR RACE **White** 5. SINGLE, MARRIED, WIDOWED OR DIVORCED. **Married** (word.)

6. DATE OF BIRTH **October 4** 19**56**
(Month) (Day) (Year)

7. AGE **52 yrs. 4 mos. 14 ds.** IF LESS than 1 day how many _____ hrs. or _____ min?

8. OCCUPATION

(a) Trade, profession or particular kind of work
(b) General nature of industry business or establishment in which employed (or employer)

Stationary Engineer
P. S. Shop

9. BIRTHPLACE
(State or Country)

South Wales

10. NAME OF FATHER

James I. Barnes

11. BIRTHPLACE OF FATHER
(State or Country)

England

12. MAIDEN NAME OF MOTHER

Prudence Hillman

13. BIRTHPLACE OF MOTHER
(State or Country)

England

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) **G. G. Christensen**

15.

Filed **3-4-1913**

Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH **July 17** 19**13**
(Month) (Day) (Year)

17. I HEREBY CERTIFY That I attended deceased from **Sept-15** 19**13**, to **July 17** 19**13** that I last saw him alive on **17th July** 19**13** and that death occurred on the date stated above at **12:40 PM**.

The CAUSE OF DEATH* was as follows:

Circumstances of Death

(Duration) _____ yrs. _____ mos. _____ ds.
Contributory (Secondary)

(Duration) _____ yrs. _____ mos. _____ ds.
(Signed) **Ed M. Russell** M. D.
2-18-1913 (Address) **Montpelier Idaho**

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place _____ In the _____
of death _____ yrs. _____ mos. _____ ds. State _____ yrs. _____ mos. _____ ds.
Where was disease contracted,
If not at place of death?
Former or
usual residence _____

19. PLACE OF BURIAL OR REMOVAL DATE OF BURIAL

Idaho Falls 19**13**

20. UNDERTAKER ADDRESS

Ed M. Russell **Pocatello Ida.**

Reg. Emb. #105

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Form V. S. No. 5. 12½ M. 7-24-11

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH. Registration District No. 24
County of Beauregard Primary Registration District No. 2098
City of Montpelier (No. 20, St.)

File No. 4206
Registered No. 12

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

Clara Robinson

If death occurred in a hospital, institution or camp give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX Male 4. COLOR OR RACE white 5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.)

6. DATE OF BIRTH

June 11 1912
(Month) (Day) (Year)

7. AGE

7 yrs. 7 mos. 21 ds. IF LESS than 1 day how many hrs. or min?

8. OCCUPATION

(a) Trade, profession or particular kind of work.
(b) General nature of industry business or establishment in which employed (or employer)

None

9. BIRTHPLACE

(State or Country)

Idaho

10. NAME OF FATHER

Char Robinson

11. BIRTHPLACE OF FATHER

(State or Country)

Utah

12. MAIDEN NAME OF MOTHER

Core Passey

13. BIRTHPLACE OF MOTHER

(State or Country)

Idaho

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

(Address)

Char Robinson

15.

Filed 3-4- 1913 Justusward
Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH

Feb 4 1913
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from

Feb 2 1913, to Feb 4 1913
that I last saw him alive on Feb 3 1913

and that death occurred on the date stated above, at 99 M.

The CAUSE OF DEATH* was as follows:

Pneumonia (Bacterial)

(Duration) yrs. mos. ds.

Contributory (Secondary)

(Duration) yrs. mos. ds.

(Signed) Chas Robinson M. D.
Feb 4 1913 (Address) Montpelier

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place 7 In the
of death yrs. mos. ds. State yrs. mos. ds.

Where was disease contracted,

If not at place of death?

Former or

usual residence.

19. PLACE OF BURIAL OR REMOVAL DATE OF BURIAL

Montpelier Feb 5 1913

20. UNDERTAKER ADDRESS

none

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Form V. S. No. 5. 12½ M. 7-24-11

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics
File No. 1201
Registered No. 9

1. PLACE OF DEATH. Registration District No. 24
County of Bear Lake Primary Registration District No. 2094
City of Pocatello (No. , St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Bodelia Maria Jensen

If death occurred in a hospital, institution or camp give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX F. 4. COLOR OR RACE W. 5. SINGLE, MARRIED, WIDOWED OR DIVORCED. Widow (Write the word.)

6. DATE OF BIRTH July 8 1839 (Month) (Day) (Year)

7. AGE 72 yrs. 7 mos. 20 ds. IF LESS than 1 day how many hrs. or min?

8. OCCUPATION (a) Trade, profession or particular kind of work. Housewife (b) General nature of industry business or establishment in which employed (or employer)

9. BIRTHPLACE (State or Country) Denmark

10. NAME OF FATHER Ole Jacobsen

11. BIRTHPLACE OF FATHER Denmark (State or Country)

12. MAIDEN NAME OF MOTHER Annie Paulson

13. BIRTHPLACE OF MOTHER Denmark (State or Country)

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE (Informant) L. P. Jensen (Address) Pocatello Ida

15. Mar 1 1913 J. W. Hayward Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH Feb 28 1913 (Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from 191 to 191 that I last saw h alive on 191 and that death occurred on the date stated above, at M. The CAUSE OF DEATH* was as follows:

They had no physician had been sick until few hours before death, health failing (Duration) yrs. mos. ds. Contributory (Secondary) Scivility (Duration) yrs. mos. ds. (Signed) J. W. Hayward M. D. Mar 1 1913 (Address) Pocatello Ida

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; (2) whether ACCIDENTAL, SUICIDAL OR HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place In the of death yrs. mos. ds. State yrs. mos. ds. Where was disease contracted, If not at place of death? Former or usual residence.

19. PLACE OF BURIAL OR REMOVAL DATE OF BURIAL Pocatello Ida Mar 3 1913

20. UNDERTAKER ADDRESS C. Lindsey Bp Pocatello Ida

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. MARGIN RESERVED FOR BINDING

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Form V. S. No. 5. 12½ M. 7-24-11

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics
File No. 4208
Registered No. 11

1. PLACE OF DEATH. Registration District No. 24
County of Ben Lake Primary Registration District No. 2091
City of Bloomington (No. _____, _____ St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Elizabeth Mary Jane Madsen

If death occurred in a hospital, institution or camp give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX _____ 4. COLOR OR RACE _____ 5. SINGLE, MARRIED, WIDOWED OR DIVORCED. _____

(Write the word.)

6. DATE OF BIRTH Feb. 19 1854
(Month) (Day) (Year)

7. AGE (1 day less than 59 yrs) IF LESS than 1 day
58 yrs. 11 mos. 29 ds. how many _____ hrs. or _____ min?

8. OCCUPATION

(a) Trade, profession or particular kind of work. Housewife
(b) General nature of industry business or establishment in which employed (or employer) _____

9. BIRTHPLACE

(State or Country) Utah

10. NAME OF FATHER

Thomas B. Nelson

11. BIRTHPLACE OF FATHER

(State or Country) Illinois

12. MAIDEN NAME OF MOTHER

Mary C. Welker

13. BIRTHPLACE OF MOTHER

(State or Country) Ohio

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Elmer Madsen
(Address) Bloomington

15.

Filed 3-4-1913 J. W. Hayward
Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH Feb. 18 1913
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from Sept. 12 1912, to Feb 18 1913
that I last saw h. alive on Feb 18 1913
and that death occurred on the date stated above, at 1:35 P. M.

The CAUSE OF DEATH* was as follows:

Chronic Valvular Heart disease

3 (Duration) 3 yrs. 15 mos. 15 ds.

Contributory Influenza, Bronchitis, Nephritis
(Secondary)

(Duration) 15 yrs. 15 mos. 15 ds.
(Signed) L. A. Hottel M. D.
Feb. 20 1913 (Address) Bloomington

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place _____ In the _____
of death _____ yrs. _____ mos. _____ ds. State _____ yrs. _____ mos. _____ ds.
Where was disease contracted, _____
If not at place of death? _____
Former or _____
usual residence _____

19. PLACE OF BURIAL OR REMOVAL DATE OF BURIAL

Bloomington 2-21 1913

20. UNDERTAKER ADDRESS

none

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Form V. S. No. 5. 12½ M. 7-24-11

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics
File No. 4209

1. PLACE OF DEATH Registration District No. 24
County of Blaine Lake Primary Registration District No. 2091
City of Bloomington (No. St.)

Registered No. 13

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Mary Pressa Christensen

If death occurred in a hospital, institution or camp give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX F 4. COLOR OR RACE W 5. SINGLE, MARRIED, WIDOWED OR DIVORCED. Married

6. DATE OF BIRTH June 22 1894
(Month) (Day) (Year)

7. AGE 78 yrs. 7 mos. 16 ds. IF LESS than 1 day how many hrs. or min?

8. OCCUPATION (a) Trade, profession or particular kind of work... Housewife (b) General nature of industry business or establishment in which employed (or employer)

9. BIRTHPLACE (State or Country) Denmark

10. NAME OF FATHER Myers

11. BIRTHPLACE OF FATHER (State or Country) Denmark

12. MAIDEN NAME OF MOTHER Don't know

13. BIRTHPLACE OF MOTHER (State or Country) Denmark

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE (Informant) A. O. Christensen (Address)

15. Filed Feb 10 1913 J. H. Hayward Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH Feb 8 1913
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from Jan 20 1913, to Feb 8 1913 that I last saw her alive on Feb 2 1913 and that death occurred on the date stated above, at 2 A.M. The CAUSE OF DEATH* was as follows:

Chronic Parenchymatous Nephritis
(Duration) 3 yrs. mos. ds.
Contributory (Secondary) Scurvy
(Duration) yrs. mos. ds.
(Signed) J. H. Hayward M. D.
2-10 1913 (Address) Paris, Ida

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place In the of death yrs. mos. ds. State yrs. mos. ds. Where was disease contracted, If not at place of death? Former or usual residence.

19. PLACE OF BURIAL OR REMOVAL DATE OF BURIAL Bloomington Ida Feb 11 1913

20. UNDERTAKER ADDRESS Alma Findley Bp Bloomington Ida

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Form V. S. No. 5. 12½ M. 7-24-11

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics
File No. 1210
Registered No. 14

1. PLACE OF DEATH. Registration District No. 2090 24
County of Bear Lake Primary Registration District No. 2090
City of St. Charles (No. St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

Lars Larson

If death occurred in a hospital, institution or camp give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX M. 4. COLOR OR RACE White 5. SINGLE, MARRIED, WIDOWED OR DIVORCED. married
(Write the word.)

6. DATE OF BIRTH July 17 1895
(Month) (Day) (Year)

7. AGE 77 yrs. 7 mos. 19 ds. IF LESS than 1 day how many hrs. or min?

8. OCCUPATION

(a) Trade, profession or particular kind of work. Farmer
(b) General nature of industry business or establishment in which employed (or employer)

9. BIRTHPLACE

(State or Country) Denmark

10. NAME OF FATHER

Lars Nielson

11. BIRTHPLACE OF FATHER

(State or Country) Denmark

12. MAIDEN NAME OF MOTHER

Kirsten Michelson

13. BIRTHPLACE OF MOTHER

(State or Country) Denmark

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Thomas Pugmire
(Address) St. Charles

15.

Filed Feb 9 1913 J. H. Hayward
Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH Feb 6 1913
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from Jan 15 1913, to Feb 6 1913 that I last saw him alive on Feb 1 1913 and that death occurred on the date stated above, at 4 P. M.

The CAUSE OF DEATH* was as follows:

Lagrippe

(Duration) yrs. mos. 21 ds.

Contributory (Secondary)

Senility

(Duration) yrs. mos. ds.

(Signed)

M. D.

Feb 9 1913 (Address) J. H. Hayward

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place In the
of death yrs. mos. ds. State yrs. mos. ds.
Where was disease contracted,
If not at place of death?
Former or usual residence.

19. PLACE OF BURIAL OR REMOVAL DATE OF BURIAL
St. Charles Feb 10 1913

20. UNDERTAKER

ADDRESS

Th. Pugmire St. Charles

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Form V. S. No. 5. 10M. 6-20-11.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics
File No. 4213

1. PLACE OF DEATH.
County of Bannock
City of Hatch

Registration District No. 11
Primary Registration District No. 2048
(No. _____, St.)

Registered No. 13

If death occurs away from usual residence, give facts called for under special information.

If death occurred in a hospital, institution or camp give its NAME instead of street and number.

2. FULL NAME

Oreon Parkin Higginson

PERSONAL AND STATISTICAL PARTICULARS

3. SEX M 4. COLOR OR RACE W 5. SINGLE, MARRIED, WIDOWED OR DIVORCED.
(Write the word.) Single

6. DATE OF BIRTH Feb 8 1911
(Month) (Day) (Year)

7. AGE 2 yrs. 2 mos. 2 ds. IF LESS than 1 day how many 2 hrs. or 2 min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work none
(b) General nature of industry business or establishment in which employed (or employer)

9. BIRTHPLACE Hatch
(State or Country)

10. NAME OF FATHER Thomas Higginson

11. BIRTHPLACE OF FATHER Utah
(State or Country)

12. MAIDEN NAME OF MOTHER Mina Drtton

13. BIRTHPLACE OF MOTHER Utah
(State or Country)

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Thos. Higginson
(Address) Hatch, Ida

15. Filed Feb 10, 1913 Elin Kurey
Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH Feb 10 1913
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from Feb 7 1913, to Feb 10 1913 that I last saw him alive on Feb 10 1913 and that death occurred on the date stated above, at 2:25 P.M.

The CAUSE OF DEATH* was as follows:

Asthma

(Duration) yrs. mos. ds.
Contributory (Secondary) Septicemia from uricelias.
(Duration) yrs. mos. ds.
(Signed) Russell Smith M. D.
2/10/13 (Address) Bauer St

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death. yrs. mos. ds. State. yrs. mos. ds.
Where was disease contracted, If not at place of death? Former or usual residence.

19. PLACE OF BURIAL OR REMOVAL Chubbuck, Ida DATE OF BURIAL Feb 13, 1913

20. UNDERTAKER B. J. Lunsford ADDRESS Chubbuck

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Form V. S. No. 5. 10M. 6-20-11.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics
File No. 4214

1. PLACE OF DEATH.
County of Bannock
City of Turner

Registration District No. 11
Primary Registration District No. 2048
(No. _____, St.)

Registered No. 12

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

Raymon McCann

If death occurred in a hospital, institution or camp give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX m 4. COLOR OR RACE w 5. SINGLE, MARRIED, WIDOWED OR DIVORCED.
single
(Write the word.)

6. DATE OF BIRTH Oct 2 1911
(Month) (Day) (Year)

7. AGE 1 yrs. 4 mos. 26 ds. IF LESS than 1 day
how many hrs. or
..... min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work
(b) General nature of industry business or establishment in which employed (or employer)

9. BIRTHPLACE Turner, Ida
(State or Country)

10. NAME OF FATHER Brigham McCann

11. BIRTHPLACE OF FATHER Utah
(State or Country)

12. MAIDEN NAME OF MOTHER Nora Egbert

13. BIRTHPLACE OF MOTHER Utah
(State or Country)

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) J. J. McCann
(Address) Turner, Ida

15.

Filed Mar 10, 1913 Edith K. Cary
Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH Feb 28 1913
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from Feb 10 1913, to Feb 28 1913

that I last saw him alive on Feb 28 1913, and that death occurred on the date stated above, at 5:30 P. M.

The CAUSE OF DEATH was as follows:

Asbestosis

(Duration) yrs. mos. ds.
Contributory Bronchopneumonia
(Secondary)

(Duration) yrs. mos. 21 ds.
(Signed) R. J. Smith M. D.
Mar 2 1913 (Address) Bannock, Ida

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death yrs. mos. ds. State yrs. mos. ds.
Where was disease contracted,
If not at place of death?
Former or usual residence

19. PLACE OF BURIAL OR REMOVAL Turner, Idaho DATE OF BURIAL Mar 1, 1913

20. UNDERTAKER J. J. Smith ADDRESS Bannock

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
N. B.—Every item of information should be carefully supplied. AGE should be state EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Form V. S. No. 5. 10M. 6-20-11.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics
File No. 4215
Registered No. 11

1. PLACE OF DEATH.

Registration District No. 11

County of Bannock

Primary Registration District No. 2048

City of Grace

(No. _____, _____ St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

Maebel Joseph

If death occurred in a hospital, institution or camp give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX

4. COLOR OR RACE

5. SINGLE, MARRIED, WIDOWED OR DIVORCED.

6. DATE OF BIRTH

7. AGE

IF LESS than 1 day
how many _____ hrs. or
_____ min.

8. OCCUPATION

- (a) Trade, profession or particular kind of work
(b) General nature of industry business or establishment in which employed (or employer)

9. BIRTHPLACE

(State or Country)

10. NAME OF FATHER

11. BIRTHPLACE OF FATHER

(State or Country)

12. MAIDEN NAME OF MOTHER

13. BIRTHPLACE OF MOTHER

(State or Country)

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

(Address)

15.

Filed March 10 1913

Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

17. I HEREBY CERTIFY, That I attended deceased from

Feb 10 1913, to March 8 1913

that I last saw her alive on March 7 1913

and that death occurred on the date stated above, at 99 M.

The CAUSE OF DEATH* was as follows:

Valvular Heart Disease
(Mitral)

(Duration) _____ yrs. _____ mos. _____ ds.

Contributory (Secondary)

(Duration) _____ yrs. _____ mos. _____ ds.

(Signed) Edis Kasey M. D.

March 16 1913 (Address) Snake Springs

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place _____ yrs. _____ mos. _____ ds. In the _____ yrs. _____ mos. _____ ds.

Where was disease contracted,

If not at place of death?

Former or

usual residence.

19. PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

Grace

March 12 1913

20. UNDERTAKER

ADDRESS

P. P. Babson

Grace
Idaho

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
N. B.—Every item of information should be carefully supplied. AGE should be state EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Form V. S. No. 5. 10M. 6-20-11.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics
File No. 4215
Registered No. 10

1. PLACE OF DEATH.

Registration District No. 11

County of Bannock

Primary Registration District No. 2048

City of Shoshone

(No. , St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Don't Know

If death occurred in a hospital, institution or camp give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX

4. COLOR OR RACE

5. SINGLE, MARRIED, WIDOWED OR DIVORCED.

6. DATE OF BIRTH

7. AGE

IF LESS than 1 day how many hrs. or min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work
(b) General nature of industry business or establishment in which employed (or employer)

9. BIRTHPLACE

(State or Country)

10. NAME OF FATHER

11. BIRTHPLACE OF FATHER

(State or Country)

12. MAIDEN NAME OF MOTHER

13. BIRTHPLACE OF MOTHER

(State or Country)

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

(Address)

15.

Filed

March 10, 1913

Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

17. I HEREBY CERTIFY, That I attended deceased from

Feb 24 1913, to Feb 24 1913

that I last saw him alive on Feb 24 1913

and that death occurred on the date stated above, at 8 P. M.

The CAUSE OF DEATH* was as follows:

Pneumonia, Labor

Contributory (Secondary)

(Signed) Elis Karsley M. D.

Feb 24 1913 (Address) Elis Karsley

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death yrs mos ds. State yrs mos ds.

Where was disease contracted, If not at place of death? Former or usual residence

19. PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

Burial, 2d Feb 26 1913

20. UNDERTAKER

ADDRESS

W. M. Walker Burial

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Form V. S. No. 5. 10M. 6-20-11.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH. Registration District No. 1
County of Bannock Primary Registration District No. 2048
City of Banarft (No. _____, St.)

File No. 1217Registered No. 9

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

Jacob Schneider

If death occurred in a hospital, institution or camp give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX M 4. COLOR OR RACE W 5. SINGLE, MARRIED, WIDOWED OR DIVORCED.
married
(Write the word.)

6. DATE OF BIRTH Sept 20 1849
(Month) (Day) (Year)

7. AGE 63 yrs. 4 mos. 17 ds. IF LESS than 1 day how many... hrs. or min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work
(b) General nature of industry business or establishment in which employed (or employer)

Storekeeper
General merchandise

9. BIRTHPLACE

(State or Country)

Germany

10. NAME OF FATHER

Simon Schneider

11. BIRTHPLACE OF FATHER

(State or Country)

Germany

12. MAIDEN NAME OF MOTHER

Nickolina Bierman

13. BIRTHPLACE OF MOTHER

(State or Country)

Germany

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

(Address)

Mrs. Jacob Schneider
Banarft, Ida

15.

Filed March 10, 1913

Ellis Kastle
Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

Feb 6 1913
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from Feb 1 1913, to Feb 6 1913

that I last saw him alive on Feb 5 1913

and that death occurred on the date stated above, at 5 P. M.

The CAUSE OF DEATH* was as follows:

Asthma

(Duration) 3 mos. 3 ds.
Contributory (Secondary) Mitral Regurgitation

(Signed) Russell Smith M.D.
Feb 17 1913 (Address) Banarft, Ida

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death... yrs... mos... ds. State... yrs... mos... ds.

Where was disease contracted.

If not at place of death?...

Former or

usual residence.

19. PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

LinnFeb 8, 1913

20. UNDERTAKER

ADDRESS

Jacob JensenBanarft

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. N. B.—Every item of information should be carefully supplied. AGE should be state EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Form V. S. No. 5. 10M. 6-20-11.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics
File No. 4218

1. PLACE OF DEATH. Registration District No. 11
County of Bennett Primary Registration District No. 2048
City of Soda Springs (No. _____, _____ St.)

Registered No. 8

If death occurs away from usual residence, give facts called for under special information.

If death occurred in a hospital, institution or camp give its NAME instead of street and number.

2. FULL NAME Eli Morgan +

PERSONAL AND STATISTICAL PARTICULARS

3. SEX M 4. COLOR OR RACE W 5. SINGLE, MARRIED, WIDOWED OR DIVORCED. Single
(Write the word.)

6. DATE OF BIRTH Don't Know
(Month) (Day) (Year)

7. AGE 89 yrs. — mos. — ds. IF LESS than 1 day how many hrs. or min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work Rancher
(b) General nature of industry business or establishment in which employed (or employer)

9. BIRTHPLACE

(State or Country) Iowa

10. NAME OF FATHER

Don't Know

11. BIRTHPLACE OF FATHER

(State or Country) Don't Know

12. MAIDEN NAME OF MOTHER

Don't Know

13. BIRTHPLACE OF MOTHER

(State or Country) Don't Know

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Peter Lund(Address) Soda Springs, Id.

15.

Filed March 14, 1913 Eli Kaeley

Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

Feb 16 1913
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from Feb 2, 1913, to Feb. 16, 1913

that I last saw him alive on Feb 16, 1913, and that death occurred on the date stated above, at 5 P M.

The CAUSE OF DEATH* was as follows:

Chronic Nephritis

(Duration) 2 yrs. — mos. — ds.
Contributory (Secondary) none

(Duration) — yrs. — mos. — ds.
(Signed) Eli Kaeley M. D.
March 19, 1913 (Address) Soda Springs

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death — yrs. — mos. — ds. In the State — yrs. — mos. — ds.
Where was disease contracted.
If not at place of death?
Former or usual residence.

19. PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

Burlington Iowa Feb 25 1913

20. UNDERTAKER

ADDRESS

E. D. Whelan Soda Springs

X But little was known of deceased, lived alone - no relatives in this country

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Form V. S. No. 5. 12½ M. 7-24-11

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics
File No. 4219
Registered No. 9

1. PLACE OF DEATH.
County of Cassia
City of Burley

Registration District No. 31
Primary Registration District No. 21st
(No. _____, _____ St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

Mary Bell

If death occurred in a hospital, institution or camp give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX Female 4. COLOR OR RACE White 5. SINGLE, MARRIED, WIDOWED OR DIVORCED. Married

6. DATE OF BIRTH Nov. 4 1860
(Month) (Day) (Year)

7. AGE 52 yrs. 3 mos. 6 ds. IF LESS than 1 day how many _____ hrs. or _____ min?

8. OCCUPATION

(a) Trade, profession or particular kind of work
(b) General nature of industry business or establishment in which employed (or employer)

Housewife

9. BIRTHPLACE

(State or Country)

Utah

10. NAME OF FATHER

Isiah Huntman

11. BIRTHPLACE OF FATHER

(State or Country)

Unknown

12. MAIDEN NAME OF MOTHER

Emma King

13. BIRTHPLACE OF MOTHER

(State or Country)

Unknown

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

(Address)

M. H. Bell
Burley

15.

Filed 3-11 1913

3

A. B. Buckley
Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH

Feb. 9th 1913
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from Oct. 1st 1911, to Feb. 9th 1913

that I last saw him alive on Feb. 4th 1913

and that death occurred on the date stated above, at 2:30 P.M.

The CAUSE OF DEATH* was as follows:

Cancer of Uterus

(Duration) 2 yrs. 6 mos. ds.

Contributory (Secondary)

(Duration) 7 yrs. mos. ds.

(Signed) J. C. Patterson M. D.

Feb. 10 1913 (Address) Burley, Idaho

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death _____ yrs. _____ mos. _____ ds. State _____ yrs. _____ mos. _____ ds.

Where was disease contracted,

If not at place of death?

Former or

usual residence.

19. PLACE OF BURIAL OR REMOVAL DATE OF BURIAL

Burley, Idaho 2-11 1913

20. UNDERTAKER ADDRESS

L. B. Bell

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFAADING INK—THIS IS A PERMANENT RECORD.
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIAN should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Form V. S. No. 5. 12-14-11

CERTIFICATE OF DEATH

1. PLACE OF DEATH.
County of Cassia
City of Burley

Registration District No. 31
Primary Registration District No. 21st
(No. _____, _____ St.)

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics
File No. 4220
Registered No. 8

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME George Andrew Black

If death occurred in a hospital, institution or camp give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX Male 4. COLOR OR RACE white 5. SINGLE, MARRIED, WIDOWED OR DIVORCED. Widowed
(Write the word.)

6. DATE OF BIRTH May 19 1881
(Month) (Day) (Year)

7. AGE 81 yrs. 8 mos. 13 ds. IF LESS than 1 day how many _____ hrs. or _____ min?

8. OCCUPATION
(a) Trade, profession or particular kind of work. Farmer
(b) General nature of industry business or establishment in which employed (or employer).

9. BIRTHPLACE
(State or Country) Germany

10. NAME OF FATHER Andrew Black

11. BIRTHPLACE OF FATHER
(State or Country) Germany

12. MAIDEN NAME OF MOTHER Unknown

13. BIRTHPLACE OF MOTHER
(State or Country) Germany

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) W. G. Cole
(Address) Burley, Idaho

15. Feb 13 1913
Filed 1913

Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH February 1 1913
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from Jan 25 1913, to Jan 26 1913 that I last saw him alive on Jan 25 1913 and that death occurred on the date stated above, at 11 P. M.

The CAUSE OF DEATH* was as follows:

Heart failure

(Duration) 81 yrs. 8 mos. 13 ds.

Contributory (Secondary)

(Duration) 81 yrs. 8 mos. 13 ds.
(Signed) John M. Minter, M. D.
Feb 3 1913 (Address) Burley, Idaho

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death _____ yrs. _____ mos. _____ ds. In the _____ State _____ yrs. _____ mos. _____ ds.
Where was disease contracted, _____
If not at place of death? _____
Former or usual residence _____

19. PLACE OF BURIAL OR REMOVAL Alexander Idaho DATE OF BURIAL 191

20. UNDERTAKER P. B. Gallogly ADDRESS Burley, Idaho

CLANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Form V. S. No. 5. 12½ M. 7-24-11

CERTIFICATE OF DEATH

State of Idaho

BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH,
County of Cassia
City of Burley

Registration District No. 31
Primary Registration District No. 2124
(No. _____, _____ St.)

File No. 4221
Registered No. 7

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Ammon Starbo

If death occurred in a hospital, institution or camp give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX 4. COLOR OR RACE 5. SINGLE, MARRIED, WIDOWED OR DIVORCED.

Male white Married

6. DATE OF BIRTH 1852
(Month) (Day) (Year)

7. AGE 56 yrs. 0 mos. 0 ds. IF LESS than 1 day how many hrs. or min?

8. OCCUPATION
(a) Trade, profession or particular kind of work Farmer
(b) General nature of industry business or establishment in which employed (or employer)

9. BIRTHPLACE
(State or Country) Unknown

10. NAME OF FATHER "

11. BIRTHPLACE OF FATHER "
(State or Country)

12. MAIDEN NAME OF MOTHER "

13. BIRTHPLACE OF MOTHER "
(State or Country)

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) A. G. Hayden
(Address) Burley Ida

15. 3 18 191 3 193 Starbo
Filed Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH February 12 191 3
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from Feb 10 191 3, to Feb 12 191 3 that I last saw him alive on Feb 11 191 3 and that death occurred on the date stated above, at 9:30 A.M.

The CAUSE OF DEATH* was as follows:

Pneumonia
(Duration) 7 yrs. 0 mos. 0 ds.

Contributory (Secondary)
(Duration) 7 yrs. 0 mos. 0 ds.
(Signed) John M. Minter M. D.
Feb 13 1913 (Address) Burley Ida

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place In the
of death 7 yrs. 0 mos. 0 ds. State 7 yrs. 0 mos. 0 ds.
Where was disease contracted,
If not at place of death?
Former or
usual residence.

19. PLACE OF BURIAL OR REMOVAL Burley Ida DATE OF BURIAL Feb 13 1913
20. UNDERTAKER L. B. Gallogly ADDRESS Burley Ida

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
N. B.—Every item of information should be carefully supplied. AGE should be state EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Form V. S. No. 5. 10M. 6-20-11.

1. PLACE OF DEATH. Registration District No. 31
County of Cassia Primary Registrar Harris
City of Burley (No.) (St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Harris

PERSONAL AND STATISTICAL PARTICULARS

3. SEX M. 4. COLOR OR RACE white 5. SINGLE, MARRIED, WIDOWED OR DIVORCED Single
(Write the word)

6. DATE OF BIRTH Sept 24th
(Month) (Day)

7. AGE 4 yrs. 20 mos. 20 ds. IF LIVING, how many

8. OCCUPATION
(a) Trade, profession, or particular kind of work
(b) General nature of industry, business, or establishment in which employed (or employer)

9. BIRTHPLACE (State or Country) Burley, Ida

10. NAME OF FATHER W. D. Harris

11. BIRTHPLACE OF FATHER (State or Country) Idaho

12. MAIDEN NAME OF MOTHER Alice Finkbe

13. BIRTHPLACE OF MOTHER (State or Country) Idaho

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) W. D. Harris
(Address) Burley, Idaho

15. Filed 3-11 1913 3 13

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics
File No. 4223
Registered No. 10

If death occurred in a hospital, institution or camp give its NAME instead of street and number.

CERTIFICATE OF DEATH

16. DATE OF DEATH Feb 16th 1913
(Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from Feb 16th 1913, to Feb 16th 1913

that I last saw him alive on Feb 16th 1913

and that death occurred on the date stated above, at 6 P. M.

The CAUSE OF DEATH* was as follows:

Bronchopneumonia
..... yrs. mos. 9

Contributory (Secondary) massive

(Signed) P. C. Patterson M. D.
Feb 17th (Address) Burley, Idaho

*State the DISEASE, MEANS OF INJURY; and in deaths from VIOLENT CAUSES, state (1) ACCIDENTAL, SUICIDAL or HOMICIDAL,

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Residents.)

At place ds. State yrs. mos. ds.
Where was Disease
If not at place of death
Former or usual residence

19. PLACE OF BURIAL OR REMOVAL Burley, Idaho DATE OF BURIAL Feb 17th 1913

20. UNDERTAKER L. B. ... ADDRESS Burley, Idaho

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Form V. S. No. 5. 12½ M. 7-24-11

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics
File No. 1225
Registered No. 40

1. PLACE OF DEATH. Registration District No. 14
County of Custer Primary Registration District No. 2061
City of Challis (No. _____, _____ St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

Baby Wilkeson

If death occurred in a hospital, institution or camp give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX male 4. COLOR OR RACE white 5. SINGLE, MARRIED, WIDOWED OR DIVORCED. Single
(Write the word.)

6. DATE OF BIRTH Feb 5 1913
(Month) (Day) (Year)

7. AGE _____ yrs. _____ mos. _____ ds. IF LESS than 1 day how many _____ hrs. or _____ min?

8. OCCUPATION

- (a) Trade, profession or particular kind of work. none
(b) General nature of industry business or establishment in which employed (or employer) _____

9. BIRTHPLACE (State or Country) Ida.

10. NAME OF FATHER Blyde Wilkeson

11. BIRTHPLACE OF FATHER (State or Country) Nebr.

12. MAIDEN NAME OF MOTHER Annela Wankel

13. BIRTHPLACE OF MOTHER (State or Country) Ida.

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Blyde Wilkeson
(Address) Challis, Ida.

15. Filed 2/7 1913 C. H. H. H. H.
Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH Feb 6 1913
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from Feb 5 1913, to Feb 6 1913
that I last saw him alive on Feb 6 1913
and that death occurred on the date stated above, at 1 P.M.
The CAUSE OF DEATH* was as follows:

Premature birth
6 1/2 mos.

(Duration) _____ yrs. _____ mos. _____ ds.

Contributory (Secondary)

(Duration) _____ yrs. _____ mos. _____ ds.

(Signed) J. W. Keeler M. D.
Feb 6 1913 (Address) Challis, Ida.

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place _____ In the _____
of death _____ yrs. _____ mos. _____ ds. State _____ yrs. _____ mos. _____ ds.
Where was disease contracted, _____
If not at place of death? _____
Former or _____
usual residence _____

19. PLACE OF BURIAL OR REMOVAL DATE OF BURIAL

Challis Feb 7 1913

20. UNDERTAKER ADDRESS

Family Challis, Ida.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics
File No. 4226
Registered No. 42

1. PLACE OF DEATH. Registration District No. 14
County of Cassia Primary Registration District No. 2014
City of Mackay (No. _____, _____ St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

Infant Marnie

If death occurred in a hospital, institution or camp give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX M 4. COLOR OR RACE Wh 5. SINGLE, MARRIED, WIDOWED OR DIVORCED. Single
(Write the word.)

6. DATE OF BIRTH

11 15 1912
(Month) (Day) (Year)

7. AGE

_____ yrs. 2 mos. 22 ds.

IF LESS than 1 day
how many _____ hrs. or
_____ min?

8. OCCUPATION

(a) Trade, profession or particular kind of work. _____
(b) General nature of industry business or establishment in which employed (or employer) _____

9. BIRTHPLACE

(State or Country)

Idaho

10. NAME OF FATHER

John M. Marnie

11. BIRTHPLACE OF FATHER

(State or Country)

Iowa

12. MAIDEN NAME OF MOTHER

Ellena Trimmer

13. BIRTHPLACE OF MOTHER

(State or Country)

Ohio

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

(Address)

J. P. Richards

Mackay, Idaho

15.

Filed 2/13 1913

C. E. Keith
Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH

2 6 1913
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from

2/4 1913, to 2/6 1913

that I last saw him alive on 6th Feb 1913

and that death occurred on the date stated above, at 1 P. M.

The CAUSE OF DEATH* was as follows:

Lobular Pneumonia

_____ (Duration) _____ yrs. _____ mos. 4 ds.

Contributory
(Secondary)

Transient

_____ (Duration) _____ yrs. 2 mos. _____ ds.

(Signed)

J. P. Richards

M. D.

2/8 1913 (Address) Mackay, Idaho

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place _____ In the _____
of death _____ yrs. _____ mos. _____ ds. State _____ yrs. _____ mos. _____ ds.

Where was disease contracted,

If not at place of death?

Former or

usual residence

19. PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

Idaho

2/9 1913

20. UNDERTAKER

ADDRESS

Friends

Mackay

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Form V. S. No. 5. 10M. 6-20-11.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics
File No. 4227

1. PLACE OF DEATH.

Registration District No. 14

County of Custer

Primary Registration District No. 2084

City of Mackay

(No. , St.)

Registered No. 43

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Bernice Longhurst

If death occurred in a hospital, institution or camp give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX

Girl

4. COLOR OR RACE

white

5. SINGLE, MARRIED, WIDOWED OR DIVORCED.

Single
(Write the word.)

6. DATE OF BIRTH

Feb 18 1913
(Month) (Day) (Year)

7. AGE

2 yrs. 2 mos. ds.

IF LESS than 1 day
how many hrs. or min.?

8. OCCUPATION

- (a) Trade, profession or particular kind of work
(b) General nature of industry business or establishment in which employed (or employer)

9. BIRTHPLACE

(State or Country) Custer Co. Idaho

10. NAME OF FATHER

Grant Longhurst

11. BIRTHPLACE OF FATHER

(State or Country) Utah

12. MAIDEN NAME OF MOTHER

Luella Rowberry

13. BIRTHPLACE OF MOTHER

(State or Country) Utah

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Grant Longhurst

(Address) Mackay Ida

15.

Filed Feb 24 1913

Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

Feb 18 1913
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from

Feb 13 1913, to Feb 18 1913

that I last saw her alive on Feb 17 1913

and that death occurred on the date stated above, at 6 A.M.

The CAUSE OF DEATH* was as follows:

Lobar Pneumonia

(Duration) yrs. mos. 7 ds.

Contributory (Secondary)

(Duration) yrs. mos. ds.

(Signed) A. E. Mason M. D.

2/18 1913 (Address) Mackay

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL OR HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death. yrs. mos. ds. State. yrs. mos. ds.

Where was disease contracted,

If not at place of death?

Former or

usual residence.

19. PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

Mackay, Idaho. 2/21/13 1913

20. UNDERTAKER

ADDRESS

Bp Wm. H. Patton, Moon, Ida.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Form V. S. No. 5. 12½ M. 7-24-11

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics
File No. 4228
Registered No. 44

1. PLACE OF DEATH. Registration District No. 14
County of Cassia Primary Registration District No. 2084
City of Maeray (No. , St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Robert K. Moorman

If death occurred in a hospital, institution or camp give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX M 4. COLOR OR RACE wh 5. SINGLE, MARRIED, WIDOWED OR DIVORCED. Single (Write the word.)

6. DATE OF BIRTH May 22 1913 (Month) (Day) (Year)

7. AGE 8 yrs. 8 mos. 27 ds. IF LESS than 1 day how many hrs. or min?

8. OCCUPATION

(a) Trade, profession or particular kind of work.
(b) General nature of industry business or establishment in which employed (or employer)

9. BIRTHPLACE Idaho (State or Country)

10. NAME OF FATHER Eugene Moorman

11. BIRTHPLACE OF FATHER Iowa (State or Country)

12. MAIDEN NAME OF MOTHER Emma Pullis

13. BIRTHPLACE OF MOTHER Missouri (State or Country)

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) J. P. Richards (Address) Maeray, Id.

15. Filed 2/24 1913 Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH 2 19 1913 (Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from Feb 9 1913, to Feb 19 1913 that I last saw him alive on Feb 19 1913 and that death occurred on the date stated above, at 1 A. M. The CAUSE OF DEATH* was as follows:

Lobular Pneumonia

(Duration) yrs. mos. ds.

Contributory (Secondary) Pneumonia

(Duration) yrs. 6 mos. ds. (Signed) J. P. Richards M. D. 219 1913 (Address) Maeray Id.

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; (2) whether ACCIDENTAL, SUICIDAL OR HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place In the of death yrs. mos. ds. State yrs. mos. ds. Where was disease contracted, If not at place of death? Former or usual residence.

19. PLACE OF BURIAL OR REMOVAL DATE OF BURIAL

Maeray 2/24 1913

20. UNDERTAKER ADDRESS

J. H. Bapt

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Form V. S. No. 5. 12½ M. 7-24-11

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics
File No. 4225
Registered No. 18

1. PLACE OF DEATH. Registration District No. 9
County of Fremont Primary Registration District No. 2038
City of Plano (No. , St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

Clyde C. Craig

If death occurred in a hospital, institution or camp give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX 4. COLOR OR RACE 5. SINGLE, MARRIED, WIDOWED OR DIVORCED.

M

W

Babe
(Write the word.)

6. DATE OF BIRTH

Oct 3 1911
(Month) (Day) (Year)

7. AGE

1 yrs. 4 mos. 28 ds.

IF LESS than 1 day
how many hrs. or min?

8. OCCUPATION

(a) Trade, profession or particular kind of work.
(b) General nature of industry business or establishment in which employed (or employer)

Babe

9. BIRTHPLACE

(State or Country)

Idaho

10. NAME OF FATHER

Wm Craig

11. BIRTHPLACE OF FATHER

(State or Country)

Utah

12. MAIDEN NAME OF MOTHER

Iresa Boyle

13. BIRTHPLACE OF MOTHER

(State or Country)

Utah

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

Wm Craig

(Address)

Plano

15.

Filed

Mch 10 1913

Ray H. Fisher

Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH

Mch 1 1913
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from Feb 20 1913, to Mar 1 1913

that I last saw him alive on Mar 1 1913
and that death occurred on the date stated above, at 8:30 PM.

The CAUSE OF DEATH* was as follows:

Lobar Pneumonia

(Duration) yrs. mos. ds.

Contributory
(Secondary)

Ascites

(Duration) yrs. mos. ds.

(Signed) R. A. Cresman M. D.

Mar 1 1913 (Address) Redburg

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place In the
of death yrs. mos. ds. State yrs. mos. ds.

Where was disease contracted,

If not at place of death?

Former or

usual residence.

19. PLACE OF BURIAL OR REMOVAL DATE OF BURIAL

Plano

Mch 3 1913

20. UNDERTAKER

ADDRESS

John Phillips

Friends

Plano

Form V. S. No. 5. 12½ M. 7-24-11

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
 Bureau of Vital Statistics
 File No. 4230
 Registered No. 16

1. **PLACE OF DEATH.** Registration District No. 9
 County of Gremont Primary Registration District No. 2039
 City of Teton (No. _____, _____ St.)

If death occurs away from usual residence, give facts called for under special information.

2. **FULL NAME** Henry D. Thomson

If death occurred in a hospital, institution or camp give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. **SEX** m 4. **COLOR OR RACE** wh 5. **SINGLE, MARRIED, WIDOWED OR DIVORCED.** Baby
 (Write the word.)

6. **DATE OF BIRTH** Jan 30 1913
 (Month) (Day) (Year)

7. **AGE** _____ yrs. _____ mos. 28 ds. IF LESS than 1 day
 how many _____ hrs. or _____ min?

8. **OCCUPATION**

(a) Trade, profession or particular kind of work
 (b) General nature of industry business or establishment in which employed (or employer)

Baby

9. **BIRTHPLACE**

(State or Country)

Idaho

10. **NAME OF FATHER**

Robert Thomson

11. **BIRTHPLACE OF FATHER**

(State or Country)

Utah

12. **MAIDEN NAME OF MOTHER**

Josephine Pincock

13. **BIRTHPLACE OF MOTHER**

(State or Country)

Utah

14. **THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE**

(Informant)

(Address)

J. H. Pincock
Teton City

15.

Filed Mar 10 1913

Ray H. Fisher
 Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. **DATE OF DEATH**

Feb 27 1913
 (Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from _____ 191____, to _____ 191____

that I last saw h. _____ alive on _____ 191____

and that death occurred on the date stated above, at _____ M.

The CAUSE OF DEATH* was as follows:

Broncho-pneumonia

_____ (Duration) _____ yrs. _____ mos. _____ ds.

Contributory
 (Secondary)

_____ (Duration) _____ yrs. _____ mos. _____ ds.

(Signed)

J. R. Schuler M. D.
2/28 1913 (Address) Sugar

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. **LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)**

At place _____ In the _____
 of death _____ yrs. _____ mos. _____ ds. State _____ yrs. _____ mos. _____ ds.

Where was disease contracted,

If not at place of death?

Former or

usual residence.

19. **PLACE OF BURIAL OR REMOVAL**

DATE OF BURIAL

Teton 3/1 1913

20. **UNDERTAKER**

ADDRESS

John Phillips Reynoldsburg

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Form V. S. No. 5. 12½ M. 7-24-11

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics
File No. 4231
Registered No. 17

1. PLACE OF DEATH. Registration District No. 9
County of Fremont Primary Registration District No. 2039
City of Sugar (No. _____, _____ St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Don L. Garner

If death occurred in a hospital, institution or camp give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX M 4. COLOR OR RACE W 5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.)

6. DATE OF BIRTH Dec 8 1911
(Month) (Day) (Year)

7. AGE 1 yrs. 2 mos. 15 ds. IF LESS than 1 day how many _____ hrs. or _____ min?

8. OCCUPATION
(a) Trade, profession or particular kind of work Baby
(b) General nature of industry business or establishment in which employed (or employer)

9. BIRTHPLACE (State or Country) Idaho

10. NAME OF FATHER Wm L. Garner

11. BIRTHPLACE OF FATHER (State or Country) Utah

12. MAIDEN NAME OF MOTHER Lottie Pincus

13. BIRTHPLACE OF MOTHER (State or Country) Idaho

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Lyman Garner
(Address) Sugar City

15. Filed Mch 10 1913 Ray H. Fisher
Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH Feb 23 1913
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from 2-15-1913 to 2-23-1913
that I last saw him alive on 2-23-1913
and that death occurred on the date stated above, at _____ M.
The CAUSE OF DEATH* was as follows:

Pneumonia
(Duration) _____ yrs. _____ mos. _____ ds.
Contributory (Secondary) _____
(Duration) _____ yrs. _____ mos. _____ ds.
(Signed) J. R. Shupe M. D.
2/24 1913 (Address) Sugar City

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place _____ In the _____
of death _____ yrs. _____ mos. _____ ds. State _____ yrs. _____ mos. _____ ds.
Where was disease contracted, _____
If not at place of death? _____
Former or _____
usual residence _____

19. PLACE OF BURIAL OR REMOVAL DATE OF BURIAL
Sugar City 2/25 1913

20. UNDERTAKER ADDRESS
John Phillips Rexburg

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Form V. S. No. 5. 12½ M. 7-24-11

CERTIFICATE OF DEATH

State of Idaho

BOARD OF HEALTH
Bureau of Vital Statistics

File No. 4233

Registered No. 15

1. PLACE OF DEATH. Registration District No. 9
County of Fremont Primary Registration District No. 2039
City of Rexburg (No. , St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

Isaac VauSickle

If death occurred in a hospital, institution or camp give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX M 4. COLOR OR RACE W 5. SINGLE, MARRIED, WIDOWED OR DIVORCED. married

(Write the word.)

6. DATE OF BIRTH Nov. 1 1840
(Month) (Day) (Year)

7. AGE 77 yrs. 4 mos. ds. IF LESS than 1 day how many hrs. or min?

8. OCCUPATION

- (a) Trade, profession or particular kind of work.
(b) General nature of industry business or establishment in which employed (or employer)

Retired

9. BIRTHPLACE

(State or Country)

Canada

10. NAME OF FATHER

James VauSickle

11. BIRTHPLACE OF FATHER

(State or Country)

Canada

12. MAIDEN NAME OF MOTHER

Susan Miner

13. BIRTHPLACE OF MOTHER

(State or Country)

Canada

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

O. M. Shields

(Address)

Rexburg - Ida

15.

Filed

Mch 10 1913

Ray Fisher

Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH

Mch 1 1913
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from Jan 5 1913, to Feb 28 1913, that I last saw him alive on Feb 28 1913, and that death occurred on the date stated above, at 230 M.

The CAUSE OF DEATH* was as follows:

Chronic Intestinal Nephritis

(Duration) yrs. mos. ds.

Contributory (Secondary)

Unknown

(Duration) yrs. mos. ds.

(Signed)

R. A. Crismon M. D.

Mch 1 1913 (Address) Rexburg - Ida

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place

In the

of death yrs. mos. ds. State yrs. mos. ds.

Where was disease contracted,

If not at place of death?

Former or

usual residence.

19. PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

Rexburg

Mch 3 1913

20. UNDERTAKER

ADDRESS

John Phillips

Rexburg

Form V. S. No. 5 20M.1-16-12

CERTIFICATE OF DEATH

 State of Idaho
 BOARD OF HEALTH
 Bureau of Vital Statistics

1. PLACE OF DEATH.

Registration District No. 9County of JeromePrimary Registration District No. 2040City of Meridian

(No. _____, St.)

File No. 4234Registered No. 20.

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

Mary Susan Jones.

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX

F

4. COLOR OR RACE

W

5. SINGLE, MARRIED, WIDOWED OR DIVORCED

Married
(Write the word.)

6. DATE OF BIRTH

Nov 19 1852
 (Month) (Day) (Year)

7. AGE

60 yrs. 3 mos. 16 ds.

IF LESS than 1 day
 how many hrs. or
 mins?

8. OCCUPATION

(a) Trade, profession or particular kind of work
 (b) General nature of industry, business, or establishment in which employed (or employer)

Housewife

9. BIRTHPLACE

(State or Country)

West. Va.

10. NAME OF FATHER

Wm. S. Brightwell

11. BIRTHPLACE OF FATHER

(State or Country)

Virginia

12. MAIDEN NAME OF MOTHER

Baldwin

13. BIRTHPLACE OF MOTHER

(State or Country)

Va.

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

W. S. Jones

(Address)

Meridian Ida

15.

Filed

Mar 10 1913 Ray H. Fiske, M.D.
 Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH

Mar. 8 1913
 (Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from Feb. 17 1913 to Mar. 6 1913, that I last saw her alive on Mar 6 1913, and that death occurred on the date stated above, at 3 A. M.

The CAUSE OF DEATH* was as follows:

Lobar Pneumonia

(Duration) yrs. mos. ds.

Contributory (Secondary)

Delayed Respiration

(Duration) yrs. mos. ds.

(Signed)

J. E. Melton M. D.Mar 9 1913 (Address) Meridian - Ida

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death yrs. mos. days. In the State yrs. mos. days.

Where was disease contracted if not at place of death?

Former or usual residence.

19. PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

Little Butte CemeteryMar 9 1913

20. UNDERTAKER

ADDRESS

G. H. HuntIdaho Falls

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Form V. S. No. 5. 12½ M. 7-24-11

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics
File No. 4235
Registered No. 124

1. PLACE OF DEATH. Registration District No. 9
County of Fremont Primary Registration District No. 2040
City of Rigley (No. , St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

Lynner Briggs.

If death occurred in a hospital, institution or camp give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX Male 4. COLOR OR RACE White 5. SINGLE, MARRIED, WIDOWED OR DIVORCED. Child
(Write the word.)

6. DATE OF BIRTH Apr. 20th 1913
(Month) (Day) (Year)

7. AGE 1 yrs. 10 mos. — ds. IF LESS than 1 day how many..... hrs. or min?

8. OCCUPATION

(a) Trade, profession or particular kind of work.
(b) General nature of industry business or establishment in which employed (or employer)

Child.

9. BIRTHPLACE

(State or Country)

Idaho.

10. NAME OF FATHER

Unknown.

11. BIRTHPLACE OF FATHER

(State or Country)

"

12. MAIDEN NAME OF MOTHER

Viola Briggs.

13. BIRTHPLACE OF MOTHER

(State or Country)

Idaho.

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

Geo. Briggs.

(Address)

Rigley - Idaho

15.

Filed

Feb 10 1913

Ray W. Jones
Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH

Feb. 21 1913
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from Jan 22 1913, to Feb 21 1913 that I last saw him alive on Feb 20 1913 and that death occurred on the date stated above, at 9 A.M.
The CAUSE OF DEATH* was as follows:

Empyema.

(Duration) yrs. mos. ds.
Contributory Cause: Broncho Pneumonia
(Secondary)

(Duration) yrs. 1 mos. ds.
(Signed) Ray W. Jones, M. D.
Feb. 21 1913 (Address) Rigley - Idaho

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place In the
of death..... yrs. mos. ds. State..... yrs. mos. ds.
Where was disease contracted,
If not at place of death?
Former or
usual residence.....

19. PLACE OF BURIAL OR REMOVAL DATE OF BURIAL

Rigley. Feb. 24 1913

20. UNDERTAKER

ADDRESS

M. J. Beck & Sons Rigley - Idaho

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Form V. S. No. 5 20M.1-16-12

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH

Registration District No. 9

County of Fremont

Primary Registration District No. 2040

City of Rigby

(No. St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

Susan Boat

Registered No. 24

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX

F

4. COLOR OR RACE

W.

5. SINGLE, MARRIED, WIDOWED OR DIVORCED.

married

(Write the word.)

6. DATE OF BIRTH

Feb 17

1880

(Month)

(Day)

(Year)

7. AGE

33

yrs.

5

mos.

5

da.

IF LESS than 1 day
how many hrs. or
mins.?

8. OCCUPATION

(a) Trade, profession or particular kind of work

(b) General nature of industry, business, or establishment in which employed (or employer)

Housewife

9. BIRTHPLACE

(State or Country)

Okla.

10. NAME OF FATHER

Mack Morland

11. BIRTHPLACE OF FATHER

(State or Country)

Unknown

12. MAIDEN NAME OF MOTHER

"

13. BIRTHPLACE OF MOTHER

(State or Country)

"

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

Jordan Boat

(Address)

Spring, RFD 2

15.

Filed

Feb 10 1913

Ray Foster

Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

Feb 17

(Month)

(Day)

1913

(Year)

17. I HEREBY CERTIFY, That I attended deceased from

Feb 17 1913, to Feb 17 1913

that I last saw her alive on Feb 17 1913

and that death occurred on the date stated above, at 6 P. M.

The CAUSE OF DEATH* was as follows:

Coronary paralysis and prostration
following removal of morbid
forces. (Duration) yrs. mos. ds.Contributory
(Secondary)

Arteriosclerosis and glaucoma

(Duration)

yrs.

mos.

ds.

(Signed)

H. A. Anderson M. D.

Feb 17 1913 (Address) Rigby - Ida

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place

of death

yrs.

mos.

days

In the

State

yrs.

mos.

days

Where was disease contracted
if not at place of death?Former or
usual residence

19. PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

Covington Texas

Shipped 1913

20. UNDERTAKER

ADDRESS

G. H. Hunt

Idaho Falls

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Form V. S. No. 5 20M.1-16-12

CERTIFICATE OF DEATH

 State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

 1. PLACE OF DEATH. Registration District No. 9
 County of Blaine Primary Registration District No. 7040
 City of Meridian (No. _____ St.)

 File No. 4237
 Registered No. 21

If death occurs away from usual residence, give facts called for under special information.

 2. FULL NAME Hallie Clark

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

 3. SEX M 4. COLOR OR RACE W 5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.)

 6. DATE OF BIRTH June 1 1913
 (Month) (Day) (Year)

 7. AGE 9 4 yrs. 4 mos. 4 ds. IF LESS than 1 day how many hrs. or mins.

8. OCCUPATION

 (a) Trade, profession or particular kind of work
 (b) General nature of industry, business, or establishment in which employed (or employer)

9. BIRTHPLACE

(State or Country)

Idaho

10. NAME OF FATHER

E. C. Clark

11. BIRTHPLACE OF FATHER

(State or Country)

Ohio

12. MAIDEN NAME OF MOTHER

Mary Jones

13. BIRTHPLACE OF MOTHER

(State or Country)

W. Va.

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

Mary Jones Clark

(Address)

Meridian - Idaho
 15. Filed Mich 10 1913 Ray H. Fisher
 Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

Mar 6

(Month)

(Day)

1913
(Year)
 17. I HEREBY CERTIFY, That I attended deceased from Mar 1 1913, to Mar 6 1913, that I last saw him alive on Mar 6 1913, and that death occurred on the date stated above, at 4:30 P. M.

The CAUSE OF DEATH* was as follows:

Broncho-pneumonia

(Duration) yrs. mos. ds.

Contributory (Secondary)

(Duration) yrs. mos. ds.

(Signed)

J. E. Melton M. D.Mar 6 1913 (Address) Meridian - Ida

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death yrs. mos. days. In the State yrs. mos. days.

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

Little Butte CemeteryMar 8 1913

20. UNDERTAKER

ADDRESS

J. H. HuntIda Falls - Ida

A stillbirth must be registered both as a birth and death. The date of death should be the date of delivery and the death certificate should further state, if known, the cause of the stillbirth and the period of utero gestation in months.

STATEMENT OF OCCUPATION.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer, Physician, Stenographer, Compositor, Architect, Locomotive engineer, Civil engineer, Stationary fireman, etc.* But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner*, (b) *Cotton mill*; (a) *Salesman*, (b) *Grocery*; (a) *Foreman*, (b) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification, as *Day laborer, Farm laborer, Laborer—Coal mine*, etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers*, who receive a definite salary), may be entered as *Housewife, Housework*, or *At home*, and children, not gainfully employed, as *At school* or *At home*. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer (retired, 6 yrs.)*. For persons who have no occupation whatever, write *None*.

STATEMENT OF CAUSE OF DEATH.—Name, first the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebro-*

spinal fever (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid Pneumonia") *Lobar pneumonia*; *Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritoneum*, etc., *Carcinoma, Sarcoma*, etc., of (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles*; *Whooping cough*; *Chronic valvular heart disease*; *Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent affection need not be stated unless important. Example: *Measles* (disease causing death), 29 ds.; *Bronchopneumonia* (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "Asthenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility," ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Haemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uraemia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify as "PUERPERAL, septicemia", "PUERPERAL peritonitis," etc., all diseases resulting from childbirth or miscarriage. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning*; *Struck by railway train—accident*; *Revolver wound of head—homicide*; *Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "Contributory."

2
9#

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Form V. S. No. 5 20M.1-16-12

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH.

Registration District No. 9

County of

Primary Registration District No. 2037.

City of

(No. , St.)

File No. 4238

Registered No. 22

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

Myron Wooley Cherry

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX

M

4. COLOR OR RACE

W.

5. SINGLE, MARRIED, WIDOWED OR DIVORCED.

Single
(Write the word.)

6. DATE OF BIRTH

May 11 1907
(Month) (Day) (Year)

7. AGE

11 yrs. 8 mos. 11 ds.

IF LESS than 1 day
how many hrs. or mins.?

8. OCCUPATION

(a) Trade, profession or particular kind of work

(b) General nature of industry business, or establishment in which employed (or employer)

Chief

9. BIRTHPLACE

(State or Country)

Idaho Co. Ida.

10. NAME OF FATHER

Thomas Cherry

11. BIRTHPLACE OF FATHER

(State or Country)

Utah

12. MAIDEN NAME OF MOTHER

Mary Wooley

13. BIRTHPLACE OF MOTHER

(State or Country)

Utah

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

Curren B. Curtis

(Address)

Vico, Idaho

15.

Filed

Nov 10 1913

Ray H. Fisher

Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH

Jan 23 1913
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from Jan 16 1913, to Jan 23 1913, that I last saw him alive on Jan 22 1913, and that death occurred on the date stated above, at 2 P. M.

The CAUSE OF DEATH* was as follows:

Lagrippe

(Duration) yrs. mos. 6 ds.

Contributory (Secondary)

Epilepsy

(Duration) yrs. mos. ds.

(Signed)

M. P. Orville

M. D.

Jan 23 1913 (Address) Driggs, Ida.

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death.....yrs.....mos.....days. In the State.....yrs.....mos.....days.

Where was disease contracted if not at place of death?

Former or usual residence.....

19. PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

Curtis

Jan 25 1913

20. UNDERTAKER

ADDRESS

H. R. Gaffes

Vico, Idaho

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Form V. S. No. 5 20M.1-16-12

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH.

Registration District No. 9

County of Blaine

Primary Registration District No. 2037

City of Driggs

(No. St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

Ellen Kite

File No. 4240

Registered No. 25

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX

F

4. COLOR OR RACE

W.

5. SINGLE, MARRIED, WIDOWED OR DIVORCED.

Single
(Write the word.)

6. DATE OF BIRTH

May 17 1910
(Month) (Day) (Year)

7. AGE

2 yrs. 7 mos. 5 da.

IF LESS than 1 day
how many hrs. or
 mins?

8. OCCUPATION

(a) Trade, profession or particular kind of work
(b) General nature of industry, business, or establishment in which employed (or employer)

Child

9. BIRTHPLACE

(State or Country)

Idaho

10. NAME OF FATHER

J. G. Kite

11. BIRTHPLACE OF FATHER

(State or Country)

Idaho

12. MAIDEN NAME OF MOTHER

Mary E. Edlefsen

13. BIRTHPLACE OF MOTHER

(State or Country)

Idaho

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

Frank G. Kite

(Address)

Driggs - Idaho

15.

Filed

Feb 10 1913 Ray H. Fisher

Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

Feb. 17 1913
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from Feb. 16 1913, to Feb. 17 1913,

that I last saw her alive on Feb. 17 1913, and that death occurred on the date stated above, at 3:45 P. M.

The CAUSE OF DEATH* was as follows:

Broncho-pneumonia

(Duration) yrs. mos. ds.

Contributory (Secondary)

(Duration) yrs. mos. ds.

(Signed)

E. A. D. Keith M. D.

Feb. 1913 (Address) Driggs

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death yrs. mos. days. In the State yrs. mos. days.

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

Clawson, Ida Feb 19 1913

20. UNDERTAKER

ADDRESS

C. Cherrington Driggs

Form V. S. No. 5 20M.1-16-12

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH.

Registration District No. 9

County of

Primary Registration District No. 2037

City of

(No. , St.)

File No. 4241

Registered No. 26

If death occurs away from usual residence, give facts called for under special instruction.

2. FULL NAME

Dwain Cornelius Curtis

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX

M

4. COLOR OR RACE

W

5. SINGLE, MARRIED, WIDOWED OR DIVORCED

Married
(Write the word.)

6. DATE OF BIRTH

Apr. 1887

(Month)

(Day)

(Year)

7. AGE

25 yrs. 9 mos. 17 ds.

IF LESS than 1 day
how many hrs. or mins.?

8. OCCUPATION

(a) Trade, profession or particular kind of work

Mail Carrier

(b) General nature of industry business, or establishment in which employed (or employer)

9. BIRTHPLACE

(State or Country)

Utah

10. NAME OF FATHER

O. B. Curtis

11. BIRTHPLACE OF FATHER

(State or Country)

Utah

12. MAIDEN NAME OF MOTHER

Elizabeth Bruns

13. BIRTHPLACE OF MOTHER

(State or Country)

Utah

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

O. B. Curtis

(Address)

Victor - Ida

15.

Filed

Feb. 24 1913

M. J. Crisler

Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH

Jan 21 1913

(Month)

(Day)

(Year)

17. I HEREBY CERTIFY, That I attended deceased from

1911, to

1911,

that I last saw him alive on

1911,

and that death occurred on the date stated above, at

M.

The CAUSE OF DEATH* was as follows:

Snow Blindness

(Duration) yrs. mos. ds.

Contributory
(Secondary)

(Duration) yrs. mos. ds.

(Signed) M. D.

19 (Address)

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death.....yrs.....mos.....days. In the State.....yrs.....mos.....days.

Where was disease contracted if not at place of death?

Former or usual residence.....

19. PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

Victor

Jan 23 1913

20. UNDERTAKER

ADDRESS

H. R. Griffiths

Victor Ida

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Form V. S. No. 5 20M.1-16-12

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH

Registration District No. 9County of BozemanPrimary Registration District No. 2040City of Reilly(No. Bozeman)

St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

BELVA May FillmoreFile No. 4242Registered No. 27

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX

7

4. COLOR OR RACE

W5. SINGLE, MARRIED, WID-
OWED OR DIVORCED.Widow
(Write the word.)

6. DATE OF BIRTH

Jan. 29th 1913
(Month) (Day) (Year)

7. AGE

10 yrs. 10 mos. 10 ds.IF LESS than 1 day
how many hrs. or
mins.?

8. OCCUPATION

(a) Trade, profession or
particular kind of work(b) General nature of industry
business, or establishment in
which employed (or employer)

9. BIRTHPLACE

(State or Country)

Idaho10. NAME OF
FATHEROvin Fillmore11. BIRTHPLACE
OF FATHER

(State or Country)

Idaho12. MAIDEN NAME
OF MOTHERMay Briggs13. BIRTHPLACE
OF MOTHER

(State or Country)

Idaho

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

Ovin Fillmore

(Address)

Reilly, Idaho

15.

Filed

Feb 10 1913

Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH

Feb. 8 1913
(Month) (Day) (Year)17. I HEREBY CERTIFY, That I attended deceased from
Jan 29 1913, to Feb 8 1913,that I last saw her alive on Feb 8 1913,and that death occurred on the date stated above, at 7 A.M.

The CAUSE OF DEATH* was as follows:

8 mo. Pregnancy
Abortion

(Duration) yrs. mos. ds.

Contributory
(Secondary)

(Duration) yrs. mos. ds.

(Signed) H. D. Anderson M. D.Feb 9 1913 (Address) Reilly - Ida.

*State the DISEASE CAUSING DEATH; or in death from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions,
Transients or Recent Residents.)

At place of death.....yrs.....mos.....days. In the State.....yrs.....mos.....days.

Where was disease contracted
if not at place of death?Former or
usual residence.

19. PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

Reilly, Idaho Feb 10 1913

20. UNDERTAKER

ADDRESS

Friends Reilly

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Form V. S. No. 5. 12½ M. 7-24-11

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics
File No. 4243
Registered No. 99

1. PLACE OF DEATH. Registration District No. 10
County of Idaho Primary Registration District No. 2042
City of Traugott (No. , St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Ida May Smith

If death occurred in a hospital, institution or camp give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX Female 4. COLOR OR RACE White 5. SINGLE, MARRIED, WIDOWED OR DIVORCED. Married
(Write the word.)
6. DATE OF BIRTH Feb Sept 19 1881
(Month) (Day) (Year)

7. AGE 32 yrs. 4 mos. 24 ds. IF LESS than 1 day how many hrs. or min?

8. OCCUPATION
(a) Trade, profession or particular kind of work. Housewife
(b) General nature of industry business or establishment in which employed (or employer)

9. BIRTHPLACE
(State or Country) Indian Territory

10. NAME OF FATHER Edward Baker

11. BIRTHPLACE OF FATHER Pennsylvania
(State or Country)

12. MAIDEN NAME OF MOTHER Samantha Thomas

13. BIRTHPLACE OF MOTHER Kansas
(State or Country)

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Mary A. Smith
(Address) Traugott, Ida.

15. Filed Feb. 13 1913 Jesse L. Davis
Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH Feb 12 1913
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from Feb 10 1913, to Feb 10 1913, that I last saw her alive on Feb 10 1913, and that death occurred on the date stated above, at 5 A. M. The CAUSE OF DEATH* was as follows:

Tuberculosis of lungs and larynx
(Duration) yrs. 6 mos. ds.

Contributory (Secondary)
(Duration) yrs. mos. ds.
(Signed) W. H. Warner M. D.
Feb 13 1913 (Address) Traugott

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place In the
of death yrs. mos. ds. State yrs. mos. ds.
Where was disease contracted,
If not at place of death?
Former or usual residence.

19. PLACE OF BURIAL OR REMOVAL DATE OF BURIAL
Fairview Cemetery Feb. 14 1913

20. UNDERTAKER ADDRESS
W. E. Mahan Traugott

MARGIN RESERVED FOR BINDING
WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
N. B.—Every item of information should be carefully supplied. AGE should be state EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Form V. S. No. 5. 10M. 6-20-11.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics
File No. 1244

1. PLACE OF DEATH
County of Idaho
City of Denver St.)
Registration District No. 2044

Registered No. 100

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Essie Adams

If death occurred in a hospital, institution or camp give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX Female 4. COLOR OR RACE white 5. SINGLE, MARRIED, WIDOWED OR DIVORCED. married
(Write the word.)

6. DATE OF BIRTH March 6th 1887
(Month) (Day) (Year)

7. AGE 25-11-17 IF LESS than 1 day how many hrs. or min.
yrs. mos. ds. 45 min 17 11 25

8. OCCUPATION

(a) Trade, profession or particular kind of work

Farmer

(b) General nature of industry business or establishment in which employed (or employer)

House wife

9. BIRTHPLACE

(State or Country)

Georgie Elberton

10. NAME OF FATHER

John Hiram Rosser

11. BIRTHPLACE OF FATHER

(State or Country)

Elberton Georgie

12. MAIDEN NAME OF MOTHER

Maddie Rowley

13. BIRTHPLACE OF MOTHER

(State or Country)

Elberton Georgie

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

O. B. Adams

(Address)

Denver

15.

Filed Feb. 26 1913

Jose L. Pains

Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

February 23 1913
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from

September 12 1911, to Feb 23 1913

that I last saw him alive on Feb 18 1913

and that death occurred on the date stated above, at 6:45 PM

The CAUSE OF DEATH* was as follows:

Pulmonary Tuberculosis

(Duration) about 4 years mos. ds.

Contributory (Secondary)

(Duration) 1 yrs. mos. ds.

(Signed) C. W. Shesser M. D.

Feb 26 1913 (Address) Granville Ida.

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death..... yrs..... mos..... ds. State..... yrs..... mos..... ds.

Where was disease contracted,

If not at place of death?.....

Former or usual residence.....

19. PLACE OF BURIAL OR REMOVAL

Denver Cemetery

DATE OF BURIAL

Feb. 25 1913

20. UNDERTAKER

G. L. Hancock

ADDRESS

Granville

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Form V. S. No. 5 20M.1-16-12

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH.

Registration District No. ~~2042~~ 10County of IdahoPrimary Registration District No. ~~2042~~File No. 4245City of Cottonwood

(No. _____ St.)

Registered No. 104

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

Elizabeth A. Hale

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX Female 4. COLOR OR RACE White 5. SINGLE, MARRIED, WIDOWED OR DIVORCED. Widowed

6. DATE OF BIRTH

Oct. 6 1843
(Month) (Day) (Year)

7. AGE

69 yrs. 4 mos. 22 ds.IF LESS than 1 day
how many _____ hrs. or
_____ mins.

8. OCCUPATION

(a) Trade, profession or particular kind of work
(b) General nature of industry business, or establishment in which employed (or employer)Housewife

9. BIRTHPLACE

(State or Country)

Kentucky

10. NAME OF FATHER

Henry H. Gill

11. BIRTHPLACE OF FATHER

(State or Country)

Kentucky

12. MAIDEN NAME OF MOTHER

Eliza Rifer

13. BIRTHPLACE OF MOTHER

(State or Country)

Unknown

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

J. H. Hale

(Address)

Garfield Wash.

15.

Filed

Feb 271913James L. Rains

Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH

Feb. 27 1913
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from

Feb 9 1913, to Feb 27 1913
that I last saw her alive on Feb 27 at 12:30 1913and that death occurred on the date stated above, at 5:50 P.M.

The CAUSE OF DEATH was as follows:

Cerebral hemorrhage due to
cardiac hypertrophy & hypertension
due to Chronic nephritis3 days (Duration) _____ yrs. _____ mos. _____ ds.Contributory
(Secondary)Chronic nephritis(Duration) 10 yrs. _____ mos. _____ ds.

(Signed)

Merley F. Orr M. D.19. (Address) Cottonwood Ida

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death _____ yrs. 3 mos. _____ days. In the State _____ yrs. 3 mos. _____ days.Where was disease contracted if not at place of death? Garfield Wash.Former or usual residence Garfield Washington

19. PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

Garfield Wash.Mar 1st 1913

20. UNDERTAKER

ADDRESS

Joseph McBlaney Cottonwood Ida

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Form V. S. No. 5 20M.1-16-12

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics
File No. 1246
Registered No. 105
If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

1. PLACE OF DEATH.

Registration District No. 10County of IdahoPrimary Registration District No. 2042City of Cottamwood

(No. _____) (St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

William Beacock

PERSONAL AND STATISTICAL PARTICULARS

3. SEX

Male

4. COLOR OR RACE

White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED.

(Write the word.)

6. DATE OF BIRTH

Don't know

(Month)

(Day)

1857 (Year)

7. AGE

56 yrs. _____ mos. _____ ds.IF LESS than 1 day
how many _____ hrs. or
_____ mins.?

8. OCCUPATION

(a) Trade, profession or particular kind of work

(b) General nature of industry business, or establishment in which employed (or employer)

Carpenter

9. BIRTHPLACE

(State or Country)

County of Derry, Ireland

10. NAME OF FATHER

Unknown

11. BIRTHPLACE OF FATHER

(State or Country)

Unknown

12. MAIDEN NAME OF MOTHER

Unknown

13. BIRTHPLACE OF MOTHER

(State or Country)

Unknown

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

B. P. Duffy

(Address)

Cottamwood, Idaho

15.

Filed July 10 1913Jerome E. Rains
Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH

Feb.

(Month)

9

(Day)

1913

(Year)

17. I HEREBY CERTIFY, That I attended deceased from

Feb 8 - 1913, to Feb 9 1913,that I last saw him live on Feb 7 1913,and that death occurred on the date stated above, at 7 A. M.

The CAUSE OF DEATH* was as follows:

Heart failure due to
transmission from injury - Killed
by Horse. (Duration) _____ yrs. _____ mos. _____ ds.Contributory
(Secondary)

(Duration) _____ yrs. _____ mos. _____ ds.

(Signed)

J. D. Shinnick M. D.July 10 1913 (Address) Cottamwood

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death _____ yrs. _____ mos. _____ days. In the State _____ yrs. _____ mos. _____ days.

Where was disease contracted if not at place of death? _____

Former or usual residence _____

19. PLACE OF BURIAL OR REMOVAL DATE OF BURIAL

Protestant Cemetery, Cottamwood Feb 11, 1913

20. UNDERTAKER

Joseph McElashy

ADDRESS

Cottamwood

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact state-
ment of OCCUPATION is very important. See instructions on back of certificate.

Form V. S. No. 5 20M.1-16-12

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH.

Registration District No. 2042 10County of IdahoPrimary Registration District No. 2042 10City of Northlake Precinct(No. 2042 St.)File No. 4247Registered No. 106

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

Jack Hill

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX

Male

4. COLOR OR RACE

White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED.

Married

6. DATE OF BIRTH

Aug 1918731873

7. AGE

(39)39 yrs. 6 mos. 11 ds.IF LESS than 1 day
how many hrs. or
mins.?

8. OCCUPATION

(a) Trade, profession or particular kind of work

(b) General nature of industry business, or establishment in which employed (or employer)

Farmer

9. BIRTHPLACE

(State or Country)

Eugene Oregon

10. NAME OF FATHER

William Harris Hill

11. BIRTHPLACE OF FATHER

(State or Country)

Unknown

12. MAIDEN NAME OF MOTHER

Annie Bennett

13. BIRTHPLACE OF MOTHER

(State or Country)

Idaho

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

D H Hill

(Address)

Joseph Idaho

15.

Filed Feb 22 1913John E. Rains

Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH

February21913

(Month)

(Day)

(Year)

17. I HEREBY CERTIFY, That I attended deceased from

Jan. 31st, 1913, to Feb. 2nd, 1913,that I last saw him alive on Feb. 2nd, 1913,and that death occurred on the date stated above, at 8:50 a.m.

The CAUSE OF DEATH* was as follows:

Strangulated inguinal hernia

(Duration)

16 hours

yrs.

mos.

ds.

Contributory

(Secondary)

(Duration)

yrs.

mos.

ds.

(Signed)

2-3-1913

(Address)

J. H. Duruer, M. D. Cottonwood, Ida

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death

yrs.

mos.

days.

In the State

yrs.

mos.

days.

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

Merran Lawn CemeteryFeb 4 1913

20. UNDERTAKER

ADDRESS

Joseph McLeakyCottonwood

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

MARGIN RESERVED FOR BINDING

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Form V. S. No. 5. 12½ M. 7-24-11

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH.

Registration District No. 2042

County of Idaho

Primary Registration District No. 2042

City of Winkelman

(No. _____ St.)

File No. 1248

Registered No. 107

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

Alvie Tom Potter

If death occurred in a hospital, institution or camp give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX

male

4. COLOR OR RACE

white

5. SINGLE, MARRIED, WIDOWED OR DIVORCED.

single
(Write the word.)

6. DATE OF BIRTH

July

23

1912

(Month)

(Day)

(Year)

7. AGE

0 yrs. 6 mos. 18 ds.

IF LESS than 1 day
how many _____ hrs. or
_____ min?

8. OCCUPATION

(a) Trade, profession or particular kind of work.
(b) General nature of industry business or establishment in which employed (or employer)

Child

9. BIRTHPLACE

(State or Country)

Idaho Co. Ida.

10. NAME OF FATHER

John Potter

11. BIRTHPLACE OF FATHER

(State or Country)

Ft. Scott Kansas

12. MAIDEN NAME OF MOTHER

Effie May Swatman

13. BIRTHPLACE OF MOTHER

(State or Country)

Royal Co. S. Dak.

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

E. L. Bruck

(Address)

Vallonia, Ida.

15.

Filed July 28 1913

John E. Rains
Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH

Feb.

9

1913

(Month)

(Day)

(Year)

17. I HEREBY CERTIFY, That I attended deceased from not attended 1912 to 1913
that I last saw h not seen alive alive on 1913
and that death occurred on the date stated above, at 9 M.

The CAUSE OF DEATH* was as follows:

Probably pneumonia

(Duration) _____ yrs. _____ mos. 3 ds.

Contributory
(Secondary)

(Duration) _____ yrs. _____ mos. _____ ds.

(Signed) E. L. Bruck M. D.

_____ 19 _____ (Address) _____

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place _____ In the _____

of death _____ yrs. _____ mos. _____ ds. State _____ yrs. _____ mos. _____ ds.

Where was disease contracted,
If not at place of death?

Former or
usual residence _____

19. PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

St. Louis Co.

Feb. 10 1913

20. UNDERTAKER

ADDRESS

C. D. Leonard

Vallonia, Idaho

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Form V. S. No. 5. 12½M.7-24-11

1. PLACE OF DEATH. Registration District No. 10
County of Idaho Primary Registration District No. 2101
City of B.O. Gruen (No. _____, _____ St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Emily I. Sciebert

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics
File No. 4254
Registered No. 101

If death occurred in a hospital, institution or camp give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX Female 4. COLOR OR RACE White 5. SINGLE, MARRIED, WIDOWED OR DIVORCED. Married
(Write the word.)

6. DATE OF BIRTH April 21 1887
(Month) (Day) (Year)

7. AGE 54 yrs. 9 mos. ds. IF LESS than 1 day how many _____ hrs. or _____ min?

8. OCCUPATION

(a) Trade, profession or particular kind of work
(b) General nature of industry business or establishment in which employed (or employer)

House Keeper

9. BIRTHPLACE
(State or Country)

Ill.

10. NAME OF FATHER

Benson

11. BIRTHPLACE OF FATHER
(State or Country)

Benson

12. MAIDEN NAME OF MOTHER

Benson

13. BIRTHPLACE OF MOTHER
(State or Country)

Benson

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Daughter
(Address) Gruen

15. Filed Feb. 22 1913 Paul P. Rains
Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH January 21 1913
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased ~~from~~ on the 20th Jan 1913, to 1913
that I last saw her alive on Jan 20th 1913
and that death occurred on the date stated above, at _____ M.

The CAUSE OF DEATH* was as follows:

Carcinoma of the uterus -
spreading to rectum & Bladder
from tumor probably 2 to 3 yrs
(Duration) yrs. mos. ds.

Contributory Apparently in good health
(Secondary) otherwise
(Duration) yrs. mos. ds.

(Signed) Edw. W. Horwell M. D.
Jan 23 1913 (Address) Crofton, Ida

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place _____ In the _____
of death _____ yrs. _____ mos. _____ ds. State _____ yrs. _____ mos. _____ ds.
Where was disease contracted,
If not at place of death?
Former or
usual residence _____

19. PLACE OF BURIAL OR REMOVAL DATE OF BURIAL

Crofton Jan. 23 1913
20. UNDERTAKER ADDRESS

none

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIAN should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Form V. S. No. 5. 12½ M. 7-24-11

CERTIFICATE OF DEATH

1. PLACE OF DEATH.
County of Idaho
City of Kootenai

Registration District No. 10
Primary Registration District No. 2101
(No. _____, St. _____)

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics
File No. 4252
Registered No. 103

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Benjamin William Shriner

If death occurred in a hospital, institution or camp give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX Male 4. COLOR OR RACE White 5. SINGLE, MARRIED, WIDOWED OR DIVORCED. Married
(Write the word.)

6. DATE OF BIRTH 5 31 1863
(Month) (Day) (Year)

7. AGE 49 yrs. 8 mos. 16 ds. IF LESS than 1 day how many _____ hrs. or _____ min?

8. OCCUPATION
(a) Trade, profession or particular kind of work. Blacksmith
(b) General nature of industry business or establishment in which employed (or employer)

9. BIRTHPLACE Ohio
(State or Country)

10. NAME OF FATHER Benjamin Shriner

11. BIRTHPLACE OF FATHER Ohio
(State or Country)

12. MAIDEN NAME OF MOTHER Minerva Henderson

13. BIRTHPLACE OF MOTHER Ohio
(State or Country)

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) M. S. Ingram
(Address) Moscow

15. Filed Feb 28 1913 Jm. V. K. K.
Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH Feb 16 1913
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from November 25 1912 to Feb 16 1913 that I last saw him alive on Feb 15 1913 and that death occurred on the date stated above, at 12⁰⁰ P.M. The CAUSE OF DEATH* was as follows:
Carcinoma of kidney

(Duration) 1 yrs. _____ mos. _____ ds.
Contributory (Secondary) _____
(Duration) _____ yrs. _____ mos. _____ ds.
(Signed) Jm. V. K. K. M. D.
Feb 16 1913 (Address) Kootenai Idaho

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place _____ In the _____
of death _____ yrs. _____ mos. _____ ds. State _____ yrs. _____ mos. _____ ds.
Where was disease contracted, If not at place of death? _____
Former or usual residence _____

19. PLACE OF BURIAL OR REMOVAL Kootenai Cemetery DATE OF BURIAL Feb 17 1913
20. UNDERTAKER C. J. Johnson ADDRESS Hamlet Idaho

MARGIN RESERVED FOR BINDING
PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
of information should be carefully supplied. AGE should be stated EXACTLY. PHYSI-
child state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact state-
OCCUPATION is very important. See instructions on back of certificate.

Form V. S. No. 5. 12½ M. 7-24-11

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics
File No. 4253
Registered No. 12

1. PLACE OF DEATH. Registration District No. 13
County of Blaine Primary Registration District No. 2053
City of Blaine, Idaho (No. St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Sillian Anna Stone

If death occurred in a hospital, institution or camp give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX Female 4. COLOR OR RACE white 5. SINGLE, MARRIED, WIDOWED OR DIVORCED. Married (Write the word.)

6. DATE OF BIRTH Oct 1 1883 (Month) (Day) (Year)

7. AGE 28 yrs. 4 mos. 4 ds. IF LESS than 1 day how many hrs. or min?

8. OCCUPATION (a) Trade, profession or particular kind of work. Housewife (b) General nature of industry business or establishment in which employed (or employer)

9. BIRTHPLACE (State or Country) Utah

10. NAME OF FATHER J. H. Allred

11. BIRTHPLACE OF FATHER Utah (State or Country)

12. MAIDEN NAME OF MOTHER Stella Mulliner

13. BIRTHPLACE OF MOTHER Utah (State or Country)

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) R. H. Stone (Address) Sterling, Idaho

15. Feb 5 1913 W. E. Patrick Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH Feb. 5 1913 (Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from March 17 1911, to Feb. 5 1913 that I last saw her alive on Sept. 1 1912 and that death occurred on the date stated above, at 2:30 P.M. The CAUSE OF DEATH* was as follows:

Tuberculosis (Duration) 2 yrs. mos. ds. Contributory (Secondary)

(Signed) F. W. Metcalf M. D. Feb. 5 1913 (Address) Bluff, Idaho

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place In the of death yrs. mos. ds. State yrs. mos. ds. Where was disease contracted. If not at place of death? Former or usual residence.

19. PLACE OF BURIAL OR REMOVAL DATE OF BURIAL Thomas - Burial Feb 6 1913

20. UNDERTAKER ADDRESS R. H. Stone Sterling, Ida

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Form V. S. No. 5. 12½ M. 7-24-11

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics
File No. 1254
Registered No. 13

1. PLACE OF DEATH.

County of Bingham
City of Blackfoot

Registration District No. 13

Primary Registration District No. 2053

(No. 2 mi. South of Chapelle St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

Unmarried Pratt.

If death occurred in a hospital, institution or camp give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX

Male

4. COLOR OR RACE

White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED.

Single
(Write the word.)

6. DATE OF BIRTH

Feb 6 1913
(Month) (Day) (Year)

7. AGE

— yrs. — mos. — ds.
IF LESS than 1 day how many 22 hrs. or — min?

8. OCCUPATION

- (a) Trade, profession or particular kind of work, —
(b) General nature of industry business or establishment in which employed (or employer) —

9. BIRTHPLACE

(State or Country) Blackfoot Idaho

10. NAME OF FATHER

Joseph Pratt

11. BIRTHPLACE OF FATHER

(State or Country) Utah

12. MAIDEN NAME OF MOTHER

Mary Adair

13. BIRTHPLACE OF MOTHER

(State or Country) Holland

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) William Pratt
(Address) Greenwich Idaho
R. F. D. #2

15.

Feb 7 1913 W.E. Public

Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH

Feb 6 1913
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from

Feb 6 1913, to Feb 6 1913

that I last saw him alive on Feb 6 1913

and that death occurred on the date stated above, at 3 4 M.

The CAUSE OF DEATH* was as follows:

Pneumonia 7 months.
(Duration) — yrs. — mos. — ds.

Contributory
(Secondary)

(Duration) — yrs. — mos. — ds.
(Signed) F. W. Mottrell M. D.
Feb 6 1913 (Address) Blackfoot Idaho

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place In the
of death — yrs. — mos. — ds. State — yrs. — mos. — ds.
Where was disease contracted,
If not at place of death? —
Former or
usual residence —

19. PLACE OF BURIAL OR REMOVAL DATE OF BURIAL

William Pratt Feb 7 1913
20. UNDERTAKER ADDRESS

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Form V. S. No. 5. 10M. 6-20-11.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

File No. 4255Registered No. 14

If death occurred in a hospital, institution or camp give its NAME instead of street and number.

1. PLACE OF DEATH.
County of Bingham
City of Blackfoot

Registration District No. 13
Primary Registration District No. 2053
(No. _____, St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

Elsie Mae McKinstry

PERSONAL AND STATISTICAL PARTICULARS

3. SEX Female 4. COLOR OR RACE White 5. SINGLE, MARRIED, WIDOWED OR DIVORCED.
Married
(Write the word.)

6. DATE OF BIRTH

1889
(Month) (Day) (Year)

7. AGE

23 yrs. _____ mos. _____ ds.

IF LESS than 1 day
how many _____ hrs. or
_____ min.?

8. OCCUPATION

(a) Trade, profession, or particular kind of work

Housewife

(b) General nature of industry business, or establishment in which employed (or employer)

9. BIRTHPLACE

(State or Country)

Oregon

10. NAME OF FATHER

?

11. BIRTHPLACE OF FATHER

(State or Country)

?

12. MAIDEN NAME OF MOTHER

?

13. BIRTHPLACE OF MOTHER

(State or Country)

?

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

Francis H. Poole

(Address)

Blackfoot, Idaho

15.

Filed

Feb 101913M. E. Patrick

Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

February 8 1913
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from

Sept. 5 1912, to Feb. 8 1913

that I last saw her alive on Feb. 7 1913,

and that death occurred on the date stated above, at 3 A. M.

The CAUSE OF DEATH* was as follows:

Exhaustion due to Acute mania

(Duration) _____ yrs. 5 mos. 3 ds.

Contributory (Secondary)

(Duration) _____ yrs. _____ mos. _____ ds.

(Signed)

Francis H. Poole

M. D.

Feb. 8 1913 (Address) Blackfoot, Ida

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL,

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place _____ In the _____
of death _____ yrs. 5 mos. 3 ds. State _____ yrs. _____ mos. _____ ds.

Where was Disease contracted,

If not at place of death?

Former or

usual residence.

Twin Falls, Idaho

19. PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

Twin Falls, Ida1913

20. UNDERTAKER

ADDRESS

E. J. Peck,Blackfoot

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Form V. S. No. 5. 12½ M. 7-24-11

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics
File No. 4256
Registered No. 15

1. PLACE OF DEATH Registration District No. 13
County of Bingham Primary Registration District No. 1007
City of Blackfoot (No. 410, 80 Skilling St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

Unmarried Paxton

If death occurred in a hospital, institution or camp give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX Female 4. COLOR OR RACE White 5. SINGLE, MARRIED, WIDOWED OR DIVORCED. 5
(Write the word.)

6. DATE OF BIRTH Feb 11 1913
(Month) (Day) (Year)

7. AGE _____ yrs. _____ mos. _____ ds. IF LESS than 1 day how many _____ hrs. or _____ min?

8. OCCUPATION

- (a) Trade, profession or particular kind of work. _____
(b) General nature of industry business or establishment in which employed (or employer) _____

9. BIRTHPLACE

(State or Country) Idaho

10. NAME OF FATHER

Eph Paxton

11. BIRTHPLACE OF FATHER

(State or Country) Utah

12. MAIDEN NAME OF MOTHER

Sarah Goodson

13. BIRTHPLACE OF MOTHER

(State or Country) Utah

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) E Paxton

(Address) Blackfoot Idaho

15.

Filed Feb 11 1913

Local Registrar M. E. Patric

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH

Feb 11 1913
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from 1913 to 1913

that I last saw him alive on 1913 and that death occurred on the date stated above, at 8 A.M.

The CAUSE OF DEATH* was as follows:

Premature - 7 months in utero

_____ (Duration) _____ yrs. _____ mos. _____ ds.

Contributory (Secondary) _____

_____ (Duration) _____ yrs. _____ mos. _____ ds.

(Signed) M. E. Patric M. D.

_____ 19 _____ (Address) _____

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place _____ In the _____
of death. _____ yrs. _____ mos. _____ ds. State. _____ yrs. _____ mos. _____ ds.

Where was disease contracted, _____

If not at place of death? _____

Former or _____

usual residence. _____

19. PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

Provo City from Blackfoot

Feb 11 1913

20. UNDERTAKER

ADDRESS

E Paxton

Blackfoot

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

1. PLACE OF DEATH. Registration District No. 13
County of Bingham Primary Registration District No. 2053
City of Blackfoot (No. , St.)
Thomas Ward
If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Joseph Parson

If death occurred in a hospital, institution or camp give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX Male 4. COLOR OR RACE White 5. SINGLE, MARRIED, WIDOWED OR DIVORCED. Married
(Write the word.)

6. DATE OF BIRTH 25 Dec 1884
(Month) (Day) (Year)

7. AGE 28 yrs. 2 mos. 17 ds. IF LESS than 1 day how many hrs. or min?

8. OCCUPATION
(a) Trade, profession or particular kind of work. Farmer
(b) General nature of industry business or establishment in which employed (or employer)

9. BIRTHPLACE Idaho Bingham Co
(State or Country)

10. NAME OF FATHER John A. Parsons

11. BIRTHPLACE OF FATHER North Carolina
(State or Country)

12. MAIDEN NAME OF MOTHER Hendricks

13. BIRTHPLACE OF MOTHER Iowa
(State or Country)

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) William A. Parsons
(Address)

15. Feb 12 1913 W. E. Pattee
Filed Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH Feb 11 1913
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from Jan 14 1913, to Feb 11 1913 that I last saw him alive on Feb 11 1913 and that death occurred on the date stated above, at 5:00 P.M.

The CAUSE OF DEATH* was as follows:
Pharyngitis
followed with Paralysis of
Bowels

(Duration) yrs. mos. ds.

Contributory (Secondary)

(Duration) yrs. mos. ds.

(Signed) John B. Cooper M. D.
19 (Address)

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place In the
of death yrs. mos. ds. State yrs. mos. ds.
Where was disease contracted,
If not at place of death?
Former or
usual residence.

19. PLACE OF BURIAL OR REMOVAL DATE OF BURIAL
Riverside Thomas Cem Feb 13 1913

20. UNDERTAKER ADDRESS
E J Ruck Blackfoot

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Form V. S. No. 5. 12½ M. 7-24-11

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics
File No. 4258
Registered No. 17

1. PLACE OF DEATH. Registration District No. 13
County of Bingham Primary Registration District No. 1007
City of Blackfoot (No. 1007 St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Fredrick Carter Miller

If death occurred in a hospital, institution or camp give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX Male 4. COLOR OR RACE White 5. SINGLE, MARRIED, WIDOWED OR DIVORCED. Single (Write the word.)

6. DATE OF BIRTH 8 24 1904 (Month) (Day) (Year)

7. AGE 8 yrs. 5 mos. 18 ds. IF LESS than 1 day how many hrs. or min?

8. OCCUPATION

(a) Trade, profession or particular kind of work. School boy
(b) General nature of industry business or establishment in which employed (or employer)

9. BIRTHPLACE

(State or Country) Bingham Co Idaho

10. NAME OF FATHER

James M Miller

11. BIRTHPLACE OF FATHER

(State or Country) Id.

12. MAIDEN NAME OF MOTHER

Alice S Warren

13. BIRTHPLACE OF MOTHER

(State or Country) Bingham Co Idaho

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) J. A. Warren

(Address)

15. Feb 13 1913 M. E. Patie Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

Feb. 11 1913 (Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from Feb. 11 1913, to Feb. 11 1913

that I last saw him alive on Feb. 11 1913

and that death occurred on the date stated above, at 11:45 P. M.

The CAUSE OF DEATH* was as follows:

Pneumonia

(Duration) yrs. 0 mos. 2 ds.

Contributory (Secondary) Measels

(Duration) yrs. 0 mos. 3 ds.

(Signed) F. W. Mitchell M. D. Feb. 12 1913 (Address) Blackfoot, Idaho

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place In the of death yrs. mos. ds. State yrs. mos. ds. Where was disease contracted, If not at place of death? Former or usual residence

19. PLACE OF BURIAL OR REMOVAL DATE OF BURIAL

Iron City Cemetery 1913

20. UNDERTAKER ADDRESS

E. J. Beck Blackfoot

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Form V. S. No. 5. 12½M.7-24-11

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics
File No. 4259
Registered No. 18

1. PLACE OF DEATH, Registration District No. 13
County of Bingham Primary Registration District No. 1007
City of Blackfoot (No. 94, So Taylor St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

Mary Miller

If death occurred in a hospital, institution or camp give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX Female 4. COLOR OR RACE White 5. SINGLE, MARRIED, WIDOWED OR DIVORCED. Single
(Write the word.)

6. DATE OF BIRTH Jan 25 1903
(Month) (Day) (Year)

7. AGE 10 yrs. 2 mos. 18 ds. IF LESS than 1 day how many hrs. or min?

8. OCCUPATION

- (a) Trade, profession or particular kind of work
(b) General nature of industry business or establishment in which employed (or employer)

9. BIRTHPLACE (State or Country) Kansas

10. NAME OF FATHER Carl Miller

11. BIRTHPLACE OF FATHER (State or Country) Russia

12. MAIDEN NAME OF MOTHER Katharina Fiege

13. BIRTHPLACE OF MOTHER (State or Country) Russia

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE (Informant) Carl Miller
(Address) Blackfoot Idaho

15. Filed Feb 12 1913 M.E. Patric Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH Feb 12 1913
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from Feb 8 1913, to Feb 12 1913

that I last saw her alive on Feb 12 1913

and that death occurred on the date stated above, at 4:20 a.m.

The CAUSE OF DEATH* was as follows:

Spasmodic Croup

(Duration) yrs. mos. 2 ds.

Contributory (Secondary) Muscles

(Duration) yrs. mos. 5 ds.

(Signed) M.E. Patric M.D.
2-12 1913 (Address) Blackfoot Idaho

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; (2) whether ACCIDENTAL, SUICIDAL OR HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place In the
of death yrs. mos. ds. State yrs. mos. ds.

Where was disease contracted,

If not at place of death?

Former or

usual residence.

19. PLACE OF BURIAL OR REMOVAL DATE OF BURIAL
Burr City Idaho 2-13 1913
Blackfoot Idaho

20. UNDERTAKER ADDRESS
Carl Miller

Form V. S. No. 5. 12½ M. 7-24-11

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics
File No. 4269
Registered No. 19

1. PLACE OF DEATH Registration District No. 13
County of Bannock Primary Registration District No. 4007
City of Blackfoot (No. 700 East Court St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

Kenneth Taylor Edwards

If death occurred in a hospital, institution or camp give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX Male 4. COLOR OR RACE White 5. SINGLE, MARRIED, WIDOWED OR DIVORCED. Single
(Write the word.)

6. DATE OF BIRTH Oct 17 1910
(Month) (Day) (Year)

7. AGE 2 yrs. 3 mos. 28 ds. IF LESS than 1 day how many hrs. or min?

8. OCCUPATION

(a) Trade, profession or particular kind of work. None
(b) General nature of industry business or establishment in which employed (or employer)

9. BIRTHPLACE (State or Country) Idaho

10. NAME OF FATHER Harvey B. Edwards

11. BIRTHPLACE OF FATHER (State or Country) Ohio

12. MAIDEN NAME OF MOTHER Mary Agnes Taylor

13. BIRTHPLACE OF MOTHER (State or Country) Utah

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) H. B. Edwards
(Address) Blackfoot Idaho

15. Feb 15 1913 W. E. Patric
Filed Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH Feb. 15th 1913
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from Feb 11 1913, to Feb 15 1913
that I last saw him alive on Feb 15 1913
and that death occurred on the date stated above, at 2 P. M.

The CAUSE OF DEATH* was as follows:

Lobar Pneumonia - right side

(Duration) yrs. mos. 2 ds.
Contributory (Secondary) Lagrippe

(Duration) yrs. mos. 8 ds.
(Signed) W. E. Patric M. D.
2-15 1913 (Address) Blackfoot Idaho

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place In the
of death yrs. mos. ds. State yrs. mos. ds.
Where was disease contracted,
If not at place of death?
Former or
usual residence

19. PLACE OF BURIAL OR REMOVAL DATE OF BURIAL
Hope City Cemetery Feb. 17 1913
Blackfoot Idaho

20. UNDERTAKER ADDRESS
H B Edwards Blackfoot.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Form V. S. No. 5. 12½ M. 7-24-11

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics
File No. 1281
Registered No. 20

1. PLACE OF DEATH. Registration District No. 13
County of Bingham Primary Registration District No. 2053
City of Blackfoot (No. _____, _____ St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

Ella Fern McCalliey

If death occurred in a hospital, institution or camp give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX Female 4. COLOR OR RACE White 5. SINGLE, MARRIED, WIDOWED OR DIVORCED. Single
(Write the word.)

6. DATE OF BIRTH

May 14 1910
(Month) (Day) (Year)

7. AGE

2 yrs. 6 mos. 6 ds.

IF LESS than 1 day
how many _____ hrs. or
_____ min?

8. OCCUPATION

- (a) Trade, profession or particular kind of work. _____
(b) General nature of industry business or establishment in which employed (or employer) _____

9. BIRTHPLACE

(State or Country) Utah

10. NAME OF FATHER

Frank L. McCuley

11. BIRTHPLACE OF FATHER

(State or Country) Wis.

12. MAIDEN NAME OF MOTHER

Elice Hony

13. BIRTHPLACE OF MOTHER

(State or Country) Utah

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) F. L. McClawley

(Address) Rt. 2 Box 3 Blackfoot

15.

Filed Feb 21 1913

W. E. Patie
Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH

Feb 20 1913
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from

Feb 12 1913, to Dec 20 1913

that I last saw her alive on Dec 20 1913

and that death occurred on the date stated above, at 4:30 M.

The CAUSE OF DEATH* was as follows:

Pneumonia
(Duration) _____ yrs. _____ mos. 8 ds.

Contributory (Secondary) whooping cough

(Duration) _____ yrs. _____ mos. 7 ds.

(Signed) F. L. McClawley M. D.

Feb 20 1913 (Address) Blackfoot, Idaho

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place _____ In the _____
of death _____ yrs. _____ mos. _____ ds. State _____ yrs. _____ mos. _____ ds.

Where was disease contracted,

If not at place of death? _____

Former or

usual residence _____

19. PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

G. C. cemetery Blackfoot Feb 22 1913

20. UNDERTAKER

ADDRESS

E. J. Funk Blackfoot

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Form V. S. No. 5. 12½ M. 7-24-11

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics
File No. 4262
Registered No. 2

1. PLACE OF DEATH. Registration District No. 13
County of Bingham Primary Registration District No. 1007
City of Blackfoot (No. Blackfoot Hospital St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Hans Fredrick Peterson

If death occurred in a hospital, institution or camp give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX 4. COLOR OR RACE 5. SINGLE, MARRIED, WIDOWED OR DIVORCED.

Male white (Write the word.)
6. DATE OF BIRTH 12 18 1
(Month) (Day) (Year)

7. AGE 22 yrs. 2 mos. 1 ds. IF LESS than 1 day how many hrs. or min?

8. OCCUPATION
(a) Trade, profession or particular kind of work. Farmer
(b) General nature of industry business or establishment in which employed (or employer)

9. BIRTHPLACE (State or Country) Plain City Utah

10. NAME OF FATHER Hans. Peterson

11. BIRTHPLACE OF FATHER (State or Country) Plain City Utah

12. MAIDEN NAME OF MOTHER Sarah Wheeler

13. BIRTHPLACE OF MOTHER (State or Country) Agden

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Basil Peterson
(Address)

15. Feb 21 1913 M. G. Patric
Filed Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH 2 20 1913
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from Feb 16 1913, to Feb 20 1913, that I last saw him alive on Feb 20 1913, and that death occurred on the date stated above, at 5 A.M.

The CAUSE OF DEATH* was as follows:
operation on for appendicitis
Feb 17 at 10 a.m. died
as above state from Pneumonia

(Duration) yrs. mos. 2 ds.
Contributory (Secondary) Cause Cirrhosis administration
Pneumonia
(Duration) yrs. mos. ds.
(Signed) Chas. H. Hays M. D.
Feb 21 1913 (Address) Blackfoot, Idaho

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place In the
of death yrs. mos. ds. State yrs. mos. ds.
Where was disease contracted,
If not at place of death?
Former or
usual residence

19. PLACE OF BURIAL OR REMOVAL DATE OF BURIAL
Russell Thomas Cemetery Feb 23 1913

20. UNDERTAKER ADDRESS
E. J. Ruck Blackfoot

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Form V. S. No. 5 20M.1-16-12

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH. Registration District No. 13
County of Bingham Primary Registration District No. 2053
City of Porterville (St.)

File No. 4263
Registered No. 22

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME: Wayne Chas. Taylor

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX Male 4. COLOR OR RACE White 5. SINGLE, MARRIED, WIDOWED OR DIVORCED. Single
(Write the word.)

6. DATE OF BIRTH Oct 8 1912
(Month) (Day) (Year)

7. AGE 4 yrs. 5 mos. 5 ds. IF LESS than 1 day how many hrs. or mins.?

8. OCCUPATION

- (a) Trade, profession or particular kind of work
(b) General nature of industry, business, or establishment in which employed (or employer)

9. BIRTHPLACE

(State or Country) Idaho

10. NAME OF FATHER

Chas. A. Taylor

11. BIRTHPLACE OF FATHER

(State or Country) Utah

12. MAIDEN NAME OF MOTHER

Patricia Jackman

13. BIRTHPLACE OF MOTHER

(State or Country) Utah

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Chas. G. Taylor(Address) Blackfoot R.F.D.

15.

Filed Feb 24 19133

M.E. Patric
Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH

Feb 23 1913
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from unregulated death
1913 to 1913

that I last saw him alive on Feb 23 1913
and that death occurred on the date stated above, at 5:30 P.M.

The CAUSE OF DEATH* was as follows:

Sudden death from pneumonia

(Duration) yrs. mos. 6 ds.

Contributory (Secondary)

(Duration) yrs. mos. ds.

(Signed) M.E. Patric M.D.

Feb 24 1913 (Address) Blackfoot

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death yrs. mos. days. In the State yrs. mos. days.

Where was disease contracted if not at place of death?

Former or usual residence.

19. PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

Blackfoot Feb 25 1913

20. UNDERTAKER

ADDRESS

Chas. A. Taylor Blackfoot

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Form V. S. No. 5. 12½ M. 7-24-11

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics
File No. 4264
Registered No. 23

1. PLACE OF DEATH. Registration District No. 13
County of Blaine Primary Registration District No. 2053
City of Blackfoot (No. , St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Unnamed Mark

If death occurred in a hospital, institution or camp give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX Female 4. COLOR OR RACE White 5. SINGLE, MARRIED, WIDOWED OR DIVORCED. Single (Write the word.)

6. DATE OF BIRTH Feb. 13 1913
(Month) (Day) (Year)

7. AGE yrs. 14 ds. IF LESS than 1 day how many hrs. or min?

8. OCCUPATION
(a) Trade, profession or particular kind of work.
(b) General nature of industry business or establishment in which employed (or employer)

9. BIRTHPLACE (State or Country) Blackfoot, Idaho

10. NAME OF FATHER David Marks

11. BIRTHPLACE OF FATHER (State or Country) Austria

12. MAIDEN NAME OF MOTHER Minnie Marshmuth

13. BIRTHPLACE OF MOTHER (State or Country) Germany

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE (Informant) David Marks (Address) Blackfoot Route #3

15. Filed Feb 28 1913 M. E. Patie Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH Feb. 27 1913
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from Feb. 27 1913, to Feb. 27 1913 that I last saw ~~last~~ alive on 1913 and that death occurred on the date stated above, at 10:30 P. M. The CAUSE OF DEATH* was as follows:

Premature 7 months.
(Duration) yrs. mos. ds.
Contributory Plethora - Prura (Secondary)
(Duration) yrs. mos. ds.
(Signed) F. W. Mitchell M. D.
Feb. 27 1913 (Address) Blackfoot, Idaho

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place In the
of death yrs. mos. ds. State yrs. mos. ds.
Where was disease contracted,
If not at place of death?
Former or
usual residence.

19. PLACE OF BURIAL OR REMOVAL DATE OF BURIAL
G. C. Cem. Blackfoot Mch 1 1913

20. UNDERTAKER ADDRESS
David Marks

Form V. S. No. 5. 10M. 6-20-11.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH.

Registration District No. 13County of BenewahPrimary Registration District No. 2053City of Blackfoot Idaho(No. Idaho State Asylum St.)File No. 4265Registered No. 24

If death occurred in a hospital, institution or camp give its NAME instead of street and number.

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

Chas B. Doolittle

PERSONAL AND STATISTICAL PARTICULARS

3. SEX

M.

4. COLOR OR RACE

White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED.

Widowed
(Write the word.)

6. DATE OF BIRTH

1837

(Month)

(Day)

(Year)

7. AGE

76 yrs.

mos.

ds.

IF LESS than 1 day
how many hrs. or
..... min.?

8. OCCUPATION

(a) Trade, profession, or particular kind of work

(b) General nature of industry business, or establishment in which employed (or employer)

Live Stock dealer

9. BIRTHPLACE

(State or Country)

New York

10. NAME OF FATHER

Do not know

11. BIRTHPLACE OF FATHER

(State or Country)

" " "

12. MAIDEN NAME OF MOTHER

" " "

13. BIRTHPLACE OF MOTHER

(State or Country)

" " "

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

H. J. Simmons

(Address)

Blackfoot Idaho

15.

Filed

Mar 1 1913W. E. Patric

Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

Feb

(Month)

27

(Day)

1913

(Year)

17. I HEREBY CERTIFY, That I attended deceased from

Nov 1 27 1912, to Feb 27 1913that I last saw him alive on Feb 27 1913,and that death occurred on the date stated above, at 12:45 p.m.

The CAUSE OF DEATH* was as follows:

Paralytic Dementia(Duration) 2 yrs. mos. ds.Contributory
(Secondary)Embolus of Brain

(Duration) yrs. mos. ds.

(Signed) H. J. Simmons M. D.Feb 28 1913 (Address) Blackfoot Idaho

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL,

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place

In the

of death 1 yrs. 8 mos. ds. State 7 yrs. mos. ds.

Where was Disease contracted,

If not at place of death?

Former or

usual residence

Idaho

19. PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

Elkhart IowaMarch 2 1913

20. UNDERTAKER

ADDRESS

E. J. PuckBlackfoot

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Form V. S. No. 5. 12½M.7-24-11

CERTIFICATE OF DEATH

1. PLACE OF DEATH.
County of Trin Falls
City of Buhl

Registration District No. 1087
Primary Registration District No. 23
(No. _____, _____ St.)

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics
File No. 4266
Registered No. _____

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Baby Ambres

If death occurred in a hospital, institution or camp give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX male 4. COLOR OR RACE white 5. SINGLE, MARRIED, WIDOWED OR DIVORCED. single
(Write the word.)

6. DATE OF BIRTH Feb 10 1913
(Month) (Day) (Year)

7. AGE _____ yrs. _____ mos. 5 ds. IF LESS than 1 day how many _____ hrs. or _____ min?

8. OCCUPATION
(a) Trade, profession or particular kind of work. none
(b) General nature of industry business or establishment in which employed (or employer) _____

9. BIRTHPLACE
(State or Country) Buhl Ida.

10. NAME OF FATHER W.A. Ambres

11. BIRTHPLACE OF FATHER
(State or Country) ILL.

12. MAIDEN NAME OF MOTHER Clara Celgrove

13. BIRTHPLACE OF MOTHER
(State or Country) Neb

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) J. Murphy
(Address) Buhl

15. Filed 2-16 1913 J. Murphy
Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH Feb 15 1913
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from Feb 10 1913 to Feb 15 1913
that I last saw him alive on Feb 15 1913
and that death occurred on the date stated above, at 5pm M.

The CAUSE OF DEATH* was as follows:
Occlusion of bowels

(Duration) _____ yrs. _____ mos. _____ ds.
Contributory none
(Secondary)

(Duration) _____ yrs. _____ mos. _____ ds.
(Signed) J. Murphy M. D.
2-16 1913 (Address) Buhl.

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place _____ In the _____
of death _____ yrs. _____ mos. _____ ds. State _____ yrs. _____ mos. _____ ds.
Where was disease contracted,
If not at place of death? _____
Former or
usual residence _____

19. PLACE OF BURIAL OR REMOVAL at Home. DATE OF BURIAL 2-16 1913.

20. UNDERTAKER None. ADDRESS _____

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Form V. S. No. 5. 12½M.7-24-11

CERTIFICATE OF DEATH

1. PLACE OF DEATH.
County of Twine Falls
City of Buhl

Registration District No. 2087
Primary Registration District No. 23
(No. _____, _____ St.)

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics
File No. 4267
Registered No. _____

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

Gas Albert Wilson

If death occurred in a hospital, institution or camp give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX M. 4. COLOR OR RACE white 5. SINGLE, MARRIED, WIDOWED OR DIVORCED. Single
(Write the word.)

6. DATE OF BIRTH Jan 13 1913
(Month) (Day) (Year)

7. AGE _____ yrs. 1 mos. 2 ds. IF LESS than 1 day
how many _____ hrs. or _____ min?

8. OCCUPATION

(a) Trade, profession or particular kind of work None
(b) General nature of industry business or establishment in which employed (or employer)

9. BIRTHPLACE

(State or Country) Buhl Ida.

10. NAME OF FATHER D. C. Wilson

11. BIRTHPLACE OF FATHER Oakley Kan.
(State or Country)

12. MAIDEN NAME OF MOTHER Louella Miller

13. BIRTHPLACE OF MOTHER Waukegan Mo.
(State or Country)

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) D. C. Wilson
(Address) Buhl

15. _____
Filed 2-15 1913 J. Murphy
Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH Feb. 15 1913
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from Feb. 14 1913, to 1913

that I last saw him alive on Feb. 14 1913
and that death occurred on the date stated above, at 10 P. M.

The CAUSE OF DEATH* was as follows:

Consultation

(Duration) _____ yrs. _____ mos. 1 ds.
Contributory Precedure birth
(Secondary)

(Duration) _____ yrs. _____ mos. _____ ds.
(Signed) J. Murphy M. D.
2-15 1913 (Address) Buhl Ida.

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place _____ In the _____
of death _____ yrs. _____ mos. _____ ds. State _____ yrs. _____ mos. _____ ds.
Where was disease contracted,
If not at place of death?
Former or
usual residence.

19. PLACE OF BURIAL OR REMOVAL Home DATE OF BURIAL 2-17 1913

20. UNDERTAKER None ADDRESS _____

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Form V. S. No. 5 20M.1-16-12

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH

Registration District No. 23

County of Twin Falls

Primary Registration District No. 2086

City of Filer

(No. _____)

St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

Paul Sommer

Registered No. _____

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX

4. COLOR OR RACE

5. SINGLE, MARRIED, WIDOWED OR DIVORCED.

6. DATE OF BIRTH

7. AGE

IF LESS than 1 day
how many _____ hrs. or
_____ mins.

8. OCCUPATION

- (a) Trade, profession or particular kind of work
(b) General nature of industry business, or establishment in which employed (or employer)

9. BIRTHPLACE

(State or Country)

10. NAME OF FATHER

11. BIRTHPLACE OF FATHER

(State or Country)

12. MAIDEN NAME OF MOTHER

13. BIRTHPLACE OF MOTHER

(State or Country)

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

(Address)

15.

Filed

2-10

1913

John H. Longley
Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH

2

8

1913

(Month)

(Day)

(Year)

17. I HEREBY CERTIFY, That I attended deceased from

Feb 7 1913, to Feb 7 1913,

that I last saw him alive on Feb 7 1913,

and that death occurred on the date stated above, at 402 M.

The CAUSE OF DEATH* was as follows:

Pneumonia

(Duration) _____ yrs. 4 mos. 4 ds.

Contributory
(Secondary)

(Duration) _____ yrs. _____ mos. _____ ds.

(Signed) A. A. Newberry M. D.

2-8 1913 (Address) Filer

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death _____ yrs. _____ mos. _____ days. In the State _____ yrs. _____ mos. _____ days.

Where was disease contracted if not at place of death? _____

Former or usual residence _____

19. PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

Filer Cemetery Feb 8 1913

20. UNDERTAKER

ADDRESS

J. J. Grossman Twin Falls

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Form V. S. No. 5 20M.1-16-12		CERTIFICATE OF DEATH		State of Idaho BOARD OF HEALTH Bureau of Vital Statistics	
1. PLACE OF DEATH		Registration District No. 23		File No. 1270	
County of Twin Falls		Primary Registration District No. 2086		Registered No.	
City of Tiler, Idaho (No. St.)		2. FULL NAME Lewis J. Pond		If death occurred in a hospital, institution or camp, give its NAME instead of street and number.	
PERSONAL AND STATISTICAL PARTICULARS					
3. SEX Male		4. COLOR OR RACE White		5. SINGLE, MARRIED, WIDOWED OR DIVORCED Married	
6. DATE OF BIRTH March 4, 1952		(Month) (Day) (Year)			
7. AGE 60 yrs. 11 mos. 14 ds.		IF LESS than 1 day how many hrs. or mins.?			
8. OCCUPATION Farmer					
(a) Trade, profession or particular kind of work					
(b) General nature of industry business, or establishment in which employed (or employer)					
9. BIRTHPLACE Ohio					
(State or Country)					
10. NAME OF FATHER Julius Pond					
11. BIRTHPLACE OF FATHER Conn.					
(State or Country)					
12. MAIDEN NAME OF MOTHER Sarah Scott.					
13. BIRTHPLACE OF MOTHER N. York.					
(State or Country)					
14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE					
(Informant) L. E. Pond					
(Address) Tiler, Ida					
15. Filed 2-21 1913 John H. Hager Local Registrar					
MEDICAL CERTIFICATE OF DEATH					
16. DATE OF DEATH Feb 18 1913					
(Month) (Day) (Year)					
17. I HEREBY CERTIFY, That I attended deceased from 191. to 191. that I last saw h. alive on 191. and that death occurred on the date stated above, at M.					
The CAUSE OF DEATH* was as follows: I saw the deceased ^{alive} last, some time in the fall of 1912. He was apparently in last stages of failing compensation of a myeloid degeneration.					
(Duration) yrs. mos. ds.					
Contributory (Secondary)					
(Duration) yrs. mos. ds.					
(Signed) J. E. Pond M. D.					
2-10 1913 (Address) Twin Falls, Idaho					
*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.					
18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)					
At place of death yrs. mos. days. In the State yrs. mos. days.					
Where was disease contracted if not at place of death?					
Former or usual residence.					
19. PLACE OF BURIAL OR REMOVAL DATE OF BURIAL					
Tiler, Ida Feb 21, 1913					
20. UNDERTAKER ADDRESS					
J. F. Grossman Twin Falls					

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Form V. S. No. 5 20M.1-16-12

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH. Registration District No. 23
County of Twin Falls Primary Registration District No. 2085
City of Twin Falls (No. _____, St.)

File No. 1271

Registered No. _____

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME muhammad Brown

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX 71 4. COLOR OR RACE white 5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.)

6. DATE OF BIRTH

2 9 1913
(Month) (Day) (Year)

7. AGE

____ yrs. ____ mos. ____ ds.

IF LESS than 1 day
how many ____ hrs. or
____ mins.?

8. OCCUPATION

- (a) Trade, profession or particular kind of work
(b) General nature of industry, business, or establishment in which employed (or employer)

9. BIRTHPLACE

(State or Country) Idaho

10. NAME OF FATHER Ray E Brown

11. BIRTHPLACE OF FATHER

(State or Country) Iowa

12. MAIDEN NAME OF MOTHER Keith Bourcough

13. BIRTHPLACE OF MOTHER

(State or Country) Iowa

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) S. Claud Stewart

(Address) Twin Falls

15.

Filed 2-9 1913 John H. Bugler
Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH

2 9 1913
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from

2-9 1913, to 2-9 1913

that I last saw him alive on 2-9 1913

and that death occurred on the date stated above, at 3:40 PM

The CAUSE OF DEATH* was as follows:

Premature Birth (5 1/2 mo.)

(Duration) 40 min yrs. ____ mos. ____ ds.

Contributory
(Secondary)

(Duration) ____ yrs. ____ mos. ____ ds.

(Signed) Dr. J. L. Alexander M.D.

2-9 1913 (Address) Twin Falls Idaho

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death ____ yrs. ____ mos. ____ days. In the State ____ yrs. ____ mos. ____ days.

Where was disease contracted if not at place of death?

Former or usual residence.

19. PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

Filer

Feb 9 1913

20. UNDERTAKER

ADDRESS

P. J. Crossman

Twin Falls

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Form V. S. No. 5 20M.1-16-12

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH.

Registration District No. 23

County of Twin Falls

Primary Registration District No. 2085

City of _____

(No. _____, St.)

Registered No. _____

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

Hans J. Woge

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX

4. COLOR OR RACE

5. SINGLE, MARRIED, WIDOWED OR DIVORCED.

Male

White

Single (Use the word.)

6. DATE OF BIRTH

Unknown
(Month) (Day) (Year)

7. AGE

42 yrs. 0 mos. 0 ds.

IF LESS than 1 day
how many hrs. or
mins.

8. OCCUPATION

(a) Trade, profession or particular kind of work

Farmer

(b) General nature of industry business, or establishment in which employed (or employer)

9. BIRTHPLACE

(State or Country)

Minnesota

10. NAME OF FATHER

Arne. Woge

11. BIRTHPLACE OF FATHER

(State or Country)

Sweden

12. MAIDEN NAME OF MOTHER

Ingeborg Hermanson

13. BIRTHPLACE OF MOTHER

(State or Country)

Norway

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

C. A. Waterman

(Address)

Twin Falls

15.

Filed

Feb 12 1913

John H. Hughes
Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH

Feb. 9 1913
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from

June 1910, to July 1913,
that I last saw him alive on July 1913,
and that death occurred on the date stated above, at 5 P.M.

The CAUSE OF DEATH* was as follows:

Heart Failure secondary to
badly distended Stomach - Scirrhosis of
liver and Enlarged hypertrophied heart

(Duration) 3 yrs. 0 mos. 0 ds.

Contributory
(Secondary)

Nephritic Kidney

(Duration) 0 yrs. 0 mos. 0 ds.

(Signed)

J. R. Morgan

M. D.

Feb. 9 1913 (Address) Twin Falls, Ida

*State the DISEASE CAUSING DEATH; or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death 0 yrs. 0 mos. 0 days. In the State 0 yrs. 0 mos. 0 days.

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

Madelia, Minn.

1913

20. UNDERTAKER

ADDRESS

Charles J. Crosby Twin Falls

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Form V. S. No. 5 20M.1-16-12

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH

Registration District No. 23

County of Twin Falls

Primary Registration District No. 2085

City of Triler

(No. _____)

St.)

File No. 4273

Registered No. _____

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

Ely I Davis

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX

Male

4. COLOR OR RACE

White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED

Married

6. DATE OF BIRTH

Jan

19

1877

(Month)

(Day)

(Year)

7. AGE

36 yrs. 1 mos. 13 ds.

IF LESS than 1 day
how many hrs. or
..... mins.?

8. OCCUPATION

(a) Trade, profession or particular kind of work

Farmer

(b) General nature of industry business, or establishment in which employed (or employer)

9. BIRTHPLACE

(State or Country)

Miss.

10. NAME OF FATHER

Charles Davis

11. BIRTHPLACE OF FATHER

(State or Country)

Miss.

12. MAIDEN NAME OF MOTHER

Ellen White

13. BIRTHPLACE OF MOTHER

(State or Country)

Miss.

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

Mrs Ely I Davis

(Address)

Triler

15.

Filed

3-1

1913

John H. Hughes
Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH

Feb

25

1913

(Month)

(Day)

(Year)

17. I HEREBY CERTIFY, That I attended deceased from

Feb 20

1913

to Feb 25

1913

that I last saw him alive on Feb 26 1913

and that death occurred on the date stated above, at 7:30 P.M.

The CAUSE OF DEATH* was as follows:

Tubercular Peritonitis

(Duration) not known yrs. mos. ds.

Contributory
(Secondary)

(Duration) not known yrs. mos. ds.

(Signed)

For Boyd

M. D.

Feb 1, 1913

(Address)

For Boyd

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death yrs. mos. days. In the State yrs. mos. days.

Where was disease contracted if not at place of death?

Former or usual residence.

19. PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

Twin Falls

Feb. 15, 1913

20. UNDERTAKER

ADDRESS

J. J. Grossman

Twin Falls

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Form V. S. No. 5 20M.1-16-12

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH

Registration District No. 23County of Thom FallsPrimary Registration District No. 2085

City of _____

(No. _____)

St. _____

Registered No. _____

If death occurs away from usual residence, give facts called for under special information.

2.

FULL NAME

Louis Norris Decker

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX

4. COLOR OR RACE

5. SINGLE, MARRIED, WIDOWED OR DIVORCED.

MaleWhiteSingle (Use the word.)

6. DATE OF BIRTH

January (Month)15 (Day)1900 (Year)

7. AGE

13 yrs.1 mos.8 ds.

IF LESS than 1 day
how many _____ hrs. or
_____ mins.

8. OCCUPATION

(a) Trade, profession or particular kind of work

(b) General nature of industry business, or establishment in which employed (or employer)

School boy

9. BIRTHPLACE

(State or Country)

Nebraska

10. NAME OF FATHER

Louis Byron Decker

11. BIRTHPLACE OF FATHER

(State or Country)

Wisconsin

12. MAIDEN NAME OF MOTHER

Archie Elizabeth Williams

13. BIRTHPLACE OF MOTHER

(State or Country)

Missouri

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

L. B. Decker

(Address)

Thom Falls

15.

Filed

2-241913

John H. Decker
Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH

Feb (Month)23rd (Day)1913 (Year)

17. I HEREBY CERTIFY, That I attended deceased from

Feb (Month)11 (Day)1913 (Year)

to

Feb (Month)23rd (Day)1913 (Year)

that I last saw him alive on

and that death occurred on the date stated above, at 9:17 P.M.

The CAUSE OF DEATH* was as follows:

Acute Pericarditis
Acute Lobar pneumonia Double

(Duration)

yrs.

mos.

7 ds.

Contributory (Secondary)

Abscess of tonsils

(Duration)

yrs.

mos.

1st ds.

(Signed)

Wm. T. Alexander M. D.7/24/1913 (Address) Thom Falls, Id.

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death

yrs.

mos.

days.

In the State

yrs.

mos.

days.

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

Thom Falls2/24 1913

20. UNDERTAKER

ADDRESS

Charles J. ConleyThom Falls

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Form V. S. No. 5 20M.1-16-12

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH.

Registration District No. 23County of Twin FallsPrimary Registration District No. 2085City of Twin Falls

(No. _____, _____ St.)

File No. 1275

Registered No. _____

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Percy Loren Lighthall

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX

4. COLOR OR RACE

5. SINGLE, MARRIED, WIDOWED OR DIVORCED.

MaleWhiteSingle
(Write the word.)

6. DATE OF BIRTH

Dec. 25,1883

(Month)

(Day)

(Year)

7. AGE

29 yrs. 2 mos. 3 ds.

IF LESS than 1 day
how many _____ hrs. or
_____ mins.?

8. OCCUPATION

(a) Trade, profession or particular kind of work

Book-keeper

(b) General nature of industry business, or establishment in which employed (or employer)

9. BIRTHPLACE

(State or Country)

Picton, Canada,

10. NAME OF FATHER

A. Lighthall

11. BIRTHPLACE OF FATHER

(State or Country)

Picton, Canada

12. MAIDEN NAME OF MOTHER

Mary A. Baillie

13. BIRTHPLACE OF MOTHER

(State or Country)

Picton, Canada

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

A. Lighthall

(Address)

Bloomfield apt

15.

Filed 2-22191 3Local Registrar John H. Hughes

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH

Feb271913

(Month)

(Day)

(Year)

17. I HEREBY CERTIFY, That I attended deceased from

Sept 1"1912

to

Feb 271913,that I last saw him alive on Feb 26 1913,and that death occurred on the date stated above, at 1:30 P. M.

The CAUSE OF DEATH* was as follows:

Brain Tumor

(Duration)

yrs. 6

mos. _____

ds. _____

Contributory
(Secondary)

(Duration)

yrs. _____

mos. _____

ds. _____

(Signed)

John H. Hughes

M. D.

Feb 27, 1913 (Address) Twin Falls, Idaho

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place

of death _____ yrs. _____ mos. _____ days.

In the

State _____ yrs. _____ mos. _____ days.

Where was disease contracted if not at place of death? _____

Former or usual residence _____

19. PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

Bloomfield, Canada191

20. UNDERTAKER

ADDRESS

Twin Falls

MARGIN RESERVED FOR BINDING

WHITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Form V. S. No. 5 20M.1-16-12

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH. Registration District No. 23
County of Twin Falls Primary Registration District No. 2085
City of _____ (No. _____, St.) Registered No. _____

If death occurs away from usual residence, give facts called for under special information. 2. FULL NAME Verna Barnes

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX Female 4. COLOR OR RACE White 5. SINGLE, MARRIED, WIDOWED OR DIVORCED. Single (the word.)

6. DATE OF BIRTH May 27, 1911
(Month) (Day) (Year)

7. AGE 191 yrs. 8 mos. 25 ds. IF LESS than 1 day how many hrs. or mins.?

8. OCCUPATION
(a) Trade, profession or particular kind of work None
(b) General nature of industry business, or establishment in which employed (or employer)

9. BIRTHPLACE
(State or Country) Lincoln CO. Idaho

10. NAME OF FATHER B.O. Barnes

11. BIRTHPLACE OF FATHER Ill.
(State or Country)

12. MAIDEN NAME OF MOTHER Mamie Price

13. BIRTHPLACE OF MOTHER Colorado
(State or Country)

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Twin Falls
(Address) B.O. Barnes

15. Filed 2-21 1913 John H. Gregorian
Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH Feb 21 1913
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from Feb 17 1913, to Feb 18 1913, that I last saw her alive on Feb 18 1913 and that death occurred on the date stated above, at 19 M.

The CAUSE OF DEATH* was as follows:
Pneumonia

(Duration) _____ yrs. _____ mos. _____ ds.

Contributory (Secondary) _____

(Duration) _____ yrs. _____ mos. _____ ds.

(Signed) Harold J. M. D. 1913 (Address) Twin Falls, Ida.

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death _____ yrs. _____ mos. _____ days. In the State _____ yrs. _____ mos. _____ days.
Where was disease contracted if not at place of death? _____
Former or usual residence _____

19. PLACE OF BURIAL OR REMOVAL Twin Falls Cemetery DATE OF BURIAL 2-22 1913

20. UNDERTAKER Charles Crosby ADDRESS Twin Falls

Form V. S. No. 5 20M.1-16-12

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH
County of Twin Falls Registration District No. 23
City of Twin Falls Primary Registration District No. 2086
(No. _____ St.)

File No. 4277
Registered No. _____

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Emma Mabel Woodward

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX Female 4. COLOR OR RACE White 5. SINGLE, MARRIED, WIDOWED OR DIVORCED. Single

6. DATE OF BIRTH June 13 1906
(Month) (Day) (Year)

7. AGE 6 yrs. 8 mos. 2 ds.
IF LESS than 1 day how many hrs. or mins.?

8. OCCUPATION
(a) Trade, profession or particular kind of work Scholar
(b) General nature of industry, business, or establishment in which employed (or employer)

9. BIRTHPLACE
(State or Country) Indiana

10. NAME OF FATHER John Woodward

11. BIRTHPLACE OF FATHER
(State or Country) Indiana

12. MAIDEN NAME OF MOTHER Lillian Luckett

13. BIRTHPLACE OF MOTHER
(State or Country) Indiana

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) John Woodward
(Address) Twin Falls

15. Filed 2-17 1913 John Woodward
Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH
2 1913
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from 2/14/ 1913 to 2/15/ 1913,
that I last saw her alive on 2/15/ 1913,
and that death occurred on the date stated above, at 603 M.

The CAUSE OF DEATH* was as follows:

Cardiac dilatation

(Duration) yrs. mos. 1 ds.
Contributory Pneumonia
(Secondary)

(Duration) yrs. mos. 14 ds.
(Signed) H. G. T. M. D.
2/17/13 (Address) Twin Falls, Ida.

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death yrs. mos. days. In the State yrs. mos. days.

Where was disease contracted if not at place of death?

Former or usual residence.

19. PLACE OF BURIAL OR REMOVAL Twin Falls Cemetery DATE OF BURIAL 2/17 1913

20. UNDERTAKER J. J. Grossman ADDRESS Twin Falls

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Form V. S. No. 5 20M.1-16-12

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH

Registration District No.

23

County of

Primary Registration District No.

2085

City of

(No.

St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

Franklin Dorr King

Registered No.

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX

4. COLOR OR RACE

5. SINGLE, MARRIED, WID-
OWED OR DIVORCED.

Male

White

Single (Write the word.)

6. DATE OF BIRTH

March 10 1898

(Month)

(Day)

(Year)

7. AGE

14 yrs. 11 mos. 7 ds.

IF LESS than 1 day
how many hrs. or
mins.

8. OCCUPATION

(a) Trade, profession or
particular kind of work(b) General nature of industry
business, or establishment in
which employed (or employer)

School Boy

9. BIRTHPLACE

(State or Country)

Iowa

10. NAME OF
FATHER

William A. King

11. BIRTHPLACE
OF FATHER

(State or Country)

Iowa

12. MAIDEN NAME
OF MOTHER

Emma Dorr

13. BIRTHPLACE
OF MOTHER

(State or Country)

Iowa

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

W. A. King

(Address)

Twin Falls Idaho

15.

Filed

2-14

191

John H. English
Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH

Feb.

17

1913

(Month)

(Day)

(Year)

17. I HEREBY CERTIFY, That I attended deceased from

Feb.

14

1913, to

Feb.

17

1913,

that I last saw him alive on Feb. 17 1913,

and that death occurred on the date stated above, at 2 P.M.

The CAUSE OF DEATH* was as follows:

General Peritonitis

(Duration)

yrs.

mos.

3 ds.

Contributory
(Secondary)

Perforated Appendicitis

(Duration)

yrs.

mos.

ds.

(Signed)

J. R. Morgan

M. D.

Feb. 17 1913

(Address) Twin Falls

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place
of death

yrs.

mos.

days.

In the
State

yrs.

mos.

days.

Where was disease contracted
if not at place of death?Former or
usual residence

19. PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

Twin Falls

2/19 1913

20. UNDERTAKER

ADDRESS

J. F. Groenman

Twin Falls

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Form V. S. No. 5 20M.1-16-12

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH

Registration District No. 23

County of Twins Falls

Primary Registration District No. 2085

File No. 1279

City of " "

(No. " " St.)

Registered No. " "

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

Peter J. Costello

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX

4. COLOR OR RACE

5. SINGLE, MARRIED, WIDOWED OR DIVORCED

Male White

Married

6. DATE OF BIRTH

December 25 1866
(Month) (Day) (Year)

7. AGE

46 yrs. 1 mos. 10 ds.

IF LESS than 1 day
how many hrs. or
mins.

8. OCCUPATION

(a) Trade, profession or particular kind of work
(b) General nature of industry, business, or establishment in which employed (or employer)

Real estate

9. BIRTHPLACE

(State or Country)

Illinois

10. NAME OF FATHER

Thomas Costello

11. BIRTHPLACE OF FATHER

(State or Country)

Ireland

12. MAIDEN NAME OF MOTHER

Ellen Brennan

13. BIRTHPLACE OF MOTHER

(State or Country)

Ireland

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

Thomas Costello

(Address)

Twins Falls

15.

Filed

2-7

1913

John H. Hughes
Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

Feb. 5 1913
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from

Dec. 17 1912 to Feb. 1913

that I last saw him alive on Jan. 5 1913

and that death occurred on the date stated above, at 3:30 AM

The CAUSE OF DEATH* was as follows:

Chronic Interstitial Nephritis

(Duration) 2 yrs. " mos. " ds.

Contributory
(Secondary)

(Duration) " yrs. " mos. " ds.

(Signed)

W. Wilson M. D.
Feb. 6 1913 (Address) Twins Falls, Idaho

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death " yrs. " mos. " days. In the State " yrs. " mos. " days.

Where was disease contracted if not at place of death?

Former or usual residence.

19. PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

Twins Falls

Feb. 7 1913

20. UNDERTAKER

ADDRESS

J. J. Grossman

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Form V. S. No. 5 20M.1-16-12

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH

Registration District No. 23

County of Twin Falls

Primary Registration District No. 2084

City of Kimberly

(No. , St.)

File No. 4289

Registered No.

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

Fredrick Hemming

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX

Male

4. COLOR OR RACE

White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED

Widowed

6. DATE OF BIRTH

Jan. 17 1926
(Month) (Day) (Year)

7. AGE

87 yrs. mos. 24 da.

IF LESS than 1 day
how many hrs. or
mins?

8. OCCUPATION

(a) Trade, profession or particular kind of work

Carpenter

(b) General nature of industry, business, or establishment in which employed (or employer)

9. BIRTHPLACE

(State or Country)

Germany

10. NAME OF FATHER

Christian F. Hemming

11. BIRTHPLACE OF FATHER

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Form V. S. No. 5. 12½ M. 7-24-11

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics
File No. 1281
Registered No. _____

1. PLACE OF DEATH. Registration District No. 23
County of Twin Falls Primary Registration District No. 2084
City of Kimberly (No. _____, St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Ruth Estelle VanHouten

If death occurred in a hospital, institution or camp give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX Female 4. COLOR OR RACE White 5. SINGLE, MARRIED, WIDOWED OR DIVORCED. Single
(Write the word.)

6. DATE OF BIRTH May 16 1898
(Month) (Day) (Year)

7. AGE 14 yrs. 8.5 mos. 24 ds. IF LESS than 1 day
how many..... hrs. or min?

8. OCCUPATION

(a) Trade, profession or particular kind of work.

School girl

(b) General nature of industry business or establishment in which employed (or employer)

9. BIRTHPLACE

(State or Country)

New Jersey

10. NAME OF FATHER

Wm VanHouten

11. BIRTHPLACE OF FATHER

(State or Country)

New Jersey

12. MAIDEN NAME OF MOTHER

Sarah E. Terry

13. BIRTHPLACE OF MOTHER

(State or Country)

New York

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

John J. Whyte, M.D.

(Address)

Kimberly, Idaho

15.

Filed 7-10 1913

John H. Engle
Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH

Feb. 9 1913
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from Feb. 6 1913, to Feb. 9 1913

that I last saw her alive on Feb. 9 1913

and that death occurred on the date stated above, at 1 P. M.

The CAUSE OF DEATH* was as follows:

Acute Pneumonia

(Duration) ✓ yrs. ✓ mos. 3 ds.
Contributory Dyspepsia
(Secondary)

(Duration) ✓ yrs. ✓ mos. 14 ds.
(Signed) John J. Whyte M. D.
Feb. 9 1913 (Address) Kimberly, Idaho

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place In the
of death..... yrs..... mos..... ds. State..... yrs..... mos..... ds.
Where was disease contracted,
If not at place of death?
Former or
usual residence.....

19. PLACE OF BURIAL OR REMOVAL DATE OF BURIAL

Twin Falls Ida 2/11 1913

20. UNDERTAKER

ADDRESS

C. J. Crosby Twin Falls

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Form V. S. No. 5. 12½M.7-24-11

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics
File No. 4282
Registered No. _____

1. PLACE OF DEATH.
County of Two Face.
City of Buhl.

Registration District No. 2087
Primary Registration District No. 23
(No. _____, _____ St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

Frank Vapner

If death occurred in a hospital, institution or camp give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX M 4. COLOR OR RACE W 5. SINGLE, MARRIED, WIDOWED OR DIVORCED. Married
(Write the word.)

6. DATE OF BIRTH Jan 7 1858
(Month) (Day) (Year)

7. AGE 55 yrs. 1 mos. 1 ds. IF LESS than 1 day
how many _____ hrs. or _____ min?

8. OCCUPATION

(a) Trade, profession or particular kind of work
(b) General nature of industry business or establishment in which employed (or employer)

Mauder

9. BIRTHPLACE

(State or Country)

Bohemia

10. NAME OF FATHER

Anton Vapner

11. BIRTHPLACE OF FATHER

(State or Country)

Bohemia

12. MAIDEN NAME OF MOTHER

Not known

13. BIRTHPLACE OF MOTHER

(State or Country)

Bohemia

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

(Address)

James Vapner
Buhl Ida

15.

Filed 1-21 1913

J. Murphy
Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH

Jan 18 1913
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from Dec. 8 1913, to Jan 18 1913

that I last saw him alive on Jan 18 1913
and that death occurred on the date stated above, at 9 P. M.

The CAUSE OF DEATH* was as follows:

Paralysis & Apoplexy

(Duration) 5 yrs. _____ mos. _____ ds.

Contributory

(Secondary)

Arteriosclerosis
several years

(Duration) _____ yrs. _____ mos. _____ ds.

(Signed)

Chas. Wetherill M. D.

Jan 19 1913 (Address) Buhl Ida

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place _____ yrs. _____ mos. _____ ds. In the _____ yrs. _____ mos. _____ ds.

Where was disease contracted,

If not at place of death?

Former or

usual residence.

19. PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

H. B. Evans Jan 21 1913

20. UNDERTAKER

ADDRESS

H. B. Evans

Buhl Ida

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Form V. S. No. 5. 12½ M. 7-24-11

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics
File No. 1283
Registered No.

1. PLACE OF DEATH. Registration District No. 58
County of Shoshone Primary Registration District No. 2129
City of Burkhplace (No. Burkhplace Idaho St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

J. M. Pardie

If death occurred in a hospital, institution or camp give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX Male 4. COLOR OR RACE white 5. SINGLE, MARRIED, WIDOWED OR DIVORCED. Single
(Write the word.)

6. DATE OF BIRTH
(Month) (Day) (Year)

7. AGE 22 yrs. mos. ds. IF LESS than 1 day how many hrs. or min?

8. OCCUPATION
(a) Trade, profession or particular kind of work. miner
(b) General nature of industry business or establishment in which employed (or employer) head mines

9. BIRTHPLACE Oregon
(State or Country)

10. NAME OF FATHER J. W. Pardie

11. BIRTHPLACE OF FATHER Missouri
(State or Country)

12. MAIDEN NAME OF MOTHER Ruth Stall

13. BIRTHPLACE OF MOTHER not given
(State or Country)

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) L. E. O'Conner
(Address) Burkhplace Idaho

15. Filed Jan 3 1913

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH Jan 1st 1913
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from 191 to 191 that I last saw h. alive on 191 and that death occurred on the date stated above, at M. The CAUSE OF DEATH* was as follows:

Fractured Skull
Multiple

(Duration) Few mins. mos. ds.
Contributory Multiple crush injuries
(Secondary)
(Duration) mos. ds.
(Signed) J. R. Howry D.
Jan 15 1913 (Address) Wallace Ida

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place In the
of death yrs. mos. ds. State yrs. mos. ds.
Where was disease contracted,
If not at place of death?
Former or
usual residence.

19. PLACE OF BURIAL OR REMOVAL DATE OF BURIAL
Burkhplace Oregon Jan 4 1913
ADDRESS
Wallace

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK--THIS IS A PERMANENT RECORD.
N. B.—Every item of information should be carefully supplied. AGE should be state EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Form V. S. No. 5. 10M. 6-20-11.

CERTIFICATE OF DEATH

1. **PLACE OF DEATH.** Registration District No. 25
County of Shoshone Primary Registration District No. 2104
City of North Fork (No. Emmelle St.)
If death occurs away from usual residence, give facts called for under special information.

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics
File No. 1284
Registered No. _____
If death occurred in a hospital, institution or camp give its NAME instead of street and number.

2. **FULL NAME** Muriel Wilson

PERSONAL AND STATISTICAL PARTICULARS

3. **SEX** Female white
4. **COLOR OR RACE** white
5. **SINGLE, MARRIED, WIDOWED OR DIVORCED.** married
(Write the word.)

6. **DATE OF BIRTH**

(Month) (Day) (Year)

7. **AGE** 22 yrs. — mos. — ds.
IF LESS than 1 day how many hrs. or min.?

8. **OCCUPATION**
(a) Trade, profession or particular kind of work
(b) General nature of industry business or establishment in which employed (or employer) Housewife

9. **BIRTHPLACE**
(State or Country) Finland

10. **NAME OF FATHER** ~~Mrs. Wilson~~

11. **BIRTHPLACE OF FATHER**
(State or Country) Finland

12. **MAIDEN NAME OF MOTHER**

13. **BIRTHPLACE OF MOTHER**
(State or Country) Finland

14. **THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE**
(Informant) Andy Wilson
(Address) Emmelle Ida

15. Jan 15 1913 D. W. C. DeWitt

MEDICAL CERTIFICATE OF DEATH

16. **DATE OF DEATH**
Jan 13 1913
(Month) (Day) (Year)

17. **I HEREBY CERTIFY, That I attended deceased from** 191____, to 191____
that I last saw h. er alive on Jan 13 1913,
and that death occurred on the date stated above, at 5:30 M.

The CAUSE OF DEATH* was as follows:
Pulmonary
Tuberculosis
(Duration) 2 yrs. ____ mos. ____ ds.

Contributory (Secondary) _____
(Duration) ____ yrs. ____ mos. ____ ds.
(Signed) J. W. Mowery M. D.
Jan 14 1913 (Address) Wallace Ida

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. **LENGTH OF RESIDENCE** (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death..... yrs. ____ mos. ____ ds. State..... yrs. ____ mos. ____ ds.
Where was disease contracted, _____
If not at place of death? _____
Former or usual residence.....

19. **PLACE OF BURIAL OR REMOVAL** Kingston Ida **DATE OF BURIAL** 191____

20. **UNDERTAKER** W. H. Hardy **ADDRESS** Wallace Ida

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. PHYSICIAN'S NAME, ADDRESS, AND PHONE NUMBER SHOULD BE STATED EXACTLY. Exact state-
N. B.—Every item of information should be carefully supplied. AGE should be properly classified. Exact state-
ment of OCCUPATION is very important. See instructions on back of certificate.

Form V. S. No. 5. 12½ M. 7-24-11

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH.
County of Shoshone
City or Town Dorsey

Registration District No. 25
Primary Registration District No. 2108
(No. _____, _____ St.)

File No. 4285
Registered No. _____

If death occurs away from us-
ual residence, give facts called
for under special information.

2. FULL NAME Magnus I Anderson

If death occurred in a hospital, in-
stitution or camp give its NAME
instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX male 4. COLOR OR RACE white 5. SINGLE, MARRIED, WID-
OWED OR DIVORCED.
single
(Write the word.)

6. DATE OF BIRTH 1873
(Month) (Day) (Year)

7. AGE 40 yrs. -- mos. -- ds. IF LESS than 1 day
how many hrs. or
..... min?

8. OCCUPATION
(a) Trade, profession or
particular kind of work miner
(b) General nature of industry
business or establishment in
which employed (or employer) quartz mines

9. BIRTHPLACE
(State or Country) Sweden

10. NAME OF
FATHER not given

11. BIRTHPLACE
OF FATHER " "

12. MAIDEN NAME
OF MOTHER " "

13. BIRTHPLACE
OF MOTHER " "

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) L. T. Nyström
(Address) Big Creek, Idaho

15. Filled Jan 22 1913 Dorsey, Idaho

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH 1 17 th. 1913
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from
191, to 191
that I last saw h. alive on 191
and that death occurred on the date stated above, at M.

The CAUSE OF DEATH* was as follows:

Acute Alcoholism

Found dead

(Duration) yrs. 10 mos. 10 ds.

Contributory (Secondary)

(Duration) yrs. 10 mos. 10 ds.

(Signed) J. M. Mowery M. D.

Jan 22 1913 (Address) Wallace, Idaho

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1)
MEANS OF INJURY; (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions,
Transients or Recent Residents.)

At place In the
of death yrs. mos. ds. State yrs. mos. ds.

Where was disease contracted,
If not at place of death?

Former or
usual residence

19. PLACE OF BURIAL OR REMOVAL DATE OF BURIAL
Wallace, Idaho. 1/18 1913

20. UNDERTAKER ADDRESS
Wallace, Id.

MARGIN RESERVED FOR BINDING
WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Form V. S. No. 5 20M.1-16-12

Dr. Stanley
CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH.

Registration District No. *19*

County of *Bannock*

Primary Registration District No. *1012*

City of *Pocatello*

(No. *1012* St.)

File No. *1286*

Registered No. *176*

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME *Edward Lambardi*

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX

4. COLOR OR RACE

5. SINGLE, MARRIED, WIDOWED OR DIVORCED.

Male White

Single (Write the word.)

6. DATE OF BIRTH

May 15 1913
(Month) (Day) (Year)

7. AGE

9 mos. 2 ds.
yrs. mos. ds.

IF LESS than 1 day
how many hrs. or mins.?

8. OCCUPATION

(a) Trade, profession or particular kind of work

None

(b) General nature of industry business, or establishment in which employed (or employer)

9. BIRTHPLACE

(State or Country)

Bannock County

10. NAME OF FATHER

F. J. Lambardi

11. BIRTHPLACE OF FATHER

(State or Country)

Italy

12. MAIDEN NAME OF MOTHER

Mary Luviani

13. BIRTHPLACE OF MOTHER

(State or Country)

Italy

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

F. J. Lambardi

(Address)

Pocatello, Ida.

15.

Filed

Feb 20

191

3 18 St. St.

Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH

Feb 17 1913
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from *2-16-1913* to *2-17-1913*

that I last saw him alive on *2-17-1913*

and that death occurred on the date stated above, at *7 AM*

The CAUSE OF DEATH* was as follows:

Gastritis

(Duration) yrs. mos. ds.

Contributory (Secondary)

(Duration) yrs. mos. ds.

(Signed) M. D.

19 (Address)

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death. yrs. mos. days. In the State. yrs. mos. days.

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

St. Lawrence

Feb 18 1913

20. UNDERTAKER

ADDRESS

W. Russell

Pocatello

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Form V. S. No. 5 20M.1-16-12

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH.

Registration District No.

County of

Primary Registration District No.

City of

(No. 345, D. O. Hayes St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

File No.

Registered No.

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX

4. COLOR OR RACE

5. SINGLE, MARRIED, WIDOWED OR DIVORCED.

6. DATE OF BIRTH

7. AGE

IF LESS than 1 day
how many hrs. or
mins.

8. OCCUPATION

(a) Trade, profession or particular kind of work

(b) General nature of industry business, or establishment in which employed (or employer)

9. BIRTHPLACE

(State or Country)

10. NAME OF FATHER

11. BIRTHPLACE OF FATHER

(State or Country)

12. MAIDEN NAME OF MOTHER

13. BIRTHPLACE OF MOTHER

(State or Country)

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

(Address)

15.

Filed

1913

Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH

(Month)

(Day)

(Year)

17. I HEREBY CERTIFY, That I attended deceased from

Feb 8 1913, to Feb 9 1913

that I last saw him alive on Feb 9 1913

and that death occurred on the date stated above, at 7 A.M.

The CAUSE OF DEATH* was as follows:

Contributory
(Secondary)

(Duration) yrs. mos. ds.

(Signed) M. D.

19 (Address)

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death yrs. mos. days. In the State yrs. mos. days.

Where was disease contracted if not at place of death?

Former or usual residence.

19. PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

At New Cemetery Feb 10 1913

20. UNDERTAKER

ADDRESS

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Form V. S. No. 5 20M.1-16-12

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH.

Registration District No.

County of

Primary Registration District No.

City of

(No.

St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

File No.

Registered No.

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX

4. COLOR OR RACE

5. SINGLE, MARRIED, WIDOWED OR DIVORCED.

6. DATE OF BIRTH

7. AGE

IF LESS than 1 day
how many hrs. or mins.?

8. OCCUPATION

(a) Trade, profession or particular kind of work

(b) General nature of industry business, or establishment in which employed (or employer)

9. BIRTHPLACE

(State or Country)

10. NAME OF FATHER

11. BIRTHPLACE OF FATHER

(State or Country)

12. MAIDEN NAME OF MOTHER

13. BIRTHPLACE OF MOTHER

(State or Country)

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

(Address)

15.

Filed

191

Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH

(Month)

(Day)

(Year)

17. I HEREBY CERTIFY, That I attended deceased from

191

to

191

that I last saw her alive on

191

and that death occurred on the date stated above, at

The CAUSE OF DEATH* was as follows:

Croup

(Duration)

yrs.

mos.

ds.

Contributory
(Secondary)

(Duration)

yrs.

mos.

ds.

(Signed)

M. D.

19 (Address)

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place

of death yrs. mos. days.

In the

State yrs. mos. days.

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

20. UNDERTAKER

ADDRESS

Form V. S. No. 5 20M.1-16-12

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH.

Registration District No.

County of *Bannock*

Primary Registration District No.

City of *Bocatello*

(No. *1142*, *N. V. Vayer*. St.)

File No. *4289*

Registered No. *11*

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME *Saurah, Gof*

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX *Female* 4. COLOR OR RACE *White* 5. SINGLE, MARRIED, WIDOWED OR DIVORCED. *Widowed*

6. DATE OF BIRTH

August 1 1845
(Month) (Day) (Year)

7. AGE

67 yrs. *6* mos. *3* ds.

IF LESS than 1 day
how many hrs. or
..... mins.?

8. OCCUPATION

(a) Trade, profession or particular kind of work
(b) General nature of industry business, or establishment in which employed (or employer)

Housewife

9. BIRTHPLACE

(State or Country)

England

10. NAME OF FATHER

John Harris

11. BIRTHPLACE OF FATHER

(State or Country)

England

12. MAIDEN NAME OF MOTHER

Maria White

13. BIRTHPLACE OF MOTHER

(State or Country)

England

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

(Address)

Dann Gof Bocatello Idaho

15.

Filed *Feb 5* 191*3*

J. P. Sturley
Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH

Feb 3 191*3*
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from *Jan. 28* 191*3*, to *July 3rd* 191*3*, that I last saw her alive on *July 3rd* 191*3*

and that death occurred on the date stated above, at *4:00* M.

The CAUSE OF DEATH* was as follows:

Myocarditis

(Duration) yrs. mos. ds.

Contributory (Secondary)

(Duration) yrs. mos. ds.

(Signature) *A. Smith W. W. W. M. D.*

July 5th 1913 (Address) *Prattville Idaho*

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death yrs. mos. days. In the State yrs. mos. days.

Where was disease contracted if not at place of death?

Former or usual residence.

19. PLACE OF BURIAL OR REMOVAL DATE OF BURIAL

M. W. W. W. W. Feb 5 191*3*

20. UNDERTAKER

ADDRESS

M. W. W. W. Bocatello

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Form V. S. No. 5 20M.1-16-12

CERTIFICATE OF DEATH

1. **PLACE OF DEATH.** Registration District No. _____
 County of Bannock Primary Registration District No. _____
 City of Procatello (No. 530, 6 Landau St.)

If death occurs away from usual residence, give facts called for under special information.

2. **FULL NAME** Ernest Ervin Thorpe

State of Idaho
 BOARD OF HEALTH
 Bureau of Vital Statistics
 File No. 42904
 Registered No. 13

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. **SEX** Male 4. **COLOR OR RACE** White 5. **SINGLE, MARRIED, WIDOWED OR DIVORCED.** Single
 (Write the word.)

6. **DATE OF BIRTH** July 1 1912
 (Month) (Day) (Year)

7. **AGE** 6 yrs. 9 mos. 9 ds.
 IF LESS than 1 day how many hrs. or mins.?

8. **OCCUPATION**
 (a) Trade, profession or particular kind of work None.
 (b) General nature of industry business, or establishment in which employed (or employer)

9. **BIRTHPLACE** Lago Idaho
 (State or Country)

10. **NAME OF FATHER** Eugene Thorpe

11. **BIRTHPLACE OF FATHER** Procatello Idaho
 (State or Country)

12. **MAIDEN NAME OF MOTHER** Olive Reed Rand

13. **BIRTHPLACE OF MOTHER** Utah
 (State or Country)

14. **THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE**
 (Informant) Eugene Thorpe
 (Address) Procatello Idaho

15. Filed Feb. 12 1913 O B Stealy
 Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. **DATE OF DEATH** Feb. 9 1913
 (Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended/deceased from Jan 31 1913, to Feb 9 1913, that I last saw him alive on Feb 9 1913, and that death occurred on the date stated above, at 1:00 M.

The CAUSE OF DEATH* was as follows:
Dialow Disease.

(Duration) yrs. mos. ds.
 Contributory (Secondary)

(Signed) S. M. Newton M. D.
Feb 9 1913 (Address) Procatello Idaho

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. **LENGTH OF RESIDENCE** (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death yrs. mos. days. In the State yrs. mos. days.

Where was disease contracted if not at place of death?

Former or usual residence

19. **PLACE OF BURIAL OR REMOVAL** Lago Idaho Feb 10 1913

20. **UNDERTAKER** W. H. MacKen Procatello Idaho

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Form V. S. No. 5 20M.1-16-12

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH
County of *Bannock*
City of *McCammon*

Registration District No. *19*
Primary Registration District No. *10P 2*
(No. *Harkness Hotel* St.)

File No. *4291*
Registered No. *14*

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME *Rev. Stewart*

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX *Male* 4. COLOR OR RACE *White* 5. SINGLE, MARRIED, WIDOWED OR DIVORCED. *Married*
(Write the word.)

6. DATE OF BIRTH *Don't know*
(Month) (Day) (Year)

7. AGE *Unk - 58* IF LESS than 1 day how many hrs. or mins.
yrs. mos. ds.

8. OCCUPATION
(a) Trade, profession or particular kind of work *Labner*
(b) General nature of industry business, or establishment in which employed (or employer)

9. BIRTHPLACE
(State or Country) *Don't know*

10. NAME OF FATHER *Don't know*

11. BIRTHPLACE OF FATHER
(State or Country) *Don't know*

12. MAIDEN NAME OF MOTHER

13. BIRTHPLACE OF MOTHER
(State or Country) *Don't know*

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) *W. H. Jones*
(Address) *McCammon, Ida*

15. Filed *Feb 16* 191 *3* *O B Stiles*
Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH *2* *11* *1913*
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from *2-10-1913* to *2-11-1913*, that I last saw him alive on *2-11-1913*, and that death occurred on the date stated above, at *12 P.M.*

The CAUSE OF DEATH* was as follows:
Pulmonary Embolism

(Duration) yrs. mos. ds.
Contributory (Secondary)

(Duration) yrs. mos. ds.
(Signed) *W. H. Jones* M. D.
19 (Address) *McCammon, Ida*

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death. yrs. mos. days. In the State. yrs. mos. days.

Where was disease contracted if not at place of death?

Former or usual residence.

19. PLACE OF BURIAL OR REMOVAL *McCammon Cemetery* DATE OF BURIAL *Feb 14 1913*

20. UNDERTAKER *W. H. Jones* ADDRESS *McCammon, Ida*

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Form V. S. No. 5 20M.1-16-12

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH.

Registration District No.

County of

Primary Registration District No.

City of

(No. 304, Do Manu

St.)

File No.

Registered No.

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX

4. COLOR OR RACE

5. SINGLE, MARRIED, WIDOWED OR DIVORCED.

6. DATE OF BIRTH

7. AGE

IF LESS than 1 day
how many hrs. or
..... mins.?

8. OCCUPATION

(a) Trade, profession or particular kind of work
(b) General nature of industry business, or establishment in which employed (or employer)

9. BIRTHPLACE

(State or Country)

10. NAME OF FATHER

11. BIRTHPLACE OF FATHER

(State or Country)

12. MAIDEN NAME OF MOTHER

13. BIRTHPLACE OF MOTHER

(State or Country)

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

(Address)

15.

Filed

191

Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH

17. I HEREBY CERTIFY, That I attended deceased from

that I last saw h. ew alive on

and that death occurred on the date stated above, at

The CAUSE OF DEATH* was as follows:

(Duration) yrs. mos. ds.

Contributory (Secondary)

(Duration) yrs. mos. ds.

(Signed)

(Address)

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death yrs. mos. days. In the State yrs. mos. days.

Where was disease contracted if not at place of death?

Former or usual residence.

19. PLACE OF BURIAL OR REMOVAL DATE OF BURIAL

20. UNDERTAKER

ADDRESS

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Form V. S. No. 5 20M.1-16-12

CERTIFICATE OF DEATH

1. PLACE OF DEATH.

County of Blaine
City of Prosser

Registration District No. _____

Primary Registration District No. 1002
(No. 1031, V. Garfield St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

Bertha Astle

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

File No. 18293

Registered No. 18293

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX

Female

4. COLOR OR RACE

White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED.

Single
(Write the word.)

6. DATE OF BIRTH

Nov. 2 1899
(Month) (Day) (Year)

7. AGE

13 yrs. 3 mos. 20 ds.

IF LESS than 1 day
how many hrs. or
..... mins.?

8. OCCUPATION

(a) Trade, profession or particular kind of work.

School Girl

(b) General nature of industry, business, or establishment in which employed (or employer).

9. BIRTHPLACE

(State or Country) Utah

10. NAME OF FATHER

James Astle

11. BIRTHPLACE OF FATHER

(State or Country) England

12. MAIDEN NAME OF MOTHER

Ely Mayhew

13. BIRTHPLACE OF MOTHER

(State or Country) Utah

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

James Astle

(Address)

Prosser

15.

Filed

Feb 25 1913 RB Sturley
Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH

Feb 22 1913
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from

Feb 20 1913, to Feb 22 1913

that I last saw her alive on Feb. 22 1913

and that death occurred on the date stated above, at 2:30 M.

The CAUSE OF DEATH* was as follows:

Diabetes mellitus (acute)

(Duration) acute yrs. 3 mos. 3 ds.

Contributory (Secondary)

Perhaps had acute Pancreatitis

(Duration) 2 yrs. 0 mos. 0 ds.

(Signed)

J. M. Mayhew M. D.

19 (Address) Prosser, Ida.

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death yrs. mos. days. In the State yrs. mos. days.

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL DATE OF BURIAL

St. Vincent Cemetery Feb 27 1913

20. UNDERTAKER

W. B. Malster ADDRESS Prosser, Ida.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Form V. S. No. 5 20M.1-16-12

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH.

Registration District No.

County of

Primary Registration District No.

City of

(No. St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

File No.

Registered No.

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX

4. COLOR OR RACE

5. SINGLE, MARRIED, WIDOWED OR DIVORCED.

6. DATE OF BIRTH

7. AGE

IF LESS than 1 day
how many hrs. or
..... mins.?

8. OCCUPATION

(a) Trade, profession or particular kind of work.

(b) General nature of industry business, or establishment in which employed (or employer)

9. BIRTHPLACE

(State or Country)

10. NAME OF FATHER

11. BIRTHPLACE OF FATHER

(State or Country)

12. MAIDEN NAME OF MOTHER

13. BIRTHPLACE OF MOTHER

(State or Country)

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

(Address)

15.

Filed

191

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH

17. I HEREBY CERTIFY, That I attended deceased from

Feb 15 1913, to Feb 23 1913,

that I last saw her alive on Feb 23 1913,

and that death occurred on the date stated above, at 6:45 P. M.

The CAUSE OF DEATH* was as follows:

Myocarditis of chronic type

(Duration) 3 mos. ds.

Contributory (Secondary) old age

(Duration) yrs. mos. ds.

(Signed) A. M. Huntington M. D.

7-6-23-13 (Address) 125 N 2nd Ave

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death yrs. mos. days. In the State yrs. mos. days.

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

1st Newbury St. Feb 26 1913

20. UNDERTAKER

ADDRESS

J. J. Barker Pocahontas

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Form V. S. No. 5 20M.1-16-12

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics
File No. 4295
Registered No. 20

1. PLACE OF DEATH. Registration District No. 19
County of Blainock Primary Registration District No. 1002
City of Pocatello (No. 633, No. 5th ave St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Francis Ralph Snyder

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX 4. COLOR OR RACE 5. SINGLE, MARRIED, WIDOWED OR DIVORCED.

Male White (Wid. the word.)

6. DATE OF BIRTH

March 28th 1910
(Month) (Day) (Year)

7. AGE

1 yrs. 10 mos. 29 ds. IF LESS than 1 day how many hrs. or mins.?

8. OCCUPATION

(a) Trade, profession or particular kind of work
(b) General nature of industry business, or establishment in which employed (or employer)

None.

9. BIRTHPLACE

(State or Country)

Pocatello

10. NAME OF FATHER

Wm C Snyder

11. BIRTHPLACE OF FATHER

(State or Country)

Mayneburg Pa

12. MAIDEN NAME OF MOTHER

Lora Booth

13. BIRTHPLACE OF MOTHER

(State or Country)

Carthage Ill

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

Lora Booth (Mother)

(Address)

Pocatello Ida

15.

Filed

Feb 28 1913

3

O B Stedley

Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH

Feb 26th 1913
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from

Feb 23 1913, to Feb 26th 1913

that I last saw him alive on Feb 26th 1913

and that death occurred on the date stated above, at 2nd P. M.

The CAUSE OF DEATH* was as follows:

Broncho-pneumonia

(Duration) yrs. 10 mos. ds.

Contributory (Secondary) Probably a myocarditis due to attack of broncho-pneumonia 2 mos. ago.

(Duration) yrs. mos. ds.

(Signed) J. M. Ray M. D.

19. (Address) Pocatello, Idaho

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death yrs. mos. days. In the State yrs. mos. days.

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL DATE OF BURIAL

St. Newbury Feb 28 1913

20. UNDERTAKER

ADDRESS

W. D. Macker Pocatello Ida

Form V. S. No. 5 20M.1-16-12

CERTIFICATE OF DEATH

1. PLACE OF DEATH Panwock
 County of Pocatello
 City of Pocatello
 Registration District No. 119
 Primary Registration District No. 1002
 (No. 853 N. Main St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Margaret Martin

State of Idaho
 BOARD OF HEALTH
 Bureau of Vital Statistics
 File No. 4296
 Registered No. 21

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX Female 4. COLOR OR RACE White 5. SINGLE, MARRIED, WIDOWED OR DIVORCED. Married

6. DATE OF BIRTH Sept 18 1905
 (Month) (Day) (Year)

7. AGE 7 yrs. 5 mos. 9 ds.
 IF LESS than 1 day how many hrs. or mins.?

8. OCCUPATION School Girl
 (a) Trade, profession or particular kind of work
 (b) General nature of industry, business, or establishment in which employed (or employer)

9. BIRTHPLACE Pocatello
 (State or Country)

10. NAME OF FATHER H. J. Martin

11. BIRTHPLACE OF FATHER Wisconsin
 (State or Country)

12. MAIDEN NAME OF MOTHER Alice Gugler

13. BIRTHPLACE OF MOTHER Iowa
 (State or Country)

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) E. J. Fuschke
 (Address) 853 N. Main St Pocatello

15. Filed Mar 2nd 1913 O B Starley
 Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH Feb 27 1913
 (Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from 1913, to Feb 27th 1913, that I last saw her alive on Feb 27th 1913, and that death occurred on the date stated above, at 2:45 P. M.

The CAUSE OF DEATH* was as follows:

Influenza

(Duration) yrs. mos. 18 ds.
 Contributory (Secondary)

(Duration) yrs. mos. ds.
 (Signed) O B Starley M. D.
2-27-1913 (Address) Pocatello Idaho

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death yrs. mos. days. In the State yrs. mos. days.

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL At View DATE OF BURIAL Mar 2 1913

20. UNDERTAKER M. M. M. M. ADDRESS Pocatello Idaho

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics
File No. 1297
Registered No. 22

1. PLACE OF DEATH. Registration District No. 19
County of Bannock Primary Registration District No. 1002
City of Oneida (No. ✓ St.)
If death occurs away from usual residence, give facts called for under special information.

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME F. M. J. Finney

PERSONAL AND STATISTICAL PARTICULARS

3. SEX Male 4. COLOR OF RACE White 5. SINGLE, MARRIED, WIDOWED OR DIVORCED. Single
(Write the word.)

6. DATE OF BIRTH 1890
(Month) (Day) (Year)

7. AGE 22 yrs. mos. ds.
IF LESS than 1 day how many hrs. or mins.?

8. OCCUPATION Laborer
(a) Trade, profession or particular kind of work
(b) General nature of industry, business, or establishment in which employed (or employer)

9. BIRTHPLACE ✓
(State or Country)

10. NAME OF FATHER ✓

11. BIRTHPLACE OF FATHER ✓
(State or Country)

12. MAIDEN NAME OF MOTHER ✓

13. BIRTHPLACE OF MOTHER ✓
(State or Country)

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) M. J. Walker
(Address) Pocatello

15. Filed Mar 4 1913 U B Staley
Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH Feb. 28 1913
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from 191, to 191, that I last saw him alive on 191, and that death occurred on the date stated above, at M.

The CAUSE OF DEATH* was as follows:
R. R. Accident
(Duration) yrs. mos. ds.
Contributory (Secondary)
(Duration) yrs. mos. ds.
(Signed) O. J. Jones M. D.
(Address) 19

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death yrs. mos. days. In the State yrs. mos. days.
Where was disease contracted if not at place of death?
Former or usual residence

19. PLACE OF BURIAL OR REMOVAL Chester Hill DATE OF BURIAL 191

20. UNDERTAKER M. J. Walker ADDRESS Pocatello, Ida

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Form V. S. No. 5. 10M. 6-20-11.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics
File No. 4298
Registered No. 27

1. PLACE OF DEATH.
County of Canyon
City of Manupa

Registration District No. 3
Primary Registration District No. 1006
(No. _____, St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Elna Lemora Robbins

If death occurred in a hospital, institution or camp give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX Female 4. COLOR OR RACE white 5. SINGLE, MARRIED, WIDOWED OR DIVORCED. X
(Write the word.)

6. DATE OF BIRTH Oct 20 1912
(Month) (Day) (Year)

7. AGE 4 yrs. 5 mos. 5 ds. IF LESS than 1 day how many hrs. or min.

8. OCCUPATION

- (a) Trade, profession or particular kind of work X
(b) General nature of industry business or establishment in which employed (or employer) X

9. BIRTHPLACE

(State or Country) Manupa Idaho

10. NAME OF FATHER C. L. Robbins

11. BIRTHPLACE OF FATHER Id
(State or Country)

12. MAIDEN NAME OF MOTHER Lola Lolla Soddard

13. BIRTHPLACE OF MOTHER Iowa
(State or Country)

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Mrs C. L. Robbins
(Address) Manupa Idaho

15. Filed 2-28-1913 OTB Bellier mi
Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH Feb 25 1913
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from Feb 24 1913, to Feb 25 1913, that I last saw her alive on Feb 25 1913, and that death occurred on the date stated above, at 3:30 P. M.

The CAUSE OF DEATH* was as follows:

Capillary Bronchitis

(Duration) 3 yrs. 3 mos. 3 ds.
Contributory (Secondary) La Grippe

(Duration) 6 yrs. 6 mos. 6 ds.
(Signed) J. H. Murray M. D.
Feb 25 1913 (Address) Manupa Idaho

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death _____ yrs. _____ mos. _____ ds. In the State _____ yrs. _____ mos. _____ ds.
Where was disease contracted.
If not at place of death?
Former or usual residence _____

19. PLACE OF BURIAL OR REMOVAL Kohlerfawn Cam. DATE OF BURIAL Feb 26 1913

20. UNDERTAKER SB Shellebarger ADDRESS Manupa Idaho

Form V. S. No. 5. 10M. 6-20-11.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics1. PLACE OF DEATH.
County of Canyon
City of MarbleRegistration District No. 1003
Primary Registration District No. 1006
(No. _____, _____ St.)File No. 4299Registered No. 28

If death occurred in a hospital, institution or camp give its NAME instead of street and number.

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Joyce Irene Blickenstaff

PERSONAL AND STATISTICAL PARTICULARS

3. SEX Female 4. COLOR OR RACE White 5. SINGLE, MARRIED, WIDOWED OR DIVORCED. Single
(Write the word.)6. DATE OF BIRTH October 6th 1913
(Month) (Day) (Year)7. AGE 1 yrs. 4 mos. 18 ds. IF LESS than 1 day how many _____ hrs. or _____ min.?

8. OCCUPATION

- (a) Trade, profession, or particular kind of work
-
- (b) General nature of industry business, or establishment in which employed (or employer)

9. BIRTHPLACE White Co. Indiana
(State or Country)10. NAME OF FATHER Eli E. Blickenstaff11. BIRTHPLACE OF FATHER Piatt Co. Illinois
(State or Country)12. MAIDEN NAME OF MOTHER Maud S. Snyder13. BIRTHPLACE OF MOTHER Canoll Co. Indiana
(State or Country)

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Eli E. Blickenstaff
(Address) Marble Idaho15. Filed 2/26/1913 O. B. Beller M.D.
Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH Feb 24 1913
(Month) (Day) (Year)17. I HEREBY CERTIFY, That I attended deceased from Feb 10 1913, to Feb 24 1913, that I last saw her alive on Feb 23 1913, and that death occurred on the date stated above, at 9 old.

The CAUSE OF DEATH* was as follows:

Bronchial Pneumonia(Duration) _____ yrs. _____ mos. 14 ds.
Contributory (Secondary) _____(Duration) _____ yrs. _____ mos. _____ ds.
(Signed) J. D. Calhoun M. D.
19 _____ (Address)

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place _____ In the _____
of death _____ yrs _____ mos _____ ds. State _____ yrs _____ mos _____ ds.
Where was Disease contracted,
If not at place of death? _____
Former or
usual residence _____19. PLACE OF BURIAL OR REMOVAL Kohlerman Cem. DATE OF BURIAL 2/26 191320. UNDERTAKER H. K. Robinson ADDRESS Marble

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
 N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Form V. S. No. 5. 10M. 6-20-11.

CERTIFICATE OF DEATH

State of Idaho
 BOARD OF HEALTH
 Bureau of Vital Statistics1. PLACE OF DEATH.
 County of Canyon
 City of NampaRegistration District No. 1003
 Primary Registration District No. 1006
 (No. _____, _____ St.)File No. 4309
 Registered No. 29

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

Elsie Mae Lawlis

If death occurred in a hospital, institution or camp give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX

Female

4. COLOR OR RACE

White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED.

Single
 (Write the word.)

6. DATE OF BIRTH

Aug 29 1892
 (Month) (Day) (Year)

7. AGE

20 yrs. 6 mos. 10 ds.IF LESS than 1 day
 how many hrs. or
 min.?

8. OCCUPATION

(a) Trade, profession, or particular kind of work

Nurse

(b) General nature of industry business, or establishment in which employed (or employer)

9. BIRTHPLACE

(State or Country)

Mo

10. NAME OF FATHER

Joe Lawlis

11. BIRTHPLACE OF FATHER

(State or Country)

Mo

12. MAIDEN NAME OF MOTHER

Sara Wilmot

13. BIRTHPLACE OF MOTHER

(State or Country)

England

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

Sarah Chase

(Address)

Nampa Ida

15.

Filed 2-20-1913O. B. Beller M.D.
 Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

2 19 1913
 (Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from

Jan 25 - 1913, to Feb 19 - 1913that I last saw her alive on Feb 19 1913and that death occurred on the date stated above, at 6 P. M.

The CAUSE OF DEATH* was as follows:

Sclerosis of Liver(Duration) 2 yrs. — mos. — ds.Contributory (Secondary) Typhoid fever(Duration) — yrs. — mos. — ds.(Signed) O. B. Beller M. D.2-20-1913 (Address) O. B. Beller Nampa Ida

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place _____ In the _____
 of death yrs. mos. ds. State yrs. mos. ds.Where was Disease contracted, _____
 If not at place of death? _____Former or _____
 usual residence. _____

19. PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

Bohlerman 2/27 1913

20. UNDERTAKER

ADDRESS

St. Robinson Nampa Ida

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

State of Idaho BOARD OF HEALTH Bureau of Vital Statistics	
1. PLACE OF DEATH County of <u>Canyon</u> City of <u>Franklin</u> (No. _____ St.)	Registrars No. <u>1005</u> Primary Registrar District No. <u>1006</u> File No. <u>4301</u> Registered No. <u>31</u>
If death occurs away from usual residence, give facts called for under special information. 2. FULL NAME <u>Helen Augusta Tower</u> If death occurred in a hospital, institution or camp give its NAME instead of street and number.	
PERSONAL AND STATISTICAL PARTICULARS	
3. SEX <u>Female</u>	4. COLOR OR RACE <u>White</u>
5. SINGLE, MARRIED, WIDOWED OR DIVORCED <u>Widowed</u> (Write the word.)	
6. DATE OF BIRTH <u>2</u> <u>6</u> <u>1913</u> (Month) (Day) (Year)	
7. AGE <u>69</u> <u>5</u> yrs. mos. ds. IF LESS than 1 day how many hrs. or min.?	
8. OCCUPATION (a) Trade, profession, or particular kind of work <u>Housewife</u> (b) General nature of industry, business, or establishment in which employed (or employer)	
9. BIRTHPLACE (State or Country) <u>Oberlin Ohio</u>	
10. NAME OF FATHER <u>Vanvalkenberg</u>	
11. BIRTHPLACE OF FATHER (State or Country) <u>Unknown</u>	
12. MAIDEN NAME OF MOTHER <u>Unknown</u>	
13. BIRTHPLACE OF MOTHER <u>Scotland</u> (State or Country)	
14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE (Informant) <u>Mrs W.A. Shupe</u> (Address) <u>Idaho</u>	
15. Filed <u>2-10-1913</u> <u>O.B. Bell</u> Local Registrar	
MEDICAL CERTIFICATE OF DEATH	
16. DATE OF DEATH <u>Feb 6</u> <u>1913</u> (Month) (Day) (Year)	
17. I HEREBY CERTIFY, That I attended deceased from <u>Jan 21</u> - 191 <u>3</u> , to <u>Feb 6</u> 191 <u>3</u> that I last saw her alive on <u>Feb 3</u> - 191 <u>3</u> , and that death occurred on the date stated above, at <u>8 A.M.</u> The CAUSE OF DEATH* was as follows: <u>Valvular Heart disease</u> (Duration) <u>2</u> yrs. Contributory (Secondary) (Duration) _____ yrs. mo. (Signed) _____ 19. (Address) <u>Nampa Ida</u> *State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.	
18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.) At place _____ In the _____ of death _____ yrs. _____ mos. _____ ds. State _____ yrs. _____ mos. _____ ds. Where was Disease contracted, If not at place of death? Former or usual residence.	
19. PLACE OF BURIAL OR REMOVAL <u>Fairview Cem</u>	DATE OF BURIAL <u>2-8-1913</u>
20. UNDERTAKER <u>T.H. Robinson</u>	ADDRESS <u>Nampa Ida</u>

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PERSONS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Form V. S. No. 5. 10M. 6-20-11.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH. Registration No. 3
County of Canyon Primary Registrar District No. 1006
City of Nampa (No. _____) St. _____

File No. 4302
Registered No. 32

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

Margaret Sprague

If death occurred in a hospital, institution or camp give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX Female 4. COLOR OR RACE White 5. SINGLE, MARRIED, WIDOWED OR DIVORCED. Married
(Write the word.)

6. DATE OF BIRTH Nov 10 1893
(Month) (Day) (Year)

7. AGE 79 yrs. 2 mos. 21 ds. IF LESS than 1 day how many _____ hrs. or _____ min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work Housekeeper
(b) General nature of industry business or establishment in which employed (or employer) _____

9. BIRTHPLACE (State or Country) New York St.

10. NAME OF FATHER Gertrude Bullock

11. BIRTHPLACE OF FATHER (State or Country) _____

12. MAIDEN NAME OF MOTHER Rebecca Dwyer

13. BIRTHPLACE OF MOTHER (State or Country) Vermont

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) W. A. Sprague
(Address) Nampa

15. _____

Filed 2/2 - 1913 B. B. Miller MD
Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

Baby 1 1913
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from Jan 28 1913, to Feb 1 1913, that I last saw him alive on Feb 1 1913, and that death occurred on the date stated above, at 3:30 P. M.

The CAUSE OF DEATH* was as follows:

Heart failure - from
organic heart trouble
has had heart trouble and
asthma for years
(Duration) _____ yrs. _____ mos. _____ ds.

Contributory (Secondary) _____

(Duration) _____ yrs. _____ mos. _____ ds.
(Signed) J. H. Murray M. D.
Feb 3 1913 (Address) Nampa Idaho

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death _____ yrs. _____ mos. _____ ds. State _____ yrs. _____ mos. _____ ds.

Where was disease contracted, _____

If not at place of death? _____

Former or _____

usual residence. _____

19. PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

Kohler Lawn

Feb 3 1913

20. UNDERTAKER

ADDRESS

Shellabarger Nampa Idaho

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

PLACE OF DEATH.

of *Canyon*
*Caldwell*Registration District No. *3*Primary Registration District No. *1005*(No. *3*, St.)File No. *4303*Registered No. *36*occurs away from house,
give facts called
for special information.

2. FULL NAME

*Laura Klepper*If death occurred in a hospital, in-
stitution or camp, give its NAME
instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

4. COLOR OR RACE 5. SINGLE, MARRIED, WID-
OWED OR DIVORCED.*W.**Widow*
(Write the word.)

DATE OF BIRTH

*Oct**24**1889*

(Month)

(Day)

(Year)

80 yrs. *4* mos. *11* ds.IF LESS than 1 day
how many hrs. or
..... mins.?

OCCUPATION

Trade, profession or
particular kind of work
General nature of industry,
business, or establishment in
which employed (or employer)*Housekeeper*

PLACE OF BIRTH

State or Country)

Beardette N.Y.

NAME OF FATHER

Name of Mother

Nathan Sevel

PLACE OF BIRTH

State or Country)

Don't know

MOTHER'S NAME

Name of Mother

Hannah Black.

PLACE OF BIRTH

State or Country)

Don't know

ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Signature)

Fred Klepper

(Address)

*Caldwell, Idaho**Mar. 7th* 1913*John L. Meyer*

Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH

*McL**5**1913*

(Month)

(Day)

(Year)

17. I HEREBY CERTIFY, That I attended deceased from

4/2/13 191, to *4/5/13* 191,that I last saw her alive on *4/5/13* 191,and that death occurred on the date stated above, at *11* M.

The CAUSE OF DEATH* was as follows:

Dilatation Heart(Duration) yrs. mos. *3* ds.Contributory *the Fibrillation*
(Secondary)(Duration) yrs. mos. *4* ds.(Signed) *Spurs Johnson* M. D.*3-6-1913* (Address) *Caldwell, Idaho**State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1)
MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.18. LENGTH OF RESIDENCE (For Hospitals, Institutions,
Transients or Recent Residents.)

At place of death yrs. mos. days. In the State yrs. mos. days.

Where was disease contracted
if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL

Richman Mo

DATE OF BURIAL

3/7 1913

20. UNDERTAKER

W. C. Dyer

ADDRESS

*3773**Caldwell Idaho*

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Form V. S. No. 5. 10M. 6-20-11.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH.

Registration District No. 3

County of Oregon

Primary Registration District No. 1005

City of Caldwell

(No. _____ St.)

File No. 4304

Registered No. 76

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

Nephthalie Bardsley

If death occurred in a hospital, institution or camp give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX

M.

4. COLOR OR RACE

W

5. SINGLE, MARRIED, WIDOWED OR DIVORCED.

Married
(Write the word.)

6. DATE OF BIRTH

Nov

24

1843

(Month)

(Day)

(Year)

7. AGE

69

yrs.

3

mos.

8

ds.

IF LESS than 1 day
how many _____ hrs. or
_____ min.?

8. OCCUPATION

(a) Trade, profession, or particular kind of work

Retired Farmer

(b) General nature of industry business, or establishment in which employed (or employer)

9. BIRTHPLACE

(State or Country)

New Jersey

10. NAME OF FATHER

Nephthalie Bardsley

11. BIRTHPLACE OF FATHER

(State or Country)

England

12. MAIDEN NAME OF MOTHER

Andrew Williams

13. BIRTHPLACE OF MOTHER

(State or Country)

England

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

J. L. Bardsley

(Address)

Caldwell

15.

Filed Mar. 6 1913

J. L. Meyer
Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

Nov

2

1913

(Month)

(Day)

(Year)

17. I HEREBY CERTIFY, That I attended deceased from

June 1 1912, to Mar 2 1913

that I last saw him alive on Mar 2 1913

and that death occurred on the date stated above, at 1:30 A.M.

The CAUSE OF DEATH* was as follows:

Uremia

(Duration)

yrs.

mos.

ds.

Contributory
(Secondary)

La Grippe + nephritis

(Duration)

yrs.

mos.

20 ds.

(Signed)

S. J. Miller

M. D.

Mar 4 1913 (Address) Caldwell, Id.

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place

In the

of death.....yrs.....mos.....ds .State.....yrs.....mos.....ds.

Where was Disease contracted,

If not at place of death?

Former or

usual residence.

19. PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

Oregon Hill

3/6 1913

20. UNDERTAKER

ADDRESS

W. C. Dyer

Caldwell, Id.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
N. B.—Every item of information should be carefully supplied. AGE should be state EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Form V. S. No. 5. 10M. 6-20-11.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH.

Registration District No. 3

County of Canyon

Primary Registration District No. 1005

City of Caldwell

(No. _____ St.)

File No. 1305

Registered No. 25

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

Matchela M. Glenn

If death occurred in a hospital, institution or camp give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX

F

4. COLOR OR RACE

W.

5. SINGLE, MARRIED, WIDOWED OR DIVORCED.

Married
(Write the word.)

6. DATE OF BIRTH

Sept.
(Month)

7
(Day)

1840
(Year)

7. AGE

72 yrs. 5 mos. 9 ds.

IF LESS than 1 day
how many _____ hrs. or
_____ min.?

8. OCCUPATION

(a) Trade, profession, or particular kind of work
(b) General nature of industry business, or establishment in which employed (or employer)

House-keeping

9. BIRTHPLACE

(State or Country)

Illinois

10. NAME OF FATHER

William L. Scott

11. BIRTHPLACE OF FATHER

(State or Country)

Kentucky

12. MAIDEN NAME OF MOTHER

Nancy Scott

13. BIRTHPLACE OF MOTHER

(State or Country)

Kentucky

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

(Address)

John P. Glenn
Caldwell, Ida

15.

Filed Feb. 18 1913

John P. Meyer
Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

July
(Month)

16
(Day)

1913
(Year)

17. I HEREBY CERTIFY, That I attended deceased from

Feb 10

1913, to

Feb 16

1913

that I last saw her alive on Feb 16 1910

and that death occurred on the date stated above, at 12 M.

The CAUSE OF DEATH* was as follows:

Chronic asthma
Coronary lesion
See Gluppe

(Duration) _____ yrs. _____ mos. 10 ds.

Contributory (Secondary)

(Duration) _____ yrs. _____ mos. _____ ds.

(Signed)

S. J. Miller

M. D.

2-17-

1913

(Address) Caldwell Idaho

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL,

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place

In the

of death _____ yrs. _____ mos. _____ ds. State _____ yrs. _____ mos. _____ ds.

Where was Disease contracted,

If not at place of death?

Former or

usual residence.

19. PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

Canyon Hill

Feb 18

1913

20. UNDERTAKER

ADDRESS

H. B. Dyer

Caldwell

WRITE PLAINLY, WITH UNFADEING INK—THIS IS A PERMANENT RECORD.
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Form V. S. No. 5. 12½ M. 7-24-11

CERTIFICATE OF DEATH

1. PLACE OF DEATH. Registration District No. 3
County of Lanyon Primary Registration District No. 1005
City of Caldwell (No. _____, _____ St.)

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics
File No. 4306
Registered No. 21

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

Louis Ingram

If death occurred in a hospital, institution or camp give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX Female 4. COLOR OR RACE White 5. SINGLE, MARRIED, WIDOWED OR DIVORCED. Widow
(Write the word.)
6. DATE OF BIRTH do not know ex act date
(Month) (Day) (Year)

7. AGE 82 yrs. _____ mos. _____ ds. IF LESS than 1 day
how many _____ hrs. or _____ min?

8. OCCUPATION
(a) Trade, profession or particular kind of work House Wife
(b) General nature of industry business or establishment in which employed (or employer)

9. BIRTHPLACE
(State or Country) England

10. NAME OF FATHER Harage

11. BIRTHPLACE OF FATHER
(State or Country) England

12. MAIDEN NAME OF MOTHER do not know

13. BIRTHPLACE OF MOTHER
(State or Country) England

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) A. D. Mayfield
(Address) Caldwell Idaho

15. Filed Feb. 4 1913 Joh. S. Meyer
Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH Feb. 2 nd 1913
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from Jan 18 1913, to Feb 2 1913
that I last saw her alive on Feb 1 1913
and that death occurred on the date stated above, at _____ M.

The CAUSE OF DEATH* was as follows:

Hepatitis & Arteriosclerosis

(Duration) Several months yrs. _____ mos. _____ ds.

Contributory (Secondary)

(Signed) J. M. C. M. D.
Feb 4 1913 (Address) Caldwell

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place _____ In the _____
of death _____ yrs. _____ mos. _____ ds. State _____ yrs. _____ mos. _____ ds.
Where was disease contracted,
If not at place of death? _____
Former or
usual residence _____

19. PLACE OF BURIAL OR REMOVAL Lanyon Hill DATE OF BURIAL 2/3 1913

20. UNDERTAKER Platt-Plattman ADDRESS Caldwell

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Form V. S. No. 5 20M.1-16-12

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH. Registration District No. 3
County of Canyon Primary Registration District No. 2007
City of Middleton (St.)

File No. 4307
Registered No. 37

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME B. B. Hamilton

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX Male 4. COLOR OR RACE White 5. SINGLE, MARRIED, WIDOWED OR DIVORCED. Single
(Write the word.)

6. DATE OF BIRTH Not obtainable 1879
(Month) (Day) (Year)

7. AGE 33 yrs. — mos. — ds.
IF LESS than 1 day how many hrs. or mins.?

8. OCCUPATION
(a) Trade, profession or particular kind of work Civil Engineer
(b) General nature of industry business, or establishment in which employed (or employer)

9. BIRTHPLACE Atchison Co., Mo.
(State or Country)

10. NAME OF FATHER Wm Hamilton

11. BIRTHPLACE OF FATHER Mo.
(State or Country)

12. MAIDEN NAME OF MOTHER Elizabeth E. Wiley

13. BIRTHPLACE OF MOTHER Mo.
(State or Country)

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) A. B. Hamilton
(Address) Middleton Idaho

15. Filed Mar. 1 1913 John S. Meyer
Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH Feb 21st 1913
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from January 31 1913, to Feb 18 1913, that I last saw him alive on Feb 18 1913, and that death occurred on the date stated above, at 10:30 M.

The CAUSE OF DEATH* was as follows:
Chronic Stomach trouble, ulcers -
He evidently suffered for
some time and I would judge
the time (Duration) one yrs. — mos. — ds.
Contributory Brain lesion
(Secondary)
(Duration) yrs. — mos. — ds. 10
(Signed) Geo. Hamer M. D.
19 (Address) Middleton Idaho

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death yrs. — mos. — days. In the State yrs. — mos. — days.

Where was disease contracted if not at place of death?

Former or usual residence.

19. PLACE OF BURIAL OR REMOVAL Middleton Cent DATE OF BURIAL 2/24 1913

20. UNDERTAKER Schreibers Undertaker ADDRESS Boise, Ida.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Form V. S. No. 5. 10M. 6-20-11.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH

Registration District No. 3County of CamdenPrimary Registration District No. 2005City of Parma(No. Kline St.)File No. 4308Registered No. 34

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

Frank Kline Lamy

If death occurred in a hospital, institution or camp give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX

M

4. COLOR OR RACE 5. SINGLE, MARRIED, WIDOWED OR DIVORCED.

W(Write the word.) Single

6. DATE OF BIRTH

Aug 22 1901
(Month) (Day) (Year)

7. AGE

11 yrs. 0 mos. 0 ds.
IF LESS than 1 day how many 0 hrs. or 0 min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work
(b) General nature of industry business or establishment in which employed (or employer)School boy

9. BIRTHPLACE

(State or Country)

Idaho

10. NAME OF FATHER

Chas R Lamy

11. BIRTHPLACE OF FATHER

(State or Country)

Idaho

12. MAIDEN NAME OF MOTHER

Lottie Kline

13. BIRTHPLACE OF MOTHER

(State or Country)

Idaho

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

Charles R Lamy

(Address)

Parma, Idaho

15.

Filed

9/141913R. Lamy

Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

February 13 1913
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from

Feb - 9 1913, to Feb 13 1913that I last saw him alive on Feb 12 1913and that death occurred on the date stated above, at 7 A M

The CAUSE OF DEATH* was as follows:

Shock following burn(Duration) yrs. 0 mos. 4 ds.

Contributory (Secondary)

Relio. embolism(Duration) yrs. 0 mos. 2 ds.

(Signed)

R. Lamy M. D.
9/13 1913 (Address) Parma, Idaho

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death. 0 yrs. 0 mos. 0 ds. State. 0 yrs. 0 mos. 0 ds.

Where was disease contracted.

If not at place of death?

Former or

usual residence.

19. PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

Parma Idaho9/14 1913

20. UNDERTAKER

ADDRESS

Chas R Lamy CoParma Ida

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Form V. S. No. 5. 10M. 6-20-11.

CERTIFICATE OF DEATH

 State of Idaho
 BOARD OF HEALTH
 Bureau of Vital Statistics

1. PLACE OF DEATH.

Registration District No. 3County CamdenPrimary Registration District No. 2005City of Parma

(No. _____ St.)

File No. 1309Registered No. 35

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Matthew Clark

If death occurred in a hospital, institution or camp give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX

m

4. COLOR OR RACE 5. SINGLE, MARRIED, WIDOWED OR DIVORCED.

w(Write the word.) single

6. DATE OF BIRTH

march

(Month)

(Day)

1841
(Year)

7. AGE

71 yrs. 11 mos. _____ ds.
 IF LESS than 1 day
 how many _____ hrs. or
 _____ min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work

farmer

(b) General nature of industry business or establishment in which employed (or employer)

9. BIRTHPLACE

(State or Country)

Ohio

10. NAME OF FATHER

no

11. BIRTHPLACE OF FATHER

(State or Country)

no

12. MAIDEN NAME OF MOTHER

no

13. BIRTHPLACE OF MOTHER

(State or Country)

no

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Levi Stephens

(Address) _____

15.

Filed 2/11 1913R. C. Cullen

Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

Feb.
(Month)9
(Day)1913
(Year)

17. I HEREBY CERTIFY, That I attended deceased from

Feb. 61913to Feb. 91913that I last saw him alive on Feb. 8 1913and that death occurred on the date stated above, at 8:15 a. m.

The CAUSE OF DEATH* was as follows:

Pneumonia right lung(Duration) _____ yrs. _____ mos. 5 ds.

Contributory (Secondary)

Valvular heart disease(Duration) 10 or more yrs. _____ mos. _____ ds.(Signed) Chas. B. Allen M. D.Feb. 10 1913 (Address) Parma, Ida.

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place _____ In the _____

of death _____ yrs. _____ mos. _____ ds. State _____ yrs. _____ mos. _____ ds.

Where was disease contracted, _____

If not at place of death? _____

Former or _____

usual residence. _____

19. PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

Parma Idaho2/12 1913

20. UNDERTAKER

ADDRESS

W. H. Cullen Parma Ida

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Form V. S. No. 5 20M.1-16-12

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH

Registration District No. 3

County of Canyon

Primary Registration District No. 2005

File No. 4310

City of Parma Ida.

(No. A)

St.)

Registered No. 20

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

John H. Gahly

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX

4. COLOR OR RACE

5. SINGLE, MARRIED, WIDOWED OR DIVORCED.

Male

White

Married
(Write the word.)

6. DATE OF BIRTH

Feb.

2

1913

(Month)

(Day)

(Year)

7. AGE

74 yrs. 4 mos. 1 ds.

IF LESS than 1 day
how many hrs. or
..... mins.?

8. OCCUPATION

(a) Trade, profession or particular kind of work

Farmer

(b) General nature of industry, business, or establishment in which employed (or employer)

9. BIRTHPLACE

(State or Country)

Germany

10. NAME OF FATHER

Frank Gahly

11. BIRTHPLACE OF FATHER

(State or Country)

Germany

12. MAIDEN NAME OF MOTHER

Christina Geyer

13. BIRTHPLACE OF MOTHER

(State or Country)

Germany

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

Jane Gahly

(Address)

Parma Idaho.

15.

Filed

Feb. 5

1913

J. H. Meyer

Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

Feb.

2

1913

(Month)

(Day)

(Year)

17. I HEREBY CERTIFY, That I attended deceased from

Jan. 30 1913, to Feb. 2 1913,

that I last saw him alive on Feb. 2 1913,

and that death occurred on the date stated above, at 2 P.M.

The CAUSE OF DEATH* was as follows:

Broncho Pneumonia

(Duration)

yrs.

mos.

3 ds.

Contributory

(Secondary)

La Grippe

(Duration)

yrs.

mos.

5

(Signed)

J. M. Henry

M.

19

(Address)

North Ida.

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death.....yrs.....mos.....days.

In the State.....yrs.....mos.....days.

Where was disease contracted if not at place of death?.....

Former or usual residence.....

19. PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

Tucker Cemetery

Feb. 11 1913.

20. UNDERTAKER

ADDRESS

Mr. Keller

Parma Ida.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
N. B.—Every item of information should be carefully supplied. AGE should be state EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Form V. S. No. 5. 10M. 6-20-11.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics
File No. 4311
Registered No. 22

1. PLACE OF DEATH.

County of Canyon
City of Mar Caldwell

Registration District No. 3Primary Registration District No. 2005

(No. _____, St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

Pauline M. Nelson

If death occurred in a hospital, institution or camp give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX

F.

4. COLOR OR RACE

W.

5. SINGLE, MARRIED, WIDOWED OR DIVORCED.

Single
(Write the word.)

6. DATE OF BIRTH

Jan 6 1912
(Month) (Day) (Year)

7. AGE

1 yrs. 1 mos. ds.

IF LESS than 1 day
how many hrs. or
..... min.?

8. OCCUPATION

- (a) Trade, profession, or particular kind of work
(b) General nature of industry business, or establishment in which employed (or employer)

9. BIRTHPLACE

(State or Country)

Idaho

10. NAME OF FATHER

Edward Nelson

11. BIRTHPLACE OF FATHER

(State or Country)

Sweden

12. MAIDEN NAME OF MOTHER

Jessie Lake

13. BIRTHPLACE OF MOTHER

(State or Country)

Idaho

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

(Address)

Miss Cora Keithley
Caldwell, Idaho

15.

Filed Feb. 7 1913

Jahel Meyers
Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

Feb 6 1913
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from

Feb. 1 1913, to Feb 6 1913

that I last saw h alive on Feb 6 1913,

and that death occurred on the date stated above, at 5 P. M.

The CAUSE OF DEATH* was as follows:

Scarlet fever

(Duration) yrs. mos. 6 ds.

Contributory
(Secondary)

(Duration) yrs. mos. ds.

(Signed) J. M. L. M. D.

Feb. 7 1913 (Address) Caldwell, Idaho

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place In the
of death yrs. mos. ds. State yrs. mos. ds.

Where was Disease contracted,

If not at place of death?

Former or

usual residence.

19. PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

Pleasant RidgeFeb. 6 1913

20. UNDERTAKER

ADDRESS

W. G. DyerCaldwellIdaho

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
N. B.—Every item of information should be carefully supplied. AGE should be state EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Form V. S. No. 5. 10M. 6-20-11.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH.
County of Canyon
City of New Caldwell

Registrar District No. 3
Primary Registration District No. 2005
(No. _____, _____ St.)

File No. 4312
Registered No. 23

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Earnest Herbert Harris

If death occurred in a hospital, institution or camp give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX M. 4. COLOR OR RACE W 5. SINGLE, MARRIED, WIDOWED OR DIVORCED. Single
(Write the word.)

6. DATE OF BIRTH Jan 8 1913
(Month) (Day) (Year)

7. AGE 1 yrs. 1 mos. — ds. IF LESS than 1 day how many — hrs. or — min.?

8. OCCUPATION

(a) Trade, profession, or particular kind of work
(b) General nature of industry, business, or establishment in which employed (or employer)

9. BIRTHPLACE

(State or Country)

10. NAME OF FATHER

11. BIRTHPLACE OF FATHER
(State or Country)

12. MAIDEN NAME OF MOTHER

13. BIRTHPLACE OF MOTHER
(State or Country)

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

(Address)

15.

Filed Feb 10 1913

Local Registrar John P. Meyer

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

Feb 8 1913
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from

Jan 28 1913, to Feb 8 1913
that I last saw him alive on Feb 8 1913

and that death occurred on the date stated above, at 2:30 P. M.

The CAUSE OF DEATH* was as follows:

Small pox

(Duration) — yrs. 11 mos. — ds.

Contributory (Secondary)

(Duration) — yrs. — mos. — ds.

(Signed)

Feb 8 1913 (Address) Idaho

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL,

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death — yrs. — mos. — ds. State — yrs. — mos. — ds.

Where was Disease contracted,

If not at place of death?

Former or

usual residence.

19. PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

Canyon Hill

Feb 9 1913

20. UNDERTAKER

ADDRESS

W. G. Dyer

Caldwell

Form V. S. No. 5. 10M. 6-20-11.

CERTIFICATE OF DEATH

1. PLACE OF DEATH.

Registration District No. 3

County of Cheyenne

Primary Registration District No. 2005

City of New Castle

(No. St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

Kieth

Hageman

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics
File No. 1313

Registered No. 24

If death occurred in a hospital, institution or camp give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX

M

4. COLOR OR RACE

W

5. SINGLE, MARRIED, WIDOWED OR DIVORCED.

Single
(Write the word.)

6. DATE OF BIRTH

Jan 26 1913
(Month) (Day) (Year)

7. AGE

14 yrs. 14 mos. ds.

IF LESS than 1 day
how many hrs. or
 min.?

8. OCCUPATION

(a) Trade, profession, or particular kind of work
(b) General nature of industry business, or establishment in which employed (or employer)

9. BIRTHPLACE

(State or Country) Idaho

10. NAME OF FATHER

Robert Roy Hageman

11. BIRTHPLACE OF FATHER

(State or Country) Texas

12. MAIDEN NAME OF MOTHER

Maudie Pearl Wiley

13. BIRTHPLACE OF MOTHER

(State or Country) Kansas

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

R. R. Hageman

(Address)

Caldwell Idaho

15.

Filed Feb. 13 1913

J. B. Myers

Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

Feb 8 1913
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from

Jan 29 1913, to Feb 8 1913
that I last saw him alive on Feb 2 1913

and that death occurred on the date stated above, at M.

The CAUSE OF DEATH* was as follows:

Premature birth

(Duration) yrs. 14 mos. ds.

Contributory
(Secondary)

(Duration) yrs. mos. ds.

(Signed) J. J. Miller M. D.

2-11 1913 (Address) Caldwell Idaho

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL,

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place In the
of death yrs. mos. ds. State yrs. mos. ds.

Where was Disease contracted,
If not at place of death?

Former or
usual residence

19. PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

Pleasant Ridge

Feb 10 1913

20. UNDERTAKER

ADDRESS

H. B. Dyer

Caldwell

Supplied casket.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. PHYSICIANS should be stated EXACTLY. Exact statement of CAUSE OF DEATH in plain terms, so that it may be properly classified. See instructions on back of certificate.

Form V. S. No. 5. 12½ M. 7-24-11

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics
File No. 4314
Registered No. 19

1. PLACE OF DEATH.

County of Idaho
City of Deary

Registration District No. 15Primary Registration District No. 2068

(No. _____, _____ St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

Barbara Miller

If death occurred in a hospital, institution or camp give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX

4.

4. COLOR OR RACE

W.

5. SINGLE, MARRIED, WIDOWED OR DIVORCED.

married
(Write the word.)

6. DATE OF BIRTH

Feb. 11 1841
(Month) (Day) (Year)

7. AGE

72 yrs. 0 mos. 15 ds.

IF LESS than 1 day
how many _____ hrs. or
_____ min?

8. OCCUPATION

(a) Trade, profession or particular kind of work

14.W.

(b) General nature of industry business or establishment in which employed (or employer)

74.W.

9. BIRTHPLACE

(State or Country)

Ohio

10. NAME OF FATHER

Casper Kappes

11. BIRTHPLACE OF FATHER

(State or Country)

Prussia

12. MAIDEN NAME OF MOTHER

unknown

13. BIRTHPLACE OF MOTHER

(State or Country)

Prussia

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

(Address)

John G. Miller
Deary

15.

Feb. 28 1913

R. E. Faust
Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH

Feb. 26 1913
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from Dec. 24, 1912, to Feb. 25, 1913

that I last saw her alive on Feb. 25, 1913

and that death occurred on the date stated above, at 8:15 P. M.

The CAUSE OF DEATH* was as follows:

senile debility

(Duration) _____ yrs. _____ mos. _____ ds.

Contributory
(Secondary)

(Duration) _____ yrs. _____ mos. _____ ds.

(Signed)

R. E. Faust M. D.
2/28 1913 (Address) Deary

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place _____ In the _____
of death _____ yrs. _____ mos. _____ ds. State _____ yrs. _____ mos. _____ ds.

Where was disease contracted,

If not at place of death?

Former or

usual residence

19. PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

Zion cemeteryFeb. 28 1913

20. UNDERTAKER

ADDRESS

E. AndersonPalouse, W.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Form V. S. No. 5. 12½ M. 7-24-11

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH.

Registration District No. 15

County of *Butte*

Primary Registration District No. 2066

City of *Pocatello*

(No. St.)

File No. 4316

Registered No. 17

If death occurs away from usual residence, give facts called for under special instruction.

2. FULL NAME

John D. Wiley

If death occurred in a hospital, institution or camp give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX

Male

4. COLOR OR RACE

White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED.

Married
(Write the word.)

6. DATE OF BIRTH

Sept 21 1858
(Month) (Day) (Year)

7. AGE

54 yrs 5 mos 4 ds.

IF LESS than 1 day
how many hrs. or min?

8. OCCUPATION

(a) Trade, profession or particular kind of work.
(b) General nature of industry business or establishment in which employed (or employer).

Lumberman

9. BIRTHPLACE

(State or Country)

Wisconsin

10. NAME OF FATHER

John L. Wiley

11. BIRTHPLACE OF FATHER

(State or Country)

New York

12. MAIDEN NAME OF MOTHER

Mary Dausman

13. BIRTHPLACE OF MOTHER

(State or Country)

Wisconsin

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

Mrs J. D. Wiley
Pocatello, Idaho
(Address)

15.

Filed *Feb. 26 1913*

D. Wm. Thompson
Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

Feb. 26 1913
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from

Jan. 1913, to *Feb. 1913*

that I last saw him alive on *Feb. 24 1913*

and that death occurred on the date stated above, at *1:25 P.M.*

The CAUSE OF DEATH* was as follows:

Chronic Valvular heart Disease.

(Duration) *3 yrs 4 mos ds.*

Contributory (Secondary)

Nephritis

(Duration) *3 yrs mos ds.*

(Signed)

Wm. Thompson

M. D.

Feb. 26 1913 (Address) *Pocatello*

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; (2) whether ACCIDENTAL, SUICIDAL OR HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place In the
of death yrs mos ds. State yrs mos ds.

Where was disease contracted,

If not at place of death?

Former or

usual residence.

19. PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

Palouse Wash

Feb 26 1913

20. UNDERTAKER

ADDRESS

E. Anderson

Palouse

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Form V.

12½ M. 7-24-11

CERTIFICATE OF DEATH

State of Idaho

OF HEALTH

Vital Statistics

1. CAUSE OF DEATH.

Registration District No. 15

County

Primary Registration District No. 2065

City of

(No. , St.)

File

Registered No. 22

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

Arnold De Long

If death occurred in a hospital, institution or camp give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX

4. COLOR OR RACE

5. SINGLE, MARRIED, WIDOWED OR DIVORCED.

Male

White

Single
(Write the word.)

6. DATE OF BIRTH

Dec

11

1913

(Month)

(Day)

(Year)

7. AGE

yrs. 13 mos. 7 ds.

If LESS than 1 day
how many hrs. or min?

8. OCCUPATION

(a) Trade, profession or particular kind of work.

None

(b) General nature of industry business or establishment in which employed (or employer)

9. BIRTHPLACE

(State or Country)

Troy Idaho

10. NAME OF FATHER

FATHER

Warren De Long

11. BIRTHPLACE OF FATHER

(State or Country)

Ohio

12. MAIDEN NAME OF MOTHER

MOTHER

Miss Byers

13. BIRTHPLACE OF MOTHER

(State or Country)

Iowa

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

Warren De Long

(Address)

Troy Idaho

15.

Filed Jan 18 1913

J. W. Olson
Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH

Jan

18

1913

(Month)

(Day)

(Year)

17. I HEREBY CERTIFY, That I attended deceased from

Jan 15

1913

to Jan 17

1913

that I last saw him alive on Jan 17 1913

and that death occurred on the date stated above, at 5:20 A.M.

The CAUSE OF DEATH* was as follows:

Pneumonia

(Duration) yrs. 7 ds.

Contributory (Secondary)

(Duration) yrs. mos. ds.

(Signed)

J. W. Olson M. D.
Jan 18 1913 (Address) Troy Idaho

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place In the
of death yrs. mos. ds. State yrs. mos. ds.

Where was disease contracted,

If not at place of death?

Former or

usual residence.

19. PLACE OF BURIAL OR REMOVAL DATE OF BURIAL

Cornwall

Jan 20 1913

20. UNDERTAKER

ADDRESS

W. A. Stephenson

Troy Idaho

Form V. S. No. 5. 12½ M. 7-24-11

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics
File No. 4318
Registered No. 23

1. PLACE OF DEATH.
County of Latah
City of Boz

Registration District No. 15
Primary Registration District No. 2065
(No. _____ St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Velma Oral McGarvey

If death occurred in a hospital, institution or camp give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX Female 4. COLOR OR RACE White 5. SINGLE, MARRIED, WIDOWED OR DIVORCED. Single
(Write the word.)

6. DATE OF BIRTH Oct 29 1912
(Month) (Day) (Year)

7. AGE 3 yrs. 22 mos. 22 ds. IF LESS than 1 day how many _____ hrs. or _____ min?

8. OCCUPATION
(a) Trade, profession or particular kind of work none
(b) General nature of industry business or establishment in which employed (or employer)

9. BIRTHPLACE (State or Country) Idaho

10. NAME OF FATHER Robt. W. McGarvey

11. BIRTHPLACE OF FATHER (State or Country) Canada

12. MAIDEN NAME OF MOTHER Rose Wood

13. BIRTHPLACE OF MOTHER (State or Country) Iowa

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Robert McGarvey
(Address) Boz Idaho

15. Filed Feb 21 1913 J. W. Olson
Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH Feb 20 1913
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from Feb 18 1913 to Feb 20 1913
that I last saw her alive on Feb 18 1913
and that death occurred on the date stated above, at 6 P. M.

The CAUSE OF DEATH* was as follows:
Pneumonia with shock

(Duration) _____ yrs. _____ mos. 10 ds.
Contributory Broncho Pneumonia
(Secondary)

(Duration) _____ yrs. _____ mos. 4 ds.
(Signed) J. W. Olson M. D.
Feb 21 1913 (Address) Boz Idaho

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place _____ In the _____
of death _____ yrs. _____ mos. _____ ds. State _____ yrs. _____ mos. _____ ds.
Where was disease contracted,
If not at place of death? _____
Former or
usual residence _____

19. PLACE OF BURIAL OR REMOVAL Cornwall cemetery. DATE OF BURIAL Feb 22 1913

20. UNDERTAKER Ed Cady ADDRESS Boz Idaho

Form V. S. No. 5. 12½ M. 7-24-11

CERTIFICATE OF DEATH

State of Idaho

BOARD OF HEALTH
Bureau of Vital Statistics1. PLACE OF DEATH.
County of Latah
City of KeedreenRegistration District No. 15
Primary Registration District No. 2064
(No. _____, _____ St.)File No. 4319
Registered No. 21

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

Rebecca Lory

If death occurred in a hospital, institution or camp give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX M 4. COLOR OR RACE W 5. SINGLE, MARRIED, WIDOWED OR DIVORCED. Single
(Write the word.)6. DATE OF BIRTH May 13 1913
(Month) (Day) (Year)7. AGE — yrs. 9 mos. 11 ds. IF LESS than 1 day how many _____ hrs. or _____ min?

8. OCCUPATION

(a) Trade, profession or particular kind of work.
(b) General nature of industry business or establishment in which employed (or employer)baby9. BIRTHPLACE
(State or Country)Keedreen Ida

10. NAME OF FATHER

E. A. Fry11. BIRTHPLACE OF FATHER
(State or Country)Mo

12. MAIDEN NAME OF MOTHER

Matthie Templeton13. BIRTHPLACE OF MOTHER
(State or Country)Kansas

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) E. A. Fry
(Address) Keedreen, Ida.

15.

Filed Feb 26 1913J. E. Hough
Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH Feb 26 1913
(Month) (Day) (Year)17. I HEREBY CERTIFY, That I attended deceased from Feb 14 1913, to Feb 24 1913 that I last saw him alive on Feb 23 1913 and that death occurred on the date stated above, at 5 P M.

The CAUSE OF DEATH* was as follows:

Croup & pneumonia(Duration) _____ yrs. _____ mos. 10 ds.Contributory
(Secondary)

(Duration) _____ yrs. _____ mos. _____ ds.

(Signed) E. Hough M. D.Feb 26 1913 (Address) Keedreen

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place _____ In the _____
of death _____ yrs. _____ mos. _____ ds. State _____ yrs. _____ mos. _____ ds.Where was disease contracted,
If not at place of death? _____Former or
usual residence. _____

19. PLACE OF BURIAL OR REMOVAL DATE OF BURIAL

Keedreen Ida Feb 25 1913

20. UNDERTAKER ADDRESS

D. J. Rowlands Keedreen
Ida

A stillbirth must be registered both as a birth and death. The date of death should be the date of delivery and the death certificate should further state, if known, the cause of the stillbirth and the period of utero gestation in months.

STATEMENT OF OCCUPATION.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer, Physician, Stenographer, Compositor, Architect, Locomotive engineer, Civil engineer, Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner*, (b) *Cotton mill*; (a) *Salesman*, (b) *Grocery*; (a) *Foreman*, (b) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification, as *Day laborer, Farm laborer, Laborer—Coal mine*, etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers*, who receive a definite salary), may be entered as *Housewife, Housework*, or *At home*, and children, not gainfully employed, as *At school* or *At home*. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer (retired, 6 yrs.)*. For persons who have no occupation whatever, write *None*.

STATEMENT OF CAUSE OF DEATH.—Name, first the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebro-*

spinal fever (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid Pneumonia") *Lobar pneumonia*; *Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritoneum*, etc., *Carcinoma, Sarcoma*, etc., of (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles*; *Whooping cough*; *Chronic valvular heart disease*; *Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent affection need not be stated unless important. Example: *Measles* (disease causing death), 29 ds.; *Bronchopneumonia* (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "Asthenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility, (Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Haemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uraemia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify as "PUERPERAL, *septicemia*", "PUERPERAL *peritonitis*," etc., all diseases resulting from childbirth or miscarriage. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning*; *Struck by railway train—accident*; *Revolver wound of head—homicide*; *Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "Contributory."

2
9#6

Form V. S. No. 5 20M.1-16-12

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics
File No. 4320
Registered No. 14

1. PLACE OF DEATH.

Registration District No. 15County of LoganPrimary Registration District No. 1008City of Moscow

(No. _____, _____ St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

Henrietta P. Caruthers

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX

F

4. COLOR OR RACE

W

5. SINGLE, MARRIED, WIDOWED OR DIVORCED.

Married

6. DATE OF BIRTH

Jan. 13 1873
(Month) (Day) (Year)

7. AGE

41 yrs. 1 mos. 11 ds.IF LESS than 1 day
how many _____ hrs. or
_____ mins.?

8. OCCUPATION

(a) Trade, profession or particular kind of work

House Wife

(b) General nature of industry, business, or establishment in which employed (or employer)

9. BIRTHPLACE

(State or Country)

Canada (Belville)

10. NAME OF FATHER

W. W. Jones

11. BIRTHPLACE OF FATHER

(State or Country)

Canada

12. MAIDEN NAME OF MOTHER

Kitchison

13. BIRTHPLACE OF MOTHER

(State or Country)

Canada

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

W. H. Caruthers(Address) Moscow Idaho.

15.

Filed Feb. 25 1917W. H. Caruthers
(Deputy) Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH

Feb. 24 1913
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from

Feb. 17 1913, to Feb. 23 1913,that I last saw h alive on Feb. 23 1913,and that death occurred on the date stated above, at 12:30 M.

The CAUSE OF DEATH* was as follows:

Pyle's Nephritis with Post-operative anuria

(Duration) _____ yrs. _____ mos. _____ ds.

Contributory Secondary anuria
(Secondary)

(Duration) _____ yrs. _____ mos. _____ ds.

(Signed) J. H. Clarke M. D.

19. (Address)

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death _____ mos. _____ days. In the State _____ yrs. _____ mos. _____ days.

Where was if not at place of death _____

Former or usual residence _____

19. PLACE OF BURIAL OR REMOVAL

Moscow Idaho.

DATE OF BURIAL

Feb. 25 1913

20. UNDERTAKER

See Helte

ADDRESS

Moscow Idaho.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Form V. S. No. 5 20M.1-16-12

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH

Registration District No. 15

County of Latah

Primary Registration District No. 1118

City of Moscow

(No. _____)

St.)

File No. 1321

Registered No. 73

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Mrs. Maria Edmundson

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX Female

4. COLOR OR RACE White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED.

Widow
(Write the word.)

6. DATE OF BIRTH

March

15

1827

(Month)

(Day)

(Year)

7. AGE

86 yrs. 11 mos. 12 ds.

IF LESS than 1 day
how many hrs. or
..... mins.?

8. OCCUPATION

(a) Trade, profession or particular kind of work

Retired

(b) General nature of industry, business, or establishment in which employed (or employer)

9. BIRTHPLACE

(State or Country)

Laurance Co. Penn.

10. NAME OF FATHER

Jacob Fox

11. BIRTHPLACE OF FATHER

(State or Country)

Penn.

12. MAIDEN NAME OF MOTHER

Nancy Keady

13. BIRTHPLACE OF MOTHER

(State or Country)

Penn.

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Mrs. Thomas S. Edmundson

(Address) Moscow Idaho

15.

Filed Mar 5 1913

D. F. Rae
Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

Feb.

27

1913

(Month)

(Day)

(Year)

17. I HEREBY CERTIFY, That I attended deceased from

Feb 21

1913

to Feb 27

1913

that I last saw her alive on Feb 27 1913

and that death occurred on the date stated above, at 7 P M

The CAUSE OF DEATH* was as follows:

Arteriosclerosis

(Duration) _____

yrs.

mos.

ds.

Contributory
(Secondary)

Gen. Debility

(Duration) _____

yrs.

mos.

ds.

(Signed) J. N. Clarke

M. D.

19 _____

(Address)

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death _____

yrs.

mos.

days.

In the State _____

yrs.

mos.

days.

Where was disease contracted if not at place of death?

Former or usual residence _____

19. PLACE OF BURIAL OR REMOVAL

Moscow

DATE OF BURIAL

1913

20. UNDERTAKER

Gen. Sletty

ADDRESS

Moscow

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Form V. S. No. 5 20M.1-16-12

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH.

Registration District No. 15

County of Idaho

Primary Registration District No. 1008

File No. 4322

City of Moscow

(No. _____, _____ St.)

Registered No. 12

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Florence L. Casey

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX M

4. COLOR OR RACE W

5. SINGLE, MARRIED, WIDOWED OR DIVORCED. Single
(Write the word.)

6. DATE OF BIRTH June 16th 1892
(Month) (Day) (Year)

7. AGE 20 yrs. _____ mos. _____ ds.

IF LESS than 1 day
how many _____ hrs. or
_____ mins.?

8. OCCUPATION

(a) Trade, profession or particular kind of work none

(b) General nature of industry, business, or establishment in which employed (or employer) _____

9. BIRTHPLACE

(State or Country) Idaho

10. NAME OF FATHER Joshua B. Casey

11. BIRTHPLACE OF FATHER

(State or Country) Vermont

12. MAIDEN NAME OF MOTHER Ida M. Little

13. BIRTHPLACE OF MOTHER

(State or Country) Conn

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Florence L. Casey

(Address) Moscow

15. Filed Feb 25 1913 D F Ray
Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH Feb 24 1913
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from _____ 1913, to _____ 1913,

that I last saw her alive on Early year 1912

and that death occurred on the date stated above, at _____ M.

The CAUSE OF DEATH* was as follows:

General debility -
Invalid since birth

_____ (Duration) _____ yrs. _____ mos. _____ ds.

Contributory
(Secondary)

_____ (Duration) _____ yrs. _____ mos. _____ ds.

(Signed) D. F. Ray M. D.

19. (Address) Moscow, Ida

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death _____ yrs. _____ mos. _____ days. In the State _____ yrs. _____ mos. _____ days.

Where was disease contracted if not at place of death? _____

Former or usual residence _____

19. PLACE OF BURIAL OR REMOVAL Moscow

DATE OF BURIAL Feb 26 1913

20. UNDERTAKER Shilly

ADDRESS Moscow

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIAN'S should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Form V. S. No. 5 20M.1-16-12

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH
County of Salah
City of Moscow
Registration District No. 15
Primary Registration District No. 1008
(No. _____, St.)

File No. 4323
Registered No. 11

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Elizabeth Alice Quinn

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX Female 4. COLOR OR RACE White 5. SINGLE, MARRIED, WIDOWED OR DIVORCED. Single
(Write the word.)

6. DATE OF BIRTH

Dec 18th 1854
(Month) (Day) (Year)

7. AGE

59 yrs. 2 mos. 3 ds.

IF LESS than 1 day
how many _____ hrs. or
_____ mins.?

8. OCCUPATION

(a) Trade, profession or particular kind of work.
(b) General nature of industry business, or establishment in which employed (or employer)

Housewife

9. BIRTHPLACE

(State or Country)

Pennsylvania

10. NAME OF FATHER

John B. Quinn

11. BIRTHPLACE OF FATHER

(State or Country)

Pennsylvania

12. MAIDEN NAME OF MOTHER

Elizabeth Rankin

13. BIRTHPLACE OF MOTHER

(State or Country)

Pennsylvania

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

John F. Schick

(Address)

Moscow, Idaho

15.

Filed Mar 5 1913

D. F. Ray
Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

Feb. 22 1913
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from

Feb. 1 1913, to Feb. 22 1913,

that I last saw him alive on Feb. 22 1913,

and that death occurred on the date stated above, at 11-9 M.

The CAUSE OF DEATH* was as follows:

acute nephritis

(Duration) _____ yrs. _____ mos. 22 ds.

Contributory

(Secondary)

(Duration) _____ yrs. _____ mos. _____ ds.

(Signed)

J. H. Clarke

M. D.

19

(Address) Moscow

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death.....yrs.....mos.....days. In the State.....yrs.....mos.....days.

Where was disease contracted if not at place of death?.....

Former or usual residence.....

19. PLACE OF BURIAL OR REMOVAL DATE OF BURIAL

Garfield, Wash Feb 27 1913

20. UNDERTAKER

Geo. B. Bly

ADDRESS

Moscow

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Form V. S. No. 5. 12½ M. 7-24-11

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics
File No. 4324
Registered No. 10

1. PLACE OF DEATH. Registration District No. 15
County of Latah Primary Registration District No. 1008
City of Moscow (No. _____, _____ St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Henry Earl Childers

If death occurred in a hospital, institution or camp give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX _____ 4. COLOR OR RACE _____ 5. SINGLE, MARRIED, WIDOWED OR DIVORCED. _____

(Write the word.)

6. DATE OF BIRTH

November 7 1884
(Month) (Day) (Year)

7. AGE

78 yrs. 3 mos. 11 ds.

IF LESS than 1 day
how many hrs. or
..... min?

8. OCCUPATION

(a) Trade, profession or particular kind of work. retired
(b) General nature of industry business or establishment in which employed (or employer) _____

9. BIRTHPLACE

(State or Country)

Indiana

10. NAME OF FATHER

Robert Childers

11. BIRTHPLACE OF FATHER

(State or Country)

Virginia

12. MAIDEN NAME OF MOTHER

Mary Schuber

13. BIRTHPLACE OF MOTHER

(State or Country)

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

Geo S Childers

(Address)

Moscow

15.

Filed Feb. 20th 1913

L. M. Childers
(Seal) Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH

Feb 18 1913
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from

June 13 1912, to Jan. 13 1913
that I last saw him alive on Jan. 13 1913

and that death occurred on the date stated above, at 5 P. M.

The CAUSE OF DEATH* was as follows:

Cancer of right side of
face

(Duration) 3 about yrs. mos. ds.

Contributory (Secondary)

(Duration) _____ yrs. mos. ds.

(Signed)

J. N. Clarke M. D.
Feb. 19 1913 (Address) Moscow

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place _____ In the _____
of death _____ yrs. _____ mos. _____ ds. State _____ yrs. _____ mos. _____ ds.

Where was disease contracted,

If not at place of death?

Former or

usual residence.

19. PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

MoscowFeb 20 1913

20. UNDERTAKER

ADDRESS

Geo S ChildersMoscow,

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Form V. S. No. 5 20M.1-16-12

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics
File No. 4325
Registered No. 18

1. PLACE OF DEATH
County of Idaho Registration District No. 15
City of Moscow, Idaho Primary Registration District No. 1008
(No. , St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Andrew Wilburn Phillips

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX Male 4. COLOR OR RACE White 5. SINGLE, MARRIED, WIDOWED OR DIVORCED. Married (word.)

6. DATE OF BIRTH Nov. 7 1872
(Month) (Day) (Year)

7. AGE 40 yrs. 3 mos. 7 ds.
IF LESS than 1 day
how many hrs. or
..... mins.

8. OCCUPATION
(a) Trade, profession or particular kind of work Grocery Business
(b) General nature of industry business, or establishment in which employed (or employer)

9. BIRTHPLACE
(State or Country) Iowa

10. NAME OF FATHER Columbus Phillips
(State or Country) Iowa

11. BIRTHPLACE OF FATHER
(State or Country) Iowa

12. MAIDEN NAME OF MOTHER Hannah Madison

13. BIRTHPLACE OF MOTHER
(State or Country) Indiana

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) C. Loring
(Address) Leovisto

15. Filed Feb. 13th 1913 D. W. Prichard
Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH Feb. 13th 1913
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from Jan. 21st 1913 to Feb. 13th 1913, that I last saw him alive on Feb. 13th 1913 and that death occurred on the date stated above, at 4:20 PM.

The CAUSE OF DEATH* was as follows:

Myoperotrophic Circumflex & Liver

(Duration) 2-3 yrs. mos. ds.
Contributory
(Secondary)

(Duration) yrs. mos. ds.
(Signed) C. Loring M. D.
2/13 1913 (Address) Leovisto, Ida.

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death 30 yrs. 0 mos. 3/4 days. In the State 2 yrs. 2 mos. days.
Where was disease contracted if not at place of death? Leovisto
Former or usual residence Iowa

19. PLACE OF BURIAL OR REMOVAL Leovisto, Idaho DATE OF BURIAL Feb. 16 1913

20. UNDERTAKER Geo. Kelly ADDRESS Moscow, Idaho

Form V. S. No. 5 20M.1-16-12

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH.

Registration District No. 15County of LatohPrimary Registration District No. 1008City of Moscow

(No. _____)

St.) _____

Registered No. 16

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Peter Olson

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX _____

4. COLOR OR RACE _____

5. SINGLE, MARRIED, WIDOWED OR DIVORCED.

(Write the word.)

6. DATE OF BIRTH

Feb 13

(Month)

(Day)

(Year) 1918

7. AGE

65 yrs.

mos.

ds.

IF LESS than 1 day
how many hrs. or
..... mins.?

8. OCCUPATION

(a) Trade, profession or

particular kind of work

(b) General nature of industry

business, or establishment in

which employed (or employer)

9. BIRTHPLACE

(State or Country) Sweden

10. NAME OF FATHER

Don't know

11. BIRTHPLACE OF FATHER

(State or Country) "

12. MAIDEN NAME OF MOTHER

"

13. BIRTHPLACE OF MOTHER

(State or Country) "

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Mona Perzell(Address) Moscow

15.

Filed Feb 161918H. H. Hunkel
Sept 13 Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH

Feb 13

(Month)

(Day)

1918

(Year)

17. I HEREBY CERTIFY, That I attended deceased from

Feb 91918, toFeb 171918,that I last saw him alive on Feb 9 1917,and that death occurred on the date stated above, at 6 P. M.

The CAUSE OF DEATH* was as follows:

Acute Nephritis

(Duration)

yrs.

mos.

ds. 7 or 8

Contributory

(Secondary) General Debility

(Duration)

yrs.

mos.

ds.

(Signed) J. N. Clarke

M. D.

19

(Address) MoscowIdaho

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place

of death.....yrs.....mos.....days.

In the

State.....yrs.....mos.....days.

Where was disease contracted if not at place of death?

Former or usual residence.....

19. PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

MoscowFeb 16 1918

20. UNDERTAKER

ADDRESS

Geo. StoltzMoscow

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Form V. S. No. 5. 12½ M. 7-24-11

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics
File No. 4327
Registered No. 15

1. PLACE OF DEATH.
County of Latah
City of Moscow
Registration District No. 15
Primary Registration District No. 1008
(No. _____, St. _____)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Samantha Ann Holden

If death occurred in a hospital, institution or camp give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX Female 4. COLOR OR RACE White 5. SINGLE, MARRIED, WIDOWED OR DIVORCED. Widower

6. DATE OF BIRTH May 14 1838
(Month) (Day) (Year)

7. AGE 24 yrs. 9 mos. 11 ds. IF LESS than 1 day how many _____ hrs. or _____ min?

8. OCCUPATION
(a) Trade, profession or particular kind of work. Housewife
(b) General nature of industry business or establishment in which employed (or employer)

9. BIRTHPLACE Camp, Co. Ills
(State or Country)

10. NAME OF FATHER Amos T. Russell

11. BIRTHPLACE OF FATHER Ills
(State or Country)

12. MAIDEN NAME OF MOTHER Anna Knight

13. BIRTHPLACE OF MOTHER Ills
(State or Country)

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) M. A. Holden
(Address) Moscow Ida

15. Filed Feb. 19 1913
R. M. Drinko
(Deputy) Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH Feb 17 1913
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from Jan 25 1913 to Feb 17 1913
that I last saw her alive on 25 Jan 1913
and that death occurred on the date stated above, at 11:30 AM.

The CAUSE OF DEATH* was as follows:
Light stroke of Apoplexy Jan 25th 1913 with gradual recovery
Hard stroke Feb 17th 1913
(Duration) as stated above _____ yrs. _____ mos. _____ ds.

Contributory Old age
(Secondary)
Last shock (Duration) about 2 hours _____ yrs. _____ mos. _____ ds.
(Signed) G. M. Leitch M. D.
Feb 17 1913 (Address) Moscow Idaho

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place _____ In the _____
of death _____ yrs. _____ mos. _____ ds. State _____ yrs. _____ mos. _____ ds.
Where was disease contracted, _____
If not at place of death? _____
Former or _____
usual residence _____

19. PLACE OF BURIAL OR REMOVAL Moscow DATE OF BURIAL Feb 19 1913

20. UNDERTAKER Geo Stutz ADDRESS Moscow

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Form V. S. No. 5. 10M. 6-20-11.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics
File No. 4328
Registered No. 4

1. PLACE OF DEATH.

Registration District No. 20

County of Elmore
City of Miner

Primary Registration District No. 2020

(No. _____ St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

Jasifa Cruzabalaga

If death occurred in a hospital, institution or camp give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX

Female

4. COLOR OR RACE

White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED.

Single
(Write the word.)

6. DATE OF BIRTH

Jan 2 1913
(Month) (Day) (Year)

7. AGE

1 yrs. 10 mos. 10 ds.
IF LESS than 1 day how many hrs. or min.?

8. OCCUPATION

- (a) Trade, profession or particular kind of work
(b) General nature of industry business or establishment in which employed (or employer)

9. BIRTHPLACE
(State or Country)Montachon Idaho

10. NAME OF FATHER

Juan Cruzabalaga11. BIRTHPLACE OF FATHER
(State or Country)Spain

12. MAIDEN NAME OF MOTHER

Martina Brasconra13. BIRTHPLACE OF MOTHER
(State or Country)Spain

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) José G. Christegu(Address) Montachon Idaho

15.

Filed Feb. 12th 1913 130 Walter
Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

February 12th 1913
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from 191 to 191

that I last saw h. 191 alive on 191,
and that death occurred on the date stated above, at 3 P. M.

The CAUSE OF DEATH* was as follows:

edema of lungssudden(Duration) 1 yrs. 10 mos. 10 ds.Contributory
(Secondary)(Duration) 1 yrs. 10 mos. 10 ds.

(Signed) H. L. Eaton coroner
Feb. 12th 1913 (Address) Montachon Idaho

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted,

If not at place of death?

Former or

usual residence

19. PLACE OF BURIAL OR REMOVAL DATE OF BURIAL

Montachon Idaho Feb 13 1913

20. UNDERTAKER

ADDRESS

J. M. Cowan Montachon

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Form V. S. No. 5. 10M. 6-20-11.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH.

Registration District No. 20County of ShoshonePrimary Registration District No. 2020City of Revere

(No. _____ St.)

File No. 1329Registered No. 2

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

Thomas Casey

If death occurred in a hospital, institution or camp give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX

Male

4. COLOR OR RACE

White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED.

Single
(Write the word)

6. DATE OF BIRTH

January
(Month)10
(Day)1863
(Year)

7. AGE

50 yrs. — mos. — ds.

IF LESS than 1 day
how many _____ hrs. or
_____ min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work

Laborer

(b) General nature of industry business or establishment in which employed (or employer)

R. R. Section Laborer

9. BIRTHPLACE

(State or Country)

Ireland

10. NAME OF FATHER

John Casey

11. BIRTHPLACE OF FATHER

(State or Country)

Ireland

12. MAIDEN NAME OF MOTHER

Mary Conroy

13. BIRTHPLACE OF MOTHER

(State or Country)

Ireland

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

P. Brennan

(Address)

Wm. Hanna

15.

Filed Feb. 8th 1913B. W. Mather
(Local Registrar)

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

February
(Month)7th
(Day)1913
(Year)

17. I HEREBY CERTIFY, That I attended deceased from

Feb. 7th 1913, to1913

that I last saw him alive on Feb. 6th 1913,
and that death occurred on the date stated above, at 2⁵⁹ P. M.

The CAUSE OF DEATH* was as follows:

Acute alcoholism
Died 20 min. before
my arrival(Duration) _____ yrs. _____ mos. 1 ds.Contributory
(Secondary)

(Duration) _____ yrs. _____ mos. _____ ds.

(Signed) B. W. Mather M. D.Feb. 7th 1913 (Address) Mountain Home

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death _____ yrs. _____ mos. _____ ds. In the State _____ yrs. _____ mos. _____ ds.

Where was disease contracted,

If not at place of death?

Former or

usual residence

19. PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

Mountain HomeFeb 9 1913

20. UNDERTAKER

ADDRESS

J. M. Connel Wm. Hanna

MARGIN RESERVED FOR BINDING
WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Form V. S. No. 5. 10M. 6-20-11.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH.

Registration District No. 20

County of Elmore

Primary Registration District No. 2021

City of King Hill

(No. , St.)

File No. 4330

Registered No. 3

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

Clara F. Foy

If death occurred in a hospital, institution or camp give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX

4. COLOR OR RACE 5. SINGLE, MARRIED, WIDOWED OR DIVORCED.

Female White

Single
(Write the word)

6. DATE OF BIRTH

March 14 1866
(Month) (Day) (Year)

7. AGE

47 yrs. mos. ds. IF LESS than 1 day how many hrs. or min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work
(b) General nature of industry business or establishment in which employed (or employer)

School Teacher

9. BIRTHPLACE

(State or Country)

Iowa

10. NAME OF FATHER

David Foy

11. BIRTHPLACE OF FATHER

(State or Country)

Ohio

12. MAIDEN NAME OF MOTHER

Myra G. Starr

13. BIRTHPLACE OF MOTHER

(State or Country)

Ohio

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

W. E. Linder

(Address)

Oscoda, Mich.

15.

Filed

Feb. 11th 1913

B. W. Mather
Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

Feb. 9th 1913
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from

191, to 191

that I last saw h. alive on 191

and that death occurred on the date stated above, at 8:30 P.M.

The CAUSE OF DEATH* was as follows:

Lack of nourishment

(Duration) yrs. 42 mos. ds.

Contributory (Secondary)

(Duration) yrs. mos. ds.

(Signed)

H. H. Eaton M. D.
Feb. 11th 1913 (Address) Lawson
Mountain Home

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted,

If not at place of death?

Former or usual residence.

19. PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

Oscoda, Nebraska Feb. 14th 1913

20. UNDERTAKER

ADDRESS

J. M. Cotton Mountain Home

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Form V. S. No. 5. 10M. 6-20-11.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH. Registration District No. 20
County of Elmore Primary Registration District No. 2020
City of Mountain Home (No. _____ St.)

File No. 1331

Registered No. 6

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

Arrena C Harris

If death occurred in a hospital, institution or camp give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX Female 4. COLOR OR RACE White 5. SINGLE, MARRIED, WIDOWED OR DIVORCED. Married
(Write the word.)

6. DATE OF BIRTH Feb 19 1835
(Month) (Day) (Year)

7. AGE 78 yrs. — mos. 1 ds. IF LESS than 1 day how many hrs. or min.?

8. OCCUPATION

- (a) Trade, profession or particular kind of work
(b) General nature of industry business or establishment in which employed (or employer)

Housewife

9. BIRTHPLACE
(State or Country)

Missouri

10. NAME OF FATHER

Seth Howard

11. BIRTHPLACE OF FATHER
(State or Country)

Kentucky

12. MAIDEN NAME OF MOTHER

Alexander

13. BIRTHPLACE OF MOTHER
(State or Country)

Tennessee

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

Wiley Coates

(Address)

Mountain Home

15.

Filed Feb 21 1913

Blair Walker
Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

Feb 20 1913
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from

Feb 13 1913, to Feb 20 1913

that I last saw him alive on Feb 21 1913,

and that death occurred on the date stated above, at 4:45 PM.

The CAUSE OF DEATH* was as follows:

Bright's disease
(Parenchymatous)

(Duration) chronic mos. _____ ds. _____

Contributory
(Secondary)

(Duration) _____ yrs. 7 mos. _____ ds. _____

(Signed) W. H. Coates M. D.

2-21-1913 (Address) Mountain Home

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL OR HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death yrs. mos. ds. State yrs. mos. ds.

Where was disease contracted,

If not at place of death?

Former or

usual residence.

19. PLACE OF BURIAL OR REMOVAL DATE OF BURIAL

Mountain Home Feb 23 1913

20. UNDERTAKER

ADDRESS

J. M. Coates Mountain Home

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Form V. S. No. 5. 10M. 6-20-11.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH

Registration District No. 20

County of Elmore

Primary Registration District No. 2020

City of Medbury

(No. St.)

File No. 1332

Registered No. 8

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

Frank J. McKune

If death occurred in a hospital, institution or camp give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX

Male

4. COLOR OR RACE

White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED.

Single
(Write the word.)

6. DATE OF BIRTH

Apr 19 1890
(Month) (Day) (Year)

7. AGE

22 yrs. 10 mos. 27 ds.

IF LESS than 1 day
how many hrs. or min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work

R.R. Breakman

(b) General nature of industry business or establishment in which employed (or employer)

9. BIRTHPLACE

(State or Country)

Shoshone Idaho

10. NAME OF FATHER

John M. McKune

11. BIRTHPLACE OF FATHER

(State or Country)

Pa

12. MAIDEN NAME OF MOTHER

Rosa Emma

13. BIRTHPLACE OF MOTHER

(State or Country)

Mo

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

(Address)

Rosa McKune
Shoshone Idaho

15.

Filed Feb. 27th 1913

Blomather
Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

Feb. 28th 1913
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from

191 to 191

that I last saw h alive on 191

and that death occurred on the date stated above, at M.

The CAUSE OF DEATH* was as follows:

Accidental by being caught between cogs of two engine

instant (Duration) yrs. mos. ds.

Contributory (Secondary)

accidental

(Duration) yrs. mos. ds.

(Signed)

4/27/13 1913 (Address) coroner

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death yrs. mos. ds. State yrs. mos. ds.

Where was disease contracted,

If not at place of death?

Former or usual residence.

19. PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

Shoshone Idaho

Feb. 28th 1913

20. UNDERTAKER

ADDRESS

McConen Mortuary
Idaho

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Form V. S. No. 5. 10M. 6-20-11.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics
File No. 4333
Registered No. 7

1. PLACE OF DEATH.

Registration District No. 20

County of Elmore

Primary Registration District No. 2020

City of Mountain Home

(No. , St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

Mary A. Reed

If death occurred in a hospital, institution or camp give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX

Female

4. COLOR OR RACE

White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED.

married
(Write the word.)

6. DATE OF BIRTH

July 10 1881
(Month) (Day) (Year)

7. AGE

25 yrs. 7 mos. 14 ds.

IF LESS than 1 day
how many.....hrs. or
min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work

(b) General nature of industry business or establishment in which employed (or employer)

Housewife

9. BIRTHPLACE

(State or Country)

Wyoming

10. NAME OF FATHER

Wm W Williams

11. BIRTHPLACE OF FATHER

(State or Country)

Nelsonville Ohio

12. MAIDEN NAME OF MOTHER

Lydia Thomas

13. BIRTHPLACE OF MOTHER

(State or Country)

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

Clayton K. Reed

(Address)

Mountain Home, Ida

15.

Filed Feb 25th 1913

B. W. Blather
Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

Feb 24 1913
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from

Feb 23 1913, to Feb 24 1913

that I last saw her alive on Feb 24 1913, and that death occurred on the date stated above, at 4 P.M.

The CAUSE OF DEATH* was as follows:

Peritonitis (Puerperal)

(Duration).....yrs.....mos. 4 ds.

Contributory

(Secondary)

(Duration).....yrs.....mos. 4 ds.

(Signed) W. H. Draper M. D.

Feb 24th 1913 (Address) Mountain Home

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place

of death.....yrs.....mo.....da. State.....yrs.....mos.....

Where was disease contracted,

If not at place of death?

Former or

usual residence

19. PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

Cabrillo Utah

Feb 28th 1913

20. UNDERTAKER

ADDRESS

M. C. Owen Mountain Home Idaho

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. Exact state-
CLANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. See instructions on back of certificate.
ment of OCCUPATION is very important.

Form V. S. No. 5. 10M. 6-20-11.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH.

Registration District No. 20

County of Elmore

Primary Registration District No. 2020

City of Mountain Home

(No. _____ St.)

File No. 1334

Registered No. 9

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

Constantine Rohrer

If death occurred in a hospital, institution or camp give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX

Male

4. COLOR OR RACE

White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED.

married
(Write the word.)

6. DATE OF BIRTH

May 5 1840
(Month) (Day) (Year)

7. AGE

72 yrs. 10 mos. 21 ds.

IF LESS than 1 day
how many hrs. or
..... min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work
(b) General nature of industry business or establishment in which employed (or employer)

Farmer

9. BIRTHPLACE

(State or Country)

Ill

10. NAME OF FATHER

don't know

11. BIRTHPLACE OF FATHER

(State or Country)

France

12. MAIDEN NAME OF MOTHER

don't know

13. BIRTHPLACE OF MOTHER

(State or Country)

Germany

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Mrs. Rose Davis

(Address) Mountain Home, Idaho

15.

Filed Feb. 27th 1913 B. W. Mather
Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

Feb. 26th 1913
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from Feb. 26th 1913, to 1913

that I last saw him alive on Feb. 26th 1913, and that death occurred on the date stated above, at 1¹⁵P. M.

The CAUSE OF DEATH* was as follows:

Comp. fracture left femur,
Concussion of brain,
Run away accident
(Duration) yrs. mos. 3 hrs.

Contributory (Secondary)

Fat embolism
(Duration) yrs. mos. 10 min.

(Signed) B. W. Mather M. D.
2/27 1913 (Address) Mountain Home

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death yrs. mos. ds. State yrs. mos. ds.
Where was disease contracted,
If not at place of death?
Former or usual residence

19. PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

Mountain Home Feb. 28th 1913

20. UNDERTAKER

ADDRESS

J. M. Cowen Mountain Home

MARGIN RESERVED FOR BINDING
WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Form V. S. No. 5. 10M. 6-20-11.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH.

Registration District No. 20

County of Elmore

Primary Registration District No. 2020

City of Mountain Home

(No. _____ St.)

File No. 1335

Registered No. 3

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

William L. Thurman

If death occurred in a hospital, institution or camp give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX Male 4. COLOR OR RACE White 5. SINGLE, MARRIED, WIDOWED OR DIVORCED. Widowed
(Write the word.)

6. DATE OF BIRTH

15 4 1830
(Month) (Day) (Year)

7. AGE

82 yrs. 2 mos. 16 ds. IF LESS than 1 day how many hrs. or min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work
(b) General nature of industry business or establishment in which employed (or employer)

Stock grower

9. BIRTHPLACE

(State or Country)

Kentucky

10. NAME OF FATHER

Wm Thurman

11. BIRTHPLACE OF FATHER

(State or Country)

Don't know

12. MAIDEN NAME OF MOTHER

Don't know

13. BIRTHPLACE OF MOTHER

(State or Country)

Don't know

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

William L. Thurman

(Address)

Boise City 1809 N 1st

15.

Filed

Feb 20th 1913

B. W. Mather

Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

Feb 20 1913
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from

Feb 16 1913, to Feb 20 1913

that I last saw him alive on Feb 19 1913,

and that death occurred on the date stated above, at 7, a. m.

The CAUSE OF DEATH* was as follows:

Oedema of Lungs

(Duration) yrs. mos. ds.

Contributory (Secondary)

Pneumonia (Lobar)

(Duration) yrs. mos. ds.

(Signed)

F. S. Hawley

M. D.

2/20 1913 (Address) Mtn Home

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted,

If not at place of death?

Former or usual residence.

19. PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

Mountain Home Idaho

Feb 21 1913

20. UNDERTAKER

ADDRESS

J. M. Corvan Mtn Home

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Form V. S. No. 5. 12½ M. 7-24-11

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics
File No. 1336
Registered No. 5

1. PLACE OF DEATH.
County of Bear
City of Salmon

Registration District No. 27
Primary Registration District No. 2116
(No. _____, _____ St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Christina Holcomb

If death occurred in a hospital, institution or camp give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX F. 4. COLOR OR RACE White 5. SINGLE, MARRIED, WIDOWED OR DIVORCED. Widow
(Write the word.)

6. DATE OF BIRTH Sept 4 1837
(Month) (Day) (Year)

7. AGE 75 yrs. 5 mos. 13 ds.
IF LESS than 1 day how many _____ hrs. or _____ min?

8. OCCUPATION
(a) Trade, profession or particular kind of work _____
(b) General nature of industry business or establishment in which employed (or employer) _____

9. BIRTHPLACE
(State or Country) Albany N. Y.

10. NAME OF FATHER Henry Fiege

11. BIRTHPLACE OF FATHER
(State or Country) Germany

12. MAIDEN NAME OF MOTHER _____

13. BIRTHPLACE OF MOTHER
(State or Country) Germany

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Melara Rudford
(Address) Salmon

15. Filed Feb 19 1913 O. P. Stratton
Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH Feb. 17 1913
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from Jan 28 1913, to Feb. 17 1913

that I last saw her alive on Feb. 17 1913

and that death occurred on the date stated above, at 1 P. M.

The CAUSE OF DEATH* was as follows:

Cerebral Apoplexy

(Duration) _____ yrs. _____ mos. 3 ds.

Contributory (Secondary) Acute bronchitis

(Duration) _____ yrs. _____ mos. 24 ds.

(Signed) Chas. F. Hammer M. D.
7/15 1913 (Address) Salmon

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place _____ In the _____
of death _____ yrs. _____ mos. _____ ds. State _____ yrs. _____ mos. _____ ds.

Where was disease contracted, _____
If not at place of death? _____

Former or _____
usual residence _____

19. PLACE OF BURIAL OR REMOVAL DATE OF BURIAL

W. C. Daehler 3/20 1913

20. UNDERTAKER ADDRESS

W. C. Daehler Salmon, Ida

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Form V. S. No. 5. 12½ M. 7-24-11

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics
File No. 1337
Registered No. 3

1. PLACE OF DEATH. Registration District No. 27
County of Jersey Primary Registration District No. 2103
City of Silmon (No. _____ St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

Frank Parks

If death occurred in a hospital, institution or camp give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX Male 4. COLOR OR RACE White 5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.)

6. DATE OF BIRTH Unknown 1. (Month) (Day) (Year)

7. AGE 36 yrs. + mos. + ds. IF LESS than 1 day how many hrs. or min?

8. OCCUPATION

(a) Trade, profession or particular kind of work. Miner.
(b) General nature of industry business or establishment in which employed (or employer)

9. BIRTHPLACE

(State or Country) Uncertain

10. NAME OF FATHER

Uncertain

11. BIRTHPLACE OF FATHER

(State or Country) Uncertain

12. MAIDEN NAME OF MOTHER

Uncertain

13. BIRTHPLACE OF MOTHER

(State or Country) Uncertain

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Joe McDowell
(Address) Silmon, Idaho

15. C. B. Butler
Filed Feb 11 1913 Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH January 5 1913
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from Jan 2 1913, to Jan 5 1913 that I last saw him alive on Jan 4 1913 and that death occurred on the date stated above, at 1:45 P. M.

The CAUSE OF DEATH* was as follows:

Lobar Pneumonia plus
Alcoholism
(Duration) yrs. mos. ds.
Contributory Cardiac Pulmonary
(Secondary) Decay
(Duration) yrs. mos. ds.
(Signed) W. H. Stearns M. D.
1-5 1913 (Address) Silmon, Idaho

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; (2) whether ACCIDENTAL, SUICIDAL OR HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death yrs. mos. ds. In the State yrs. mos. ds.
Where was disease contracted, If not at place of death Former or usual residence Silmon, Idaho

19. PLACE OF BURIAL OR REMOVAL Silmon DATE OF BURIAL 1-10 1913

20. UNDERTAKER None available ADDRESS _____

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Form V. S. No. 5. 12½ M. 7-24-11

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics
File No. 1338
Registered No. 4

1. PLACE OF DEATH. Registration District No. 27
County of Lamhi Primary Registration District No. 2153
City of Salmon (No. _____ St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

Lucile Thomas

If death occurred in a hospital, institution or camp give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX Female 4. COLOR OR RACE White 5. SINGLE, MARRIED, WIDOWED OR DIVORCED. Child, Single
(Write the word.)

6. DATE OF BIRTH Sept 15 1909
(Month) (Day) (Year)

7. AGE 4 yrs. 3 mos. ds. IF LESS than 1 day how many _____ hrs. or _____ min?

8. OCCUPATION

- (a) Trade, profession or particular kind of work. _____
(b) General nature of industry business or establishment in which employed (or employer) _____

9. BIRTHPLACE

(State or Country)

Marysville, Mont

10. NAME OF FATHER

P. D. Thomas

11. BIRTHPLACE OF FATHER

(State or Country)

Amador City, Cal.

12. MAIDEN NAME OF MOTHER

Eliza A. Connel

13. BIRTHPLACE OF MOTHER

(State or Country)

Hancock, Mich.

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

J. E. Thomas

(Address)

Salmon

15.

Filed Feb. 11 1913

Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH

Jan 24 1913
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from

July Aug 1912, to Jan 24 1913
that I last saw her alive on Jan 24 1913

and that death occurred on the date stated above, at 4:00 AM.

The CAUSE OF DEATH* was as follows:

Acute Heart Failure

(Duration) 1 yrs. 1 mos. 1 ds.

Contributory Chr. Bright's Disease & Ob.

(Secondary) Strutlike Jaundice.

(Duration) 2 yrs. 2 mos. 1 ds.

(Signed) Frank Q. Vance M. D.

Jan 24 1913 (Address) Salmon

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place _____ In the _____
of death _____ yrs. _____ mos. _____ ds. State _____ yrs. _____ mos. _____ ds.

Where was disease contracted,

If not at place of death? _____

Former or

usual residence _____

19. PLACE OF BIRTH OR REMOVAL DATE OF BURIAL

Sailey Idaho 25th 1913

20. UNDERTAKER ADDRESS

William C. Webb, Salmon, Ida

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Form V. S. No. 5. 12½M.7-24-11

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH. Registration District No. 77
County of Lemhi Primary Registration District No. 7116
City of Salmon (No. _____, _____ St.)

File No. 4339
Registered No. 6

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME James Arthur Butler

If death occurred in a hospital, institution or camp give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX male 4. COLOR OR RACE white 5. SINGLE, MARRIED, WIDOWED OR DIVORCED. married
(Write the word.)

6. DATE OF BIRTH Nov. 4 1887
(Month) (Day) (Year)

7. AGE 31 yrs. 7 mos. 20 ds. IF LESS than 1 day
how many _____ hrs. or _____ min?

8. OCCUPATION

(a) Trade, profession or particular kind of work
(b) General nature of industry business or establishment in which employed (or employer)

Rancher

9. BIRTHPLACE

(State or Country)

Baker, Idaho.

10. NAME OF FATHER

Charles Butler

11. BIRTHPLACE OF FATHER

(State or Country)

Germany

12. MAIDEN NAME OF MOTHER

Esther S. Johnson

13. BIRTHPLACE OF MOTHER

(State or Country)

Wisconsin

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Mrs. Geo. A. W. W. W.
(Address) Baker, Idaho

15. Filed 2/26 1913
Local Registrar W. L. D. D.

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH Feb. 24 1913.
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from Aug. 15 1911, to Feb. 24 1913, that I last saw him alive on 24th of Feb. 1913 and that death occurred on the date stated above, at 10 P. M. The CAUSE OF DEATH* was as follows:

Diabetes mellitus
about 7 (Duration) yrs. mos. ds.

Contributory (Secondary)
(Duration) yrs. mos. ds.
(Signed) Chas. F. Hammer M. D.
Feb. 25 1913 (Address) Salmon

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place In the
of death yrs. mos. ds. State yrs. mos. ds.
Where was disease contracted,
If not at place of death?
Former or usual residence.

19. PLACE OF BURIAL OR REMOVAL Salmon, Ida DATE OF BURIAL Feb. 26 1913

20. UNDERTAKER W. L. D. D. ADDRESS Salmon, Ida

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statements of OCCUPATION is very important. See instructions on back of certificate.

Form V. S. No. 5. 12½ M. 7-24-11

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics
File No. 4340
Registered No. 7

1. PLACE OF DEATH. Registration District No. 27
County of Lemhi Primary Registration District No. 16
City of Carmen (No. _____, _____ St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME James William Roberts.

If death occurred in a hospital, institution or camp give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX male 4. COLOR OR RACE white 5. SINGLE, MARRIED, WIDOWED OR DIVORCED.
married
(Write the word.)

6. DATE OF BIRTH July 1st 1868
(Month) (Day) (Year)

7. AGE 49 yrs. 8 mos. ds. IF LESS than 1 day
how many _____ hrs. or _____ min?

8. OCCUPATION

(a) Trade, profession or particular kind of work.

Rancher.

(b) General nature of industry business or establishment in which employed (or employer)

9. BIRTHPLACE

(State or Country)

Sherbrook, Canada.

10. NAME OF FATHER

William Roberts.

11. BIRTHPLACE OF FATHER

(State or Country)

Canada

12. MAIDEN NAME OF MOTHER

13. BIRTHPLACE OF MOTHER

(State or Country)

Canada

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Margaret Roberts
(Address) Carmen.

15. W. C. Daebler
Local Registrar
Filed March 3rd 1913.

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH

Feb 28th 1913.
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from Feb 28 1913, to Feb 28th 1913.

that I last saw him alive on Feb 28th 1913.

and that death occurred on the date stated above, at 7:30 P.M.

The CAUSE OF DEATH* was as follows:

Tubercular Meningitis

(Duration) _____ yrs. _____ mos. _____ ds.

Contributory
(Secondary)

(Duration) _____ yrs. _____ mos. _____ ds.

(Signed) F. S. Wright M. D.
Black 1913 (Address) Salmon

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place _____ In the _____
of death _____ yrs. _____ mos. _____ ds. State _____ yrs. _____ mos. _____ ds.

Where was disease contracted,

If not at place of death?

Former or

usual residence.

Carmen

19. PLACE OF BURIAL OR REMOVAL DATE OF BURIAL
Salmon Idaho March 3rd 1913.

20. UNDERTAKER

ADDRESS

W. C. Daebler Salmon
Ida.

1. PLACE OF DEATH.
County of Lincoln
City of EdenRegistration District No. 5
Primary Registration District No. 20/6
(No. _____, _____ St.)File No. 1311
Registered No. 2

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Woodrow Wilson Campbell

If death occurred in a hospital, institution or camp give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX Boy 4. COLOR OR RACE White 5. SINGLE, MARRIED, WIDOWED OR DIVORCED. Single
(Write the word.)6. DATE OF BIRTH Jan 13 1913
(Month) (Day) (Year)7. AGE _____ yrs. _____ mos. 7.3 ds. IF LESS than 1 day how many _____ hrs. or _____ min?

8. OCCUPATION

- (a) Trade, profession or particular kind of work.
-
- (b) General nature of industry business or establishment in which employed (or employer)

9. BIRTHPLACE

(State or Country)

Lincoln Co Ida

10. NAME OF FATHER

Alvero Campbell

11. BIRTHPLACE OF FATHER

(State or Country)

Utah

12. MAIDEN NAME OF MOTHER

Elizabeth Cugmire

13. BIRTHPLACE OF MOTHER

(State or Country)

Utah

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

(Address)

A. Campbell
Eden, Idaho

15.

Filed

2/10 1913C. F. Zeller

Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH

July 5 1913
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from

Jan 13 1913, to July 5 1913that I last saw him alive on July 4 1913and that death occurred on the date stated above, at 5 P. M.

The CAUSE OF DEATH* was as follows:

Capillary Bronchitis(Duration) _____ yrs. _____ mos. 7 ds.Contributory Lack of vitality from birth
(Secondary)

(Duration) _____ yrs. _____ mos. _____ ds.

(Signed) Moyley M. D.July 7 1913 (Address) Hayden Ida

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place _____ yrs. _____ mos. _____ ds. In the _____ yrs. _____ mos. _____ ds.

Where was disease contracted,

If not at place of death?

Former or

usual residence.

19. PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

Milner IdaJuly 6 1913

20. UNDERTAKER

ADDRESS

No undertaker

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Form V. S. No. 5. 10M. 6-20-11.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH.

Registration District No. 5County of LincolnPrimary Registration District No. 2016City of Shoshone

(No. _____, St.)

Registered No. _____

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

Mary Hanafin

If death occurred in a hospital, institution or camp give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX

female

4. COLOR OR RACE 5. SINGLE, MARRIED, WIDOWED OR DIVORCED.

whiteSingle
(Write the word.)

6. DATE OF BIRTH

Feb. 171913

(Month)

(Day)

(Year)

7. AGE

2 daysIF LESS than 1 day
how many _____ hrs. or
_____ min.

8. OCCUPATION

(a) Trade, profession, or particular kind of work
(b) General nature of industry business, or establishment in which employed (or employer)nurse

9. BIRTHPLACE

(State or Country)

Shoshone

10. NAME OF FATHER

James Hanafin

11. BIRTHPLACE OF FATHER

(State or Country)

Ireland

12. MAIDEN NAME OF MOTHER

Mary Deconnon

13. BIRTHPLACE OF MOTHER

(State or Country)

Ireland

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

(Address)

15.

Filed

2/19 1913C. F. Zeller

Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

February191913

(Month)

(Day)

(Year)

17. I HEREBY CERTIFY, That I attended deceased from

Feb. 171913

to

Feb. 191913that I last saw him alive on Feb. 19 1913and that death occurred on the date stated above, at 3 a. M.The CAUSE OF DEATH* was as follows: astheniaCongenital weak infant
due to debility of mother & partial
fatty degeneration of placenta

(Duration) _____ yrs. _____ mos. _____ ds.

Contributory
(Secondary)

(Duration) _____ yrs. _____ mos. _____ ds.

(Signed) Chas. F. Zeller M. D.2/20 1913 (Address) Shoshone, Ida

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place

In the

of death _____ yrs. _____ mos. _____ ds. State _____ yrs. _____ mos. _____ ds.

Where was Disease contracted,

If not at place of death? _____

Former or

usual residence _____

19. PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

Shoshone CemeteryFeb. 19 1913

20. UNDERTAKER

ADDRESS

O. J. BrumanShoshone

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Form V. S. No. 5 20M.1-16-12

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH.

Registration District No. 2County of AdaPrimary Registration District No. 104City of Boise(No. 517, Washington St.)File No. 43444Registered No. 94

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

Mary Lawery

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX

4. COLOR OR RACE

5. SINGLE, MARRIED, WIDOWED OR DIVORCED.

Female whiteMarried
(Write the word.)

6. DATE OF BIRTH

April (Month) 15 (Day) 1858 (Year)

7. AGE

54 yrs. 11 mos. 10 ds.IF LESS than 1 day
how many hrs. or
..... mins.?

8. OCCUPATION

(a) Trade, profession or particular kind of work

(b) General nature of industry, business, or establishment in which employed (or employer)

Housewife

9. BIRTHPLACE

(State or Country)

New York

10. NAME OF FATHER

Mort Kehoe

11. BIRTHPLACE OF FATHER

(State or Country)

Ireland

12. MAIDEN NAME OF MOTHER

Anna Shannon
Mary Kehoe

13. BIRTHPLACE OF MOTHER

(State or Country)

Ireland

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

C. T. Conklein

(Address)

Boise Idaho

15.

Filed 4-71913C. T. Conklein

Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH

April (Month) 5 (Day) 1913 (Year)

17. I HEREBY CERTIFY, That I attended deceased from

March 5 1913, to April 5 1913,that I last saw her alive on April 5 1913,and that death occurred on the date stated above, at 9 P. M.

The CAUSE OF DEATH* was as follows:

Chronic Bronchitis and
Cancer of Breast and probably
Cancer of Left Lung.(Duration) 1 yrs. — mos. — ds.Contributory Cancer of Breast
(Secondary)(Duration) — yrs. — mos. — ds.(Signed) L. P. McCalla M. D.4/7 1913 (Address) Boise Idaho

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death yrs. mos. days. In the State yrs. mos. days.

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

St. Johns Cemetery4/7 1913

20. UNDERTAKER

ADDRESS

Schreiber & WidewadonBoise, Idaho

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Form V. S. No. 5. 12½ M. 7-24-11

CERTIFICATE OF DEATH

1. PLACE OF DEATH.
County of Suwy
City of Wendexter

Registration District No. 72
Primary Registration District No. 2127
(No. _____, _____ St.)

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics
File No. 4345
Registered No. _____

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Emmett G. Champion

If death occurred in a hospital, institution or camp give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX Male 4. COLOR OR RACE White 5. SINGLE, MARRIED, WIDOWED OR DIVORCED. Single
(Write the word.)

6. DATE OF BIRTH July 11th 1911
(Month) (Day) (Year)

7. AGE 1 yrs. 5 mos. 18 ds. IF LESS than 1 day how many _____ hrs. or _____ min?

8. OCCUPATION
(a) Trade, profession or particular kind of work. none
(b) General nature of industry business or establishment in which employed (or employer)

9. BIRTHPLACE
(State or Country) Suwy Co. Idaho

10. NAME OF FATHER G. W. Champion

11. BIRTHPLACE OF FATHER
(State or Country) Texas

12. MAIDEN NAME OF MOTHER Ada O. Stevenson

13. BIRTHPLACE OF MOTHER
(State or Country) Oregon

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) G. W. Champion
(Address) Wendexter

15. Filed 3-20-1913 Edwin N. Rogers
Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH March 20 1913
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from March 12, 1913, to March 19, 1913 that I last saw him alive on March 20, 1913 and that death occurred on the date stated above, at 10 A. M. The CAUSE OF DEATH* was as follows:
Purified. Pneumonia

(Duration) _____ yrs. _____ mos. 10 ds.
Contributory Congenital Heart defect
(Secondary)
(Duration) _____ yrs. _____ mos. _____ ds.
(Signed) Edwin N. Rogers M. D.
3-20-1913 (Address) Wendexter

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place _____ In the _____
of death _____ yrs. _____ mos. _____ ds. State _____ yrs. _____ mos. _____ ds.
Where was disease contracted, _____
If not at place of death? _____
Former or _____
usual residence. _____

19. PLACE OF BURIAL OR REMOVAL Creative Wash DATE OF BURIAL 3-20-1913
20. UNDERTAKER S. D. Seomard ADDRESS Valencia

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Form V. S. No. 5. 10M. 6-20-11.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH.
County of Boyer
City of near Orana

Registration District No. 1003
Primary Registration District No. 1006
(No. _____ St.)

File No. 4346
Registered No. 30

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

Timothy Kennedy

If death occurred in a hospital, institution or camp give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX male 4. COLOR OR RACE white 5. SINGLE, MARRIED, WIDOWED OR DIVORCED. single
(Write the word.)

6. DATE OF BIRTH

Feb 10 1913
(Month) (Day) (Year)

7. AGE

65 yrs. - mos. - ds.

IF LESS than 1 day
how many hrs. or
..... min.?

8. OCCUPATION

(a) Trade, profession, or particular kind of work
(b) General nature of industry, business, or establishment in which employed (or employer)

miner

9. BIRTHPLACE
(State or Country)

Ireland

10. NAME OF FATHER

11. BIRTHPLACE OF FATHER
(State or Country)

Ireland

12. MAIDEN NAME OF MOTHER

13. BIRTHPLACE OF MOTHER
(State or Country)

Ireland

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

(Address)

Gas. P. Linnhan
Orana, Id.

15.

Filed

2-12-1913

C. B. Puller
Local

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

Feb. 11th 1913
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from

Feb 10 1913, to Feb 10 1913
that I last saw him alive on Feb 10 1913

and that death occurred on the date stated above, at 3 P. M.

The CAUSE OF DEATH* was as follows:

Pneumonia

(Duration) yrs. mos. 3 ds.

Contributory
(Secondary)

none

(Duration) yrs. mos. ds.

(Signed)

H. P. Ross M. D.
Feb 12 1912 (Address) Nampa Id.

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place In the
of death yrs. mos. ds. State yrs. mos. ds.

Where was Disease contracted,

If not at place of death?

Former or

usual residence.

19. PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

Catholic Cemetery, Nampa

Feb 13 1913

20. UNDERTAKER

ADDRESS

S. B. Kellabarger

Nampa, Id.

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Form V. S. No. 5. 12½ M. 7-24-11

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics
File No. 1434
Registered No. 14

1. PLACE OF DEATH.
County of Quincy
City of D. Lauer

Registration District No. 30
Primary Registration District No. 2123
(No. _____, _____ St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Alic McLeod

If death occurred in a hospital, institution or camp give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX Male 4. COLOR OR RACE white 5. SINGLE, MARRIED, WIDOWED OR DIVORCED. single
(Write the word.)

6. DATE OF BIRTH _____
(Month) (Day) (Year)

7. AGE 52 yrs. _____ mos. _____ ds.
IF LESS than 1 day
how many _____ hrs. or _____ min?

8. OCCUPATION
(a) Trade, profession or particular kind of work. Quarry - miner -
(b) General nature of industry business or establishment in which employed (or employer). General laborer.

9. BIRTHPLACE Cape Breton
(State or Country) Nova Scotia.

10. NAME OF FATHER

11. BIRTHPLACE OF FATHER
(State or Country)

12. MAIDEN NAME OF MOTHER

13. BIRTHPLACE OF MOTHER
(State or Country)

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) J. L. Davis
(Address) D. Lauer, Ida.

15. Filed Feb 2 1913 T. D. Forner
Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH Feb. 2nd 1913
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from Dec 16th 1913, to Feb. 2nd 1913
that I last saw him alive on Feb. 1st 1913
and that death occurred on the date stated above, at 3 P. M.

The CAUSE OF DEATH* was as follows:
Tuberculosis -
Exhaustion - getting cold
causing it to become active -

(Duration) 5 yrs. _____ mos. _____ ds.
Contributory (Secondary) Occupation

(Duration) _____ yrs. _____ mos. _____ ds.
(Signed) T. D. Forner M. D.
Feb 2 1913 (Address) D. Lauer

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place _____ In the _____
of death _____ yrs. _____ mos. _____ ds. State _____ yrs. _____ mos. _____ ds.
Where was disease contracted,
If not at place of death? _____
Former or
usual residence. _____

19. PLACE OF BURIAL OR REMOVAL Eagle Cemetery DATE OF BURIAL Feb 4th 1913

20. UNDERTAKER John Grote ADDRESS Shelby City.

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Form V. S. No. 5. 12½ M. 7-24-11

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics
File No. 1352
Registered No. 38

1. PLACE OF DEATH. Registration District No. 3
County of Washington Primary Registration District No. 1006
City of Wenatchee (No. _____ St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Harry A. Robb

If death occurred in a hospital, institution or camp give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX Male 4. COLOR OR RACE White 5. SINGLE, MARRIED, WIDOWED OR DIVORCED. Married
(Write the word.)

6. DATE OF BIRTH June 1 1893
(Month) (Day) (Year)

7. AGE 26 yrs. 0 mos. 0 ds. IF LESS than 1 day how many _____ hrs. or _____ min?

8. OCCUPATION
(a) Trade, profession or particular kind of work. Merchant
(b) General nature of industry business or establishment in which employed (or employer). Retail Clothing & Furniture

9. BIRTHPLACE (State or Country) Creston Iowa

10. NAME OF FATHER W. H. Robb

11. BIRTHPLACE OF FATHER (State or Country) Iowa

12. MAIDEN NAME OF MOTHER Katherine White

13. BIRTHPLACE OF MOTHER (State or Country) Iowa

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) _____
(Address) _____

15. Filed June 28 1913 Harry A. Robb
Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH Jan 26 1913
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from _____ 191____, to _____ 191____
that I last saw h _____ alive on _____ 191____
and that death occurred on the date stated above, at _____ M.

The CAUSE OF DEATH* was as follows:
Found dead in Bed died Before Physician Arrived
(Duration) _____ yrs. _____ mos. _____ ds.

Contributory (Secondary) _____
(Duration) _____ yrs. _____ mos. _____ ds.
(Signed) James T. McLean Cover
Jan 26 1913 (Address) Wenatchee Ida

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place _____ In the _____
of death _____ yrs. _____ mos. _____ ds. State _____ yrs. _____ mos. _____ ds.
Where was disease contracted, _____
If not at place of death? _____
Former or _____
usual residence _____

19. PLACE OF BURIAL OR REMOVAL Wenatchee Ida DATE OF BURIAL _____ 191____

20. UNDERTAKER _____ ADDRESS _____

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Form V. S. No. 5. 10M. 6-20-11.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH.
County of Canyon
City of Emmett

Registration District No. 22
Primary Registration District No. 2010
(No. _____, St.)

File No. 1356
Registered No. 82

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Amanda J. Powers

If death occurred in a hospital, institution or camp give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX female 4. COLOR OR RACE white 5. SINGLE, MARRIED, WIDOWED OR DIVORCED. married
(Write the word.)

6. DATE OF BIRTH Sept 20 1840
(Month) (Day) (Year)

7. AGE 72 yrs. 4 mos. 24 ds. IF LESS than 1 day how many hrs. or min.?

8. OCCUPATION housewife
(a) Trade, profession, or particular kind of work
(b) General nature of industry, business, or establishment in which employed (or employer)

9. BIRTHPLACE Illinois
(State or Country)

10. NAME OF FATHER Thomas Gray

11. BIRTHPLACE OF FATHER Indiana
(State or Country)

12. MAIDEN NAME OF MOTHER Rebecca Cochran

13. BIRTHPLACE OF MOTHER Virginia
(State or Country)

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) George Adams
(Address) Emmett, Idaho

15.

Filed 2-15 1913 J. E. Reynolds
Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH Feb 14 1913
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from Dec 1912 to Feb 12 1913
that I last saw him alive on Feb 12 1913,
and that death occurred on the date stated above, at 1 A. M.

The CAUSE OF DEATH* was as follows:
Chronic Brights disease

(Duration) Seventy yrs. mos. ds.
Contributory (Secondary) myocardial degeneration

(Duration) Seventy yrs. mos. ds.
(Signed) R. E. Cunningham M. D.
19 (Address) Emmett

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place In the
of death yrs. mos. ds. State yrs. mos. ds.
Where was Disease contracted,
If not at place of death?
Former or
usual residence.

19. PLACE OF BURIAL OR REMOVAL Emmett Cemetery DATE OF BURIAL Feb 15 1913

20. UNDERTAKER C. D. Bucknum ADDRESS Emmett

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Form V. S. No. 5. 10M. 6-20-11.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

File No. 4357
Registered No. 79

If death occurred in a hospital, institution or camp give its NAME instead of street and number.

1. PLACE OF DEATH.
County of Canyon
City of Emmett

Registration District No. 22
Primary Registration District No. 2010
(No. _____, St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Mary Ann Wright

PERSONAL AND STATISTICAL PARTICULARS

3. SEX female 4. COLOR OR RACE white 5. SINGLE, MARRIED, WIDOWED OR DIVORCED.
widowed
(Write the word.)

6. DATE OF BIRTH May 8 1839
(Month) (Day) (Year)

7. AGE 73 yrs. 10 mos. 16 ds. IF LESS than 1 day how many _____ hrs. or _____ min.?

8. OCCUPATION
(a) Trade, profession, or particular kind of work housewife
(b) General nature of industry business, or establishment in which employed (or employer)

9. BIRTHPLACE
(State or Country) New York

10. NAME OF FATHER Lyman Maxwell

11. BIRTHPLACE OF FATHER
(State or Country) Don't Know

12. MAIDEN NAME OF MOTHER Mrs Styles

13. BIRTHPLACE OF MOTHER
(State or Country) Don't Know

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) B. S. Wright
(Address) Emmett Ida

15. Filed Mar 24 1913 B. O. Clark Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH March 24 1913
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from March 21 1913, to March 21 1913, that I last saw her alive on March 21 1913, and that death occurred on the date stated above, at _____ M.

The CAUSE OF DEATH* was as follows:
Cerebral Apoplexy

(Duration) _____ yrs. _____ mos. 4 ds.

Contributory (Secondary)

(Duration) _____ yrs. _____ mos. _____ ds.

(Signed) C. E. Cummings M. D.
3/24/1913 (Address) Emmett Ida

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place _____ In the _____ of death _____ yrs. _____ mos. _____ ds. State _____ yrs. _____ mos. _____ ds.
Where was Disease contracted,
If not at place of death?
Former or usual residence _____

19. PLACE OF BURIAL OR REMOVAL Caldwells Idaho DATE OF BURIAL Mar 27 1913

20. UNDERTAKER W. Bucknum ADDRESS Emmett

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Form V. S. No. 5. 10M. 6-20-11.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics1. PLACE OF DEATH.
County of Canyon
City of EmmettRegistration District No. 22
Primary Registration District No. 2010
(No. , St.)File No. 1353
Registered No. 78

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

Nattie P. Tuttle

If death occurred in a hospital, institution or camp give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX

Female

4. COLOR OR RACE

White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED.

married
(Write the word.)

6. DATE OF BIRTH

Oct 12 1854
(Month) (Day) (Year)

7. AGE

58 yrs. 3 mos. 22 ds.IF LESS than 1 day
how many hrs. or
..... min.?

8. OCCUPATION

(a) Trade, profession, or particular kind of work
(b) General nature of industry, business, or establishment in which employed (or employer)housewife

9. BIRTHPLACE

(State or Country)

Illinois

10. NAME OF FATHER

Higgins

11. BIRTHPLACE OF FATHER

(State or Country)

Don't know

12. MAIDEN NAME OF MOTHER

Cynthia Wise

13. BIRTHPLACE OF MOTHER

(State or Country)

Don't know

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

D. B. Tuttle

(Address)

Emmett Ida

15.

Filed 2-15-1913J. L. Reynolds
Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

Feb 4 1913
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from

Aug 1911, to Jan 20 1913that I last saw him alive about Jan 20 1913, and that death occurred on the date stated above, at M.

The CAUSE OF DEATH* was as follows:

Mitral Regurgitation(Duration) yrs. mos. ds.

Contributory (Secondary)

(Duration) yrs. mos. ds.

(Signed)

B. O. Black M. D.
Feb 5 1913 (Address) Emmett

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place yrs. mos. ds. In the
of death yrs. mos. ds. State yrs. mos. ds.
Where was Disease contracted,
If not at place of death?
Former or
usual residence.

19. PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

Emmett Cemetery Feb 5 1913

20. UNDERTAKER

ADDRESS

O. S. Bucknum Emmett

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY IN YEARS. If death occurred in a hospital, institution or camp give its NAME instead of street and number. See instructions on back of certificate.

11.

CERTIFICATE OF DEATH

Registration District No. 22
Primary Registration District No. 2010
(No. _____, _____ St.)

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics
File No. 4259
Registered No. 4259

If death occurs away from usual residence, give facts called for under special information.

If death occurred in a hospital, institution or camp give its NAME instead of street and number.

2. FULL NAME

Benjamin F. Muzzy

PERSONAL AND STATISTICAL PARTICULARS

3. SEX Male 4. COLOR OR RACE White 5. SINGLE, MARRIED, WIDOWED OR DIVORCED.
widowed
(Write the word.)

6. DATE OF BIRTH Sept 16 1822
(Month) (Day) (Year)

7. AGE 90 yrs. 5 mos. — ds. IF LESS than 1 day how many _____ hrs. or _____ min.?

8. OCCUPATION
(a) Trade, profession, or particular kind of work Farmer
(b) General nature of industry business, or establishment in which employed (or employer)

9. BIRTHPLACE (State or Country) New York

10. NAME OF FATHER Calvin Muzzy

11. BIRTHPLACE OF FATHER (State or Country) New York

12. MAIDEN NAME OF MOTHER Dont Know

13. BIRTHPLACE OF MOTHER " "

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Robert J. Howard
(Address) Emmett Idaho

15.

Filed 8-1- 1913 J. P. Howard Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH Feb 16 1913
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from _____ 191____, to _____ 191____, that I last saw h_____ alive on _____ 191____, and that death occurred on the date stated above, at _____ M. The CAUSE OF DEATH* was as follows:

Dont know
had no physician
in attendance
(Duration) _____ yrs. _____ mos. _____ ds.

Contributory (Secondary) _____
(Duration) _____ yrs. _____ mos. _____ ds.
(Signed) _____ M. D.
_____ 19____ (Address)

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL,

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place _____ In the _____
of death _____ yrs. _____ mos. _____ ds. State _____ yrs. _____ mos. _____ ds.
Where was Disease contracted, _____
If not at place of death _____
Former or _____
usual residence _____

19. PLACE OF BURIAL OR REMOVAL Emmett cemetery DATE OF BURIAL Feb 18 1913

20. UNDERTAKER W. D. Krumm ADDRESS Emmett

4/1/13 J P Howard

Form V. S. No. 5. 10M. 6-20-11.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH

Registration District No. 2County of CanyonPrimary Registration District No. 20092009City of New Plymouth

(No. _____, _____ St.)

File No. 1351Registered No. 80

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME James Rodney Smith

If death occurred in a hospital, institution or camp give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX 4. COLOR OR RACE 5. SINGLE, MARRIED, WIDOWED OR DIVORCED.

MaleWhiteSingle
(Write the word.)

6. DATE OF BIRTH

Aug 16 1885
(Month) (Day) (Year)

7. AGE

27 yrs. 4 mos. 11 ds.
IF LESS than 1 day how many _____ hrs. or _____ min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work
(b) General nature of industry business or establishment in which employed (or employer)Electrician

9. BIRTHPLACE

(State or Country)

Iowa

10. NAME OF FATHER

Nazakiah Rodney Smith

11. BIRTHPLACE OF FATHER

(State or Country)

not known

12. MAIDEN NAME OF MOTHER

Abbe Fairman

13. BIRTHPLACE OF MOTHER

(State or Country)

Iowa

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

Ed Fairman

(Address)

New Plymouth, Ida.

15.

Filed

4/1/13

191

S. R. Woodward
Dep Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

Jan 11 1913
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from

Feb 1911, to death 1913that I last saw him alive on Jan 9 1913,and that death occurred on the date stated above, at 10:50 P.M.

The CAUSE OF DEATH* was as follows:

Pulmonary Tuberculosis(Duration) 2 yrs. _____ mos. _____ ds.

Contributory (Secondary)

(Duration) _____ yrs. _____ mos. _____ ds.

(Signed) M. T. S. Rydell M. D.Jan 13 1913 (Address) New Plymouth

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death _____ yrs. _____ mos. _____ ds. State _____ yrs. _____ mos. _____ ds.

Where was disease contracted,

If not at place of death?

Former or usual residence.

19. PLACE OF BURIAL OR REMOVAL DATE OF BURIAL

New Plymouth Ida Jan 13 1913

20. UNDERTAKER

J. N. Adams

ADDRESS

Payette, Ida.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Form V. S. No. 5. 10M. 6-20-11.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH.

Registration District No. 22

County of Canyon

Primary Registration District No. 2009

City of Brickland

(No. _____, _____ St.)

File No. 1262

Registered No. 87

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

Mary Walker

If death occurred in a hospital, institution or camp give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX

Female

4. COLOR OR RACE 5. SINGLE, MARRIED, WIDOWED OR DIVORCED.

White

Widow
(Write the word.)

6. DATE OF BIRTH

Nov

12

1877

(Month)

(Day)

(Year)

7. AGE

85 yrs. 2 mos. 3 ds.

IF LESS than 1 day

how many hrs. or
..... min.?

8. OCCUPATION

- (a) Trade, profession or particular kind of work
(b) General nature of industry business or establishment in which employed (or employer)

Housewife

9. BIRTHPLACE

(State or Country)

Arkansas

10. NAME OF FATHER

not known

11. BIRTHPLACE OF FATHER

(State or Country)

"

"

12. MAIDEN NAME OF MOTHER

"

"

13. BIRTHPLACE OF MOTHER

(State or Country)

"

"

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

M. M. Hunt

(Address)

New Plymouth R. #2

15.

Filed 4/1/13 1913

S. A. L. W.

Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

Jan

15

1913

(Month)

(Day)

(Year)

17. I HEREBY CERTIFY, That I attended deceased from

occasionally during the

that I last saw him alive on last 4 yrs. 1913

and that death occurred on the date stated above, at _____ M.

The CAUSE OF DEATH* was as follows:

Senile Debility

(Duration) _____ yrs. 1 mos. _____ ds.

Contributory
(Secondary)

(Duration) _____ yrs. _____ mos. _____ ds.

(Signed) Wm. J. Drysdale M. D.

Jan 16 1913 (Address) New Plymouth

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and 2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place _____ In the _____

of death _____ yrs. _____ mos. _____ ds. State _____ yrs. _____ mos. _____ ds.

Where was disease contracted, _____

If not at place of death? _____

Former or _____

usual residence _____

19. PLACE OF BURIAL OR REMOVAL DATE OF BURIAL

New Plymouth Jan 16 1913

20. UNDERTAKER ADDRESS

Eutaw, Ok.

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Form V. S. No. 5 20M.1-16-12

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH. Registration District No. 22
County of Canyon Primary Registration District No. 2004
City of New Plymouth (No. St.)

File No. 1303
Registered No. 83

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Samuel T. Easter

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX Male 4. COLOR OR RACE White 5. SINGLE, MARRIED, WIDOWED OR DIVORCED. Married
(Write the word.)

6. DATE OF BIRTH Dec 31 1836
(Month) (Day) (Year)

7. AGE 76 yrs. 2 mos. 18 ds. IF LESS than 1 day how many hrs. or mins.?

8. OCCUPATION
(a) Trade, profession or particular kind of work Farmer
(b) General nature of industry business, or establishment in which employed (or employer)

9. BIRTHPLACE Penn.
(State or Country)

10. NAME OF FATHER Easter

11. BIRTHPLACE OF FATHER Not Known
(State or Country)

12. MAIDEN NAME OF MOTHER Not Known

13. BIRTHPLACE OF MOTHER Not Known
(State or Country)

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Elmer T. Easter
(Address) New Plymouth

15. Filed 4/1/13 191 5 R. W. D. Ward
Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH March 18 1913
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from Feb 18 1913, to March 18 1913, that I last saw him alive on March 18 1913, and that death occurred on the date stated above, at 3⁰⁰ M.

The CAUSE OF DEATH* was as follows:

Arteriosclerosis
(Duration) 6 yrs. mos. ds.
Contributory Chronic serous diarrhoea,
(Secondary)
(Duration) 6 yrs. mos. ds.
(Signed) Wm T. Drysdale, M. D.
19 (Address) New Plymouth, Ida

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death. yrs. mos. days. In the State. yrs. mos. days.

Where was disease contracted if not at place of death?

Former or usual residence.

19. PLACE OF BURIAL OR REMOVAL Chapman Neb DATE OF BURIAL 3/19 1913

20. UNDERTAKER J. H. Adair ADDRESS Paquette Ida

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Form V. S. No. 5 20M.1-16-12

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH

Registration District No.

2008

County of

Payette

Primary Registration District No.

File No.

1304

City of

Payette

(No.

St.)

Registered No.

74

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

Infant Johnson

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX

4. COLOR OR RACE

5. SINGLE, MARRIED WID-
OWED OR DIVORCED.

Male

White

Single
(Write the word.)

6. DATE OF BIRTH

Mar 1

1913

(Month) (Day) (Year)

7. AGE

3 yrs. mos. ds.

IF LESS than 1 day
how many hrs. or
mins.

8. OCCUPATION

(a) Trade, profession or
particular kind of work

(b) General nature of industry
business, or establishment in
which employed (or employer)

Infant

9. BIRTHPLACE

(State or Country)

Payette

10. NAME OF
FATHER

Curtis Johnson

11. BIRTHPLACE
OF FATHER

(State or Country)

Iowa

12. MAIDEN NAME
OF MOTHER

Maggie Thebo

13. BIRTHPLACE
OF MOTHER

(State or Country)

Oregon

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

Wm Johnson

(Address)

Payette

15.

Filed

Mar 2

1913

Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH

March 1

1913

(Month)

(Day)

(Year)

17. I HEREBY CERTIFY, That I attended deceased from

Mar 1

1913, to

Mar 1

1913

that I last saw him alive on Mar 1 1913

and that death occurred on the date stated above, at 11:30 P.M.

The CAUSE OF DEATH* was as follows:

Pregnature Birth
Seven months does not
know of any cause

(Duration)

yrs.

mos.

ds.

Contributory

(Secondary)

(Duration)

yrs.

mos.

ds.

(Signed)

D. W. Barton

M. D.

3/2 1913 (Address) Payette Ida

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place

of death

yrs.

mos.

days.

In the

State

yrs.

mos.

days.

Where was disease contracted
if not at place of death?

Former or

usual residence

19. PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

Payette Idaho

Mar 2 1913

20. UNDERTAKER

ADDRESS

W. H. Davis Payette Ida

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Form V. S. No. 5 20M.1-16-12

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH.

Registration District No. 22

County of Canyon

Primary Registration District No. 2005

City of Payette

(No. _____ St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

Otto L Seaman

File No. 4365

Registered No. 75

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX

Male

4. COLOR OR RACE

White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED.

Single
(Write the word.)

6. DATE OF BIRTH

March 9 188
(Month) (Day) (Year)

7. AGE

28 yrs. 11 mos. 24 ds.

IF LESS than 1 day
how many hrs. or
..... mins?

8. OCCUPATION

(a) Trade, profession or particular kind of work

Farmer

(b) General nature of industry business, or establishment in which employed (or employer)

9. BIRTHPLACE

(State or Country)

Austria

10. NAME OF FATHER

Seaman

11. BIRTHPLACE OF FATHER

(State or Country)

Austria

12. MAIDEN NAME OF MOTHER

Not known

13. BIRTHPLACE OF MOTHER

(State or Country)

Austria

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

John C Seaman

(Address)

Payette

15.

Filed Mar 4 1913

Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

Mar 3 1913
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from

191 to 191

that I last saw him alive on 191

and that death occurred on the date stated above, at M.

The CAUSE OF DEATH* was as follows:

Suicide, probably by
strichnine
(Duration) 1 yrs. 0 mos. 0 ds.

Contributory
(Secondary)

Coroners Jury

(Duration) 1 yrs. 0 mos. 0 ds.

(Signed) F. K. Robinson M. D.

19 (Address) Coroner

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death yrs. mos. days. In the State yrs. mos. days.

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

Payette Ida Mar 5 1913

20. UNDERTAKER

ADDRESS

J. N. Udair Payette Ida

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Form V. S. No. 5. 12½ M. 7-24-11

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH. Registration District No. 72
County of Cassia Primary Registration District No. 2127
City of Winchester (No. _____, _____ St.)

File No. 1365
Registered No. 5

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Gladie Reba Margus

If death occurred in a hospital, institution or camp give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX 4. COLOR OR RACE 5. SINGLE, MARRIED, WIDOWED OR DIVORCED.

Female White Single
(Write the word.)

6. DATE OF BIRTH

Oct 13 1903
(Month) (Day) (Year)

7. AGE

9 yrs. 4 mos. 20 ds.

IF LESS than 1 day
how many _____ hrs. or
_____ min?

8. OCCUPATION

(a) Trade, profession or particular kind of work.

(b) General nature of industry business or establishment in which employed (or employer)

School girl

9. BIRTHPLACE

(State or Country)

Idaho

10. NAME OF FATHER

John F. Margus

11. BIRTHPLACE OF FATHER

(State or Country)

Idaho

12. MAIDEN NAME OF MOTHER

Sula Hastings

13. BIRTHPLACE OF MOTHER

(State or Country)

Idaho

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

(Address)

John F. Margus
Winchester

15.

Filed 3-5- 1913

Ellen B. Rogers
Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH

March 5 1913
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from February 23rd 1913, to March 5th 1913

that I last saw her alive on March 5th 1913

and that death occurred on the date stated above, at 8:45 A. M.

The CAUSE OF DEATH* was as follows:

Septic Peritonitis

..... (Duration) yrs. mos. 12 ds.

Contributory Appendiceal abscess
(Secondary)

..... (Duration) yrs. mos. 15 ds.

(Signed) Ellen B. Rogers M. D.

3-5- 1913 (Address) Winchester

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place In the
of death yrs. mos. ds. State yrs. mos. ds.

Where was disease contracted,

If not at place of death?

Former or

usual residence.....

19. PLACE OF BURIAL OR REMOVAL DATE OF BURIAL

Woodlawn Cemetery 3-7- 1913

20. UNDERTAKER

ADDRESS

none

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Form V. S. No. 5. 12½ M. 7-24-11

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH. Registration District No. 32
County of Lewis Primary Registration District No. 2127
City of Forak (No. _____, _____ St.)

File No. 436
Registered No. 6

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

If death occurred in a hospital, institution or camp give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX Female 4. COLOR OR RACE white 5. SINGLE, MARRIED, WIDOWED OR DIVORCED. single
(Write the word.)

6. DATE OF BIRTH Mar 12 1913
(Month) (Day) (Year)

7. AGE _____ yrs. _____ mos. _____ ds. IF LESS than 1 day how many _____ hrs. or _____ min?

8. OCCUPATION
(a) Trade, profession or particular kind of work none - infant
(b) General nature of industry business or establishment in which employed (or employer)

9. BIRTHPLACE (State or Country) Forak - Ida -

10. NAME OF FATHER Frank L. Shadduck
11. BIRTHPLACE OF FATHER (State or Country) Iowa

12. MAIDEN NAME OF MOTHER Alice M. Pinner
13. BIRTHPLACE OF MOTHER (State or Country) Iowa

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Frank L. Shadduck
(Address) Forak - Ida -

15. Filed 3-19-1913 Clinton B. Rogers
Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH March 12 1913
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from Mar. 12 1913, to Mar 12 1913 that I last saw him alive on March 12 1913 and that death occurred on the date stated above, at 11:30 P.M. The CAUSE OF DEATH* was as follows: PI 30 P.M.

Under development
Premature birth
digestion about six mos.
(Duration) yrs. mos. ds.
Contributory Do not know Cause of
(Secondary) Early labor
(Duration) yrs. mos. ds.
(Signed) Acce. Laughlin M. D.
March 1913 (Address) Tripholite, Ida

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; (2) whether ACCIDENTAL, SUICIDAL OR HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place _____ In the _____
of death _____ yrs. _____ mos. _____ ds. State _____ yrs. _____ mos. _____ ds.
Where was disease contracted, _____
If not at place of death? _____
Former or _____
usual residence _____

19. PLACE OF BURIAL OR REMOVAL DATE OF BURIAL
Shadduck Ranch Mar 15 1913

20. UNDERTAKER ADDRESS
none

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Form V. S. No. 5. 12½ M. 7-24-11

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH. Registration District No. 32
County of Lemhi Primary Registration District No. 2128
City of Hammar (No. _____, _____ St.)

File No. 1368
Registered No. 7

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Elmer Williams

If death occurred in a hospital, institution or camp give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX male 4. COLOR OR RACE Indian 5. SINGLE, MARRIED, WIDOWED OR DIVORCED. Married
(Write the word)
6. DATE OF BIRTH Nov 1st 1910
(Month) (Day) (Year)

7. AGE 2 yrs. 4 mos. 17 ds. IF LESS than 1 day how many _____ hrs. or _____ min?

8. OCCUPATION
(a) Trade, profession or particular kind of work _____
(b) General nature of industry business or establishment in which employed (or employer) _____

9. BIRTHPLACE (State or Country) Hammar Ida.

10. NAME OF FATHER James Williams

11. BIRTHPLACE OF FATHER (State or Country) Idaho County

12. MAIDEN NAME OF MOTHER Hollie Holl

13. BIRTHPLACE OF MOTHER (State or Country) Idaho County

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Hollie Williams
(Address) Kammar

15. W. Taylor M.D.
Filed 3-21 1913 Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH Mar. 18 1913
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from Feb. 13th 1913 to same 1913
that I last saw him alive on Feb. 13th 1913
and that death occurred on the date stated above, at 8:15 M.
The CAUSE OF DEATH* was as follows:
Phthisis Pulmonalis

(Duration) ? yrs. _____ mos. _____ ds.
Contributory (Secondary) _____
(Duration) _____ yrs. _____ mos. _____ ds.
(Signed) W. Taylor M.D. M. D.
19 _____ (Address) Kammar

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place _____ In the _____
of death _____ yrs. _____ mos. _____ ds. State _____ yrs. _____ mos. _____ ds.
Where was disease contracted, _____
If not at place of death? _____
Former or _____
usual residence _____

19. PLACE OF BURIAL OR REMOVAL Kammar DATE OF BURIAL Mar. 20th 1913

20. UNDERTAKER W. Taylor M.D. ADDRESS Kammar Ida.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICAL
CLANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact state
ment of OCCUPATION is very important. See instructions on back of certificate.

Form V, S. No. 5. 12½ M. 7-24-11

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics
File No. 4370
Registered No. 9

1. PLACE OF DEATH. Registration District No. 32
County of Lemhi Primary Registration District No. 2198
City of Hammar (No. St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Rose B. Young.

If death occurred in a hospital, institution or camp give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX Female
4. COLOR OR RACE white
5. SINGLE, MARRIED, WIDOWED OR DIVORCED. Single
(Write the word.)
6. DATE OF BIRTH Sept- 8th 1867
(Month) (Day) (Year)

7. AGE 45 yrs. 6 mos. 9 ds.
IF LESS than 1 day how many hrs. or min?

8. OCCUPATION
(a) Trade, profession or particular kind of work. Housekeeping
(b) General nature of industry, business or establishment in which employed (or employer)

9. BIRTHPLACE
(State or Country) Iowa

10. NAME OF FATHER Richard C Young

11. BIRTHPLACE OF FATHER Indiana
(State or Country)

12. MAIDEN NAME OF MOTHER Mary E Tipton

13. BIRTHPLACE OF MOTHER Ohio
(State or Country)

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) J. Taylor M.D.
(Address) Hammar Idaho

15. Filed March 22 1913
J. Taylor M.D.
Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH 3 19 1913
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from Mar 17th 1913, to same 1913
that I last saw her alive on same 1913
and that death occurred on the date stated above, at 6:00 P. M.
The CAUSE OF DEATH* was as follows:
Acute pneumonia

(Duration) yrs. mos. ds. 7 days
Contributory (Secondary) none

(Duration) yrs. mos. ds.
(Signed) W. S. Montgomery M. D.
Mar 20 1913 (Address) Hammar, Idaho

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place In the
of death yrs. mos. ds. State yrs. mos. ds.
Where was disease contracted,
If not at place of death?
Former or usual residence.

19. PLACE OF BURIAL OR REMOVAL DATE OF BURIAL

Hammar Mar 20 1913
20. UNDERTAKER ADDRESS
C. B. Johnson Hammar

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Form V. S. No. 5. 12½ M. 7-24-11

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics
File No. 4371
Registered No. 10

1. PLACE OF DEATH. Registration District No. 82
County of Benewah Primary Registration District No. 2127
City of Winchester (No. _____, _____ St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Howard Clifton Grant

If death occurred in a hospital, institution or camp give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX Male 4. COLOR OR RACE White 5. SINGLE, MARRIED, WID. Married
OWED OR DIVORCED.
(Write the word.)

6. DATE OF BIRTH Dec 5-2 1912
(Month) (Day) (Year)

7. AGE 3 yrs. 7 mos. 15 ds. IF LESS than 1 day
how many _____ hrs. or
_____ min?

8. OCCUPATION
(a) Trade, profession or particular kind of work. none
(b) General nature of industry business or establishment in which employed (or employer)

9. BIRTHPLACE (State or Country) Idaho

10. NAME OF FATHER Alex Grant

11. BIRTHPLACE OF FATHER (State or Country) Canada

12. MAIDEN NAME OF MOTHER Mollie Peterson

13. BIRTHPLACE OF MOTHER (State or Country) Kansas

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE (Informant) _____

(Address) Alex Grant Winchester, Idaho

15. Filed 3-20-1913 Elton B. Rogers Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH March 20 1913
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from March 18 1913, to March 20 1913 that I last saw him alive on March 19 1913 and that death occurred on the date stated above, at 2 M. The CAUSE OF DEATH* was as follows:
Broncho Pneumonia

(Duration) _____ yrs. _____ mos. 18 ds.
Contributory Whooping Cough (Secondary)
(Duration) _____ yrs. _____ mos. 25 ds.
(Signed) Elton B. Rogers M. D.
3-20 1913 (Address) Winchester

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place _____ In the _____
of death _____ yrs. _____ mos. _____ ds. State _____ yrs. _____ mos. _____ ds.
Where was disease contracted, _____
If not at place of death? _____
Former or _____
usual residence _____

19. PLACE OF BURIAL OR REMOVAL DATE OF BURIAL

DOOF DEO 3-21 1913

20. UNDERTAKER ADDRESS

none

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
N. B.—Every item of information should be carefully supplied. AGE should be state EXACTLY. PHYSICIAN should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Form V. S. No. 5. 10M. 6-20-11.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics
File No. 4378
Registered No. 26

1. PLACE OF DEATH.

Registration District No. 4County of AdamsPrimary Registration District No. 2012City of New Meadows

(No. _____ St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

Ethel Johnson

If death occurred in a hospital, institution or camp give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX

4. COLOR OR RACE

5. SINGLE, MARRIED, WIDOWED OR DIVORCED.

Female Whitemarried
(Write the word.)

6. DATE OF BIRTH

April 17 1893
(Month) (Day) (Year)

7. AGE

38 yrs. 11 mos. 3 ds.

IF LESS than 1 day
how many _____ hrs. or
_____ min.?

8. OCCUPATION

- (a) Trade, profession, or particular kind of work
(b) General nature of industry, business, or establishment in which employed (or employer)

Housewife

9. BIRTHPLACE

(State or Country)

Norfolk Eng.

10. NAME OF FATHER

Greenfield Cobb

11. BIRTHPLACE OF FATHER

(State or Country)

England

12. MAIDEN NAME OF MOTHER

Mary Edwards

13. BIRTHPLACE OF MOTHER

(State or Country)

England

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

(Address)

Frank E. Bion
New Meadows

15.

Filed 331 1913Frank E. Bion
Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

March 20th 1913
(Month) (Day) (Year)17. I HEREBY CERTIFY, That I attended deceased from March 19th 1913, to March 20th 1913, that I last saw him alive on March 21st 1913, and that death occurred on the date stated above, at 8:15 P.M.

The CAUSE OF DEATH* was as follows:

Childbirth

(Duration) yrs. mos. 2 4 hrs.
Contributory (Secondary) General Post Partum Hemorrhage

(Duration) yrs. mos. 20 min.
(Signed) T. E. Johnson M. D.
March 21, 1913 (Address) New Meadows

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place In the
of death yrs. mos. ds. State yrs. mos. ds.
Where was Disease contracted,
If not at place of death?
Former or
usual residence.

19. PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

Meadows, Ida March 22nd 1913

20. UNDERTAKER

ADDRESS

Edgard Johnson New Meadows

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Form V. S. No. 5. 10M. 6-20-11.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH
County of Adams
City of Council

Registration District No. 4
Primary Registration District No. 2011
(No. _____, _____ St.)

File No. 4381
Registered No. 24

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Dora Kiser

If death occurred in a hospital, institution or camp give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX Female 4. COLOR OR RACE whs 5. SINGLE, MARRIED, WIDOWED OR DIVORCED. married
(Write the word.)

6. DATE OF BIRTH March 7 1867
(Month) (Day) (Year)

7. AGE 46 yrs. 8 mos. 8 ds. IF LESS than 1 day how many _____ hrs. or _____ min.?

8. OCCUPATION
(a) Trade, profession, or particular kind of work Housewife
(b) General nature of industry, business, or establishment in which employed (or employer)

9. BIRTHPLACE Colorado
(State or Country)

10. NAME OF FATHER William Muller

11. BIRTHPLACE OF FATHER England
(State or Country)

12. MAIDEN NAME OF MOTHER Jane Deull

13. BIRTHPLACE OF MOTHER New York
(State or Country)

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Chas. Kiser
(Address) Council

15. Filed 3-18 1913 Frank E. Brown
Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH March 15 1913
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from March 1913, to March 15 1913, that I last saw him alive on Mar 15 1913, and that death occurred on the date stated above, at 3:30 P. M.

The CAUSE OF DEATH* was as follows:
Chronic nephritis

(Duration) _____ yrs. _____ mos. _____ ds.
Contributory Scarlet Fever
(Secondary)

(Duration) _____ yrs. _____ mos. _____ ds.
(Signed) Frank E. Brown M. D.
3-18 1913 (Address) Council

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place _____ In the _____
of death _____ yrs. _____ mos. _____ ds. State _____ yrs. _____ mos. _____ ds.
Where was Disease contracted,
If not at place of death?
Former or
usual residence.

19. PLACE OF BURIAL OR REMOVAL Council DATE OF BURIAL 3-16 1913

20. UNDERTAKER Ross Young ADDRESS Council

Form V. S. No. 5. 10M. 6-20-11.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH
County of Idaho
City of Council

Registration District No. 4
Primary Registration District No. 2011
(No. _____, _____ St.)

File No. 4381
Registered No. 27

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

Carl Roth

If death occurred in a hospital, institution or camp give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX m 4. COLOR OR RACE w 5. SINGLE, MARRIED, WIDOWED OR DIVORCED.

(Write the word.)

6. DATE OF BIRTH

Sept 2 1924
(Month) (Day) (Year)

7. AGE

89 yrs. 5 mos. 22 ds.

IF LESS than 1 day
how many _____ hrs. or
_____ min.?

8. OCCUPATION

(a) Trade, profession, or particular kind of work
(b) General nature of industry, business, or establishment in which employed (or employer)

Farmer

9. BIRTHPLACE
(State or Country)

Germany

10. NAME OF FATHER

11. BIRTHPLACE OF FATHER
(State or Country)

12. MAIDEN NAME OF MOTHER

13. BIRTHPLACE OF MOTHER
(State or Country)

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

Otto E Brauer

(Address)

15.

Filed

3-18-1913 Frank E. Brown
Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

Feb 24 1913
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from

Feb 20 1913, to Feb 23 1913

that I last saw him alive on Feb 23 1913

and that death occurred on the date stated above, at 10 P. M.

The CAUSE OF DEATH* was as follows:

Apoplexy

(Duration) _____ yrs. _____ mos. _____ ds.

Contributory
(Secondary)

stroke

(Duration) _____ yrs. _____ mos. _____ ds.

(Signed) Frank E. Brown M. D.

3-18-1913 (Address) Council

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place _____ In the _____
of death _____ yrs. _____ mos. _____ ds. State _____ yrs. _____ mos. _____ ds.

Where was Disease contracted,
If not at place of death?

Former or
usual residence.

19. PLACE OF BURIAL OR REMOVAL

Council

DATE OF BURIAL

3-25-1913

20. UNDERTAKER

Robt Young

ADDRESS

Council

Form 10-1-11

1. 37

County of Idaho

City of Council

If death occurs away from usual residence, give facts called for under special information.

Registration District No. 207

Primary Registration District No. 207

(No. 207 St.)

Registered No. 20

2. FULL NAME John C. Derrick

State of Idaho

DEPARTMENT OF HEALTH

Office of Vital Statistics

File No. 4382

If death occurred in a hospital, institution or camp give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX Male 4. COLOR OR RACE White 5. SINGLE, MARRIED, WIDOWED OR DIVORCED. Widowed
(Write the word.)

6. DATE OF BIRTH Dec 22 1887
(Month) (Day) (Year)

7. AGE 86 yrs. 1 mos. ds. IF LESS than 1 day how many hrs. or min.

8. OCCUPATION
(a) Trade, profession, or particular kind of work Farmer
(b) General nature of industry, business, or establishment in which employed (or employer)

9. BIRTHPLACE (State or Country) Holland

10. NAME OF FATHER

11. BIRTHPLACE OF FATHER (State or Country)

12. MAIDEN NAME OF MOTHER

13. BIRTHPLACE OF MOTHER (State or Country)

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) John C. Rath
(Address) Council

15.

Filed 3-18 1913 Frank E. Brown
Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH Feb 17 1913
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from Feb 9 1913, to Feb 17 1913, that I last saw him alive on Feb 9 1913, and that death occurred on the date stated above, at 7 P. M.
The CAUSE OF DEATH* was as follows:

Pneumonia
(Duration) 10 yrs. ds.

Contributory (Secondary)
(Duration) 10 yrs. ds.
(Signed) D. I. Martin M. D.
3-19-1913 (Address) Council Idaho

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL,

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place In the
of death 10 yrs. ds. State Idaho
Where was Disease contracted,
If not at place of death?
Former or
usual residence.

19. PLACE OF BURIAL OR REMOVAL Council DATE OF BURIAL Feb 18 1913

20. UNDERTAKER Robt. Young ADDRESS Council

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. N. B.—Every item of information should be carefully supplied. AGE should be state EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Form V. S. No. 5. 10M. 6-20-11.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH.

Registration District No. 4County of AdamsPrimary Registration District No. 2012City of New Meadows

(No. _____) (St.)

File No. 4383Registered No. 19

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

Mrs Sarah E. Kiezer

If death occurred in a hospital, institution or camp give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX

Female

4. COLOR OR RACE

White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED.

Widowed
(Write the word.)

6. DATE OF BIRTH

Jan. - 24 - 1837
(Month) (Day) (Year)

7. AGE

76 yrs. — mos. — ds.
IF LESS than 1 day
how many hrs. or
..... min.?

8. OCCUPATION

(a) Trade, profession, or particular kind of work
(b) General nature of industry business, or establishment in which employed (or employer)none

9. BIRTHPLACE

(State or Country)

State of Missouri

10. NAME OF FATHER

Thomas Ramabey

11. BIRTHPLACE OF FATHER

(State or Country)

unknown

12. MAIDEN NAME OF MOTHER

Adams

13. BIRTHPLACE OF MOTHER

(State or Country)

unknown

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

M. E. Kiezer

(Address)

Meadows, Ida.

15.

Filed 3-18 1913 Frank E. Brown
Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

Jan. - 25 - 1913
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from

about June 1912, to Jan 24 1913
that I last saw her alive on Jan 24 1913and that death occurred on the date stated above, at 7 A. M.

The CAUSE OF DEATH was as follows:

Senility(Duration) 3 yrs. — mos. — ds.

Contributory (Secondary)

(Duration) — yrs. — mos. — ds.

(Signed)

Jan 25 1913 (Address) Meadows, Ida.

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions Transients or Recent Residents.)

At place _____ In the _____
of death yrs mos ds. State yrs mos ds.

Where was Disease contracted,

If not at place of death?

Former or

usual residence.

19. PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

Cottage Grove, Oregon Jan 29 - 1913

20. UNDERTAKER

ADDRESS

R. W. Bowen Weiser, Ida.

Form V. S. No. 5.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
 Bureau of Vital Statistics
 File No. 4380
 Registered No. 109

1. **PLACE OF DEATH.** Registration District No. 10
 County of Idaho Primary Registration District No. 2044
 City of Grangeville (No. _____, _____ St.)

If death occurs away from usual residence, give facts called for under special information.

2. **FULL NAME** Emily May Steinhouse

If death occurred in a hospital, institution or camp give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. **SEX** 4. **COLOR OR RACE** 5. **SINGLE, MARRIED, WIDOWED OR DIVORCED.**

Female white single
 (Write the word.)

6. **DATE OF BIRTH** Sept 25 1912
 (Month) (Day) (Year)

7. **AGE** 5 yrs. 13 mos. 13 ds.
 IF LESS than 1 day how many hrs. or min?

8. **OCCUPATION**

(a) Trade, profession or particular kind of work. none
 (b) General nature of industry business or establishment in which employed (or employer)

9. **BIRTHPLACE** Idaho County
 (State or Country)

10. **NAME OF FATHER** A. E. Steinhouse

11. **BIRTHPLACE OF FATHER** Pennayle
 (State or Country)

12. **MAIDEN NAME OF MOTHER** Edith A. Harris

13. **BIRTHPLACE OF MOTHER** Oregon
 (State or Country)

14. **THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE**
 (Informant) J. Harris
 (Address) Grangeville Idaho

15. Filed Mar. 14 1913 Isse L. Rains
 Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. **DATE OF DEATH** March 10 1913
 (Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from March 10 1913 to March 10 1913 that I last saw her alive on March 10 1913 and that death occurred on the date stated above, at 12 M. The CAUSE OF DEATH* was as follows:

Pneumonia

(Duration) about 10 yrs. 10 mos. 10 ds.

Contributory (Secondary)

(Duration) 10 yrs. 10 mos. 10 ds.
 (Signed) G. S. Strickton M. D.
March 14 1913 (Address) Grangeville Idaho

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. **LENGTH OF RESIDENCE** (For Hospitals, Institutions, Transients or Recent Residents.)

At place In the
 of death yrs. mos. ds. State yrs. mos. ds.
 Where was disease contracted,
 If not at place of death?
 Former or
 usual residence.

19. **PLACE OF BURIAL OR REMOVAL** Denver Cemetery **DATE OF BURIAL** Mar. 11 1913

20. **UNDERTAKER** W. E. Graham **ADDRESS** Grangeville

MARGIN RESERVED FOR BINDING. WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Form V. S. No. 5. 12½ M. 7-24-11

CERTIFICATE OF DEATH

1. PLACE OF DEATH. Registration District No. ~~244~~ 10
County of Idaho Primary Registration District No. 2043
City of Hamiah (No. _____, _____ St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Walter Hayes

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics
File No. 438
Registered No. 116

If death occurred in a hospital, institution or camp give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX Male 4. COLOR OR RACE Indian 5. SINGLE, MARRIED, WIDOWED OR DIVORCED. Single
(Write the word.)
6. DATE OF BIRTH April 4 1891
(Month) (Day) (Year)

7. AGE 22 yrs. 11 mos. 30 ds.
IF LESS than 1 day how many _____ hrs. or _____ min?

8. OCCUPATION
(a) Trade, profession or particular kind of work Farmer
(b) General nature of industry business or establishment in which employed (or employer)

9. BIRTHPLACE
(State or Country) Union Oregon

10. NAME OF FATHER James Hayes

11. BIRTHPLACE OF FATHER
(State or Country) Idaho

12. MAIDEN NAME OF MOTHER Fanny Bailey

13. BIRTHPLACE OF MOTHER
(State or Country) Idaho

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) William Bean
(Address) Hamiah Idaho

15. Filed Mar 21 1913 Jon Verbeek
Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH Mar 1 1913
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from Sept 1912 to Mar 1st 1913
that I last saw him alive on Feb 24th 1913
and that death occurred on the date stated above, at 10 P. M.
The CAUSE OF DEATH* was as follows:

Pneumonia Pulmonalis

(Duration) 1 yrs. 1 mos. 0 ds.
Contributory Perineal Abscess
(Secondary)
(Signed) Wilber F. McWhan M. D.
Mar 3rd 1913 (Address) Hamiah, Ia.

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place _____ In the _____
of death _____ yrs. _____ mos. _____ ds. State _____ yrs. _____ mos. _____ ds.
Where was disease contracted,
If not at place of death?
Former or
usual residence _____

19. PLACE OF BURIAL OR REMOVAL Indian Cemetery #1 DATE OF BURIAL 1913

20. UNDERTAKER C. J. Johnson ADDRESS Hamiah

MARGIN RESERVED FOR BINDING
WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Form V. S. No. 5. 12½ M. 7-24-11

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH. Registration District No. 2043
County of Idaho Primary Registration District No. 2043
City of Tamiah (No. _____, _____ St.)

File No. 4389
Registered No. 117

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME James Egkiel

If death occurred in a hospital, institution or camp give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX male 4. COLOR OR RACE Indian 5. SINGLE, MARRIED, WIDOWED OR DIVORCED. Single
(Write the word.)

6. DATE OF BIRTH 1892
(Month) (Day) (Year)

7. AGE 21 yrs. 0 mos. 0 ds. IF LESS than 1 day how many _____ hrs. or _____ min?

8. OCCUPATION
(a) Trade, profession or particular kind of work Farmer
(b) General nature of industry business or establishment in which employed (or employer)

9. BIRTHPLACE
(State or Country) Tamiah Idaho

10. NAME OF FATHER Egkiel

11. BIRTHPLACE OF FATHER
(State or Country) Wont know

12. MAIDEN NAME OF MOTHER

13. BIRTHPLACE OF MOTHER
(State or Country)

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Mathias Egkiel
(Address) Tamiah Idaho

15. Filed March 31 1913
James Egkiel
Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH 3 24 1913
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from Mar 24th 1913, to same 1913
that I last saw him alive on 3/24 1913
and that death occurred on the date stated above, at 4:00 P.M.
The CAUSE OF DEATH* was as follows:
Phthisis Pulmonalis

(Duration) ? yrs. ? mos. ? ds.

Contributory (Secondary) none

(Duration) _____ yrs. _____ mos. _____ ds.

(Signed) William F. McLean M. D.
Mar 24th 1913 (Address) Tamiah Idaho

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place _____ In the _____
of death _____ yrs. _____ mos. _____ ds. State _____ yrs. _____ mos. _____ ds.
Where was disease contracted,
If not at place of death? _____
Former or
usual residence _____

19. PLACE OF BURIAL OR REMOVAL DATE OF BURIAL

Indian Cemetery No 1 Mar 26th 1913
20. UNDERTAKER Egkiel ADDRESS Tamiah Idaho

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Form V. S. No. 5. 12½ M. 7-24-11

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics
File No. 4389
Registered No. 118

1. PLACE OF DEATH. Registration District No. 10
County of Idaho Primary Registration District No. #101 2043
City of Koskia (No. _____, St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Anna Louise Laird

If death occurred in a hospital, institution or camp give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX Female 4. COLOR OR RACE White 5. SINGLE, MARRIED, WIDOWED OR DIVORCED. Married
(Write the word.)

6. DATE OF BIRTH April 26 1883
(Month) (Day) (Year)

7. AGE 28 yrs. 10 mos. 27 ds. IF LESS than 1 day how many hrs. or min?

8. OCCUPATION Housekeeper
(a) Trade, profession or particular kind of work.
(b) General nature of industry business or establishment in which employed (or employer)

9. BIRTHPLACE New Jersey
(State or Country)

10. NAME OF FATHER Rudolph Harrison Smith

11. BIRTHPLACE OF FATHER New York
(State or Country)

12. MAIDEN NAME OF MOTHER Anna Louise Springer

13. BIRTHPLACE OF MOTHER New York
(State or Country)

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Geo. H. Treuhaft
(Address) Koskia Idaho

15. Filed March 31 1913 Jm. Verbeekman
Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH March 23 1913
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from March 19 1913, to March 23 1913 that I last saw him alive on March 23 1913 and that death occurred on the date stated above, at 5 PM.
The CAUSE OF DEATH* was as follows:
Pneumonia following marriage

(Duration) yrs. mos. 6 ds.
Contributory (Secondary)
(Duration) yrs. mos. ds.
(Signed) Jm. Verbeekman M. D.
March 24 1913 (Address) Koskia Idaho

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place In the
of death yrs. mos. ds. State yrs. mos. ds.
Where was disease contracted,
If not at place of death?
Former or
usual residence.....

19. PLACE OF BURIAL OR REMOVAL Koskia Cemetery DATE OF BURIAL March 1913

20. UNDERTAKER Ep. Johnson ADDRESS Koskia

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Form V. S. No. 5. 12½ M. 7-24-11

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH. Registration District No. 10
County of Idaho Primary Registration District No. 2042
City of Kenterville (No. _____, _____ St.)

File No. 1391
Registered No. 120

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

Unnamed infant of Frederick Romain

If death occurred in a hospital, institution or camp give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX Male 4. COLOR OR RACE White 5. SINGLE, MARRIED, WIDOWED OR DIVORCED. Single
(Write the word.)

6. DATE OF BIRTH March 4 1913
(Month) (Day) (Year)

7. AGE _____ yrs. _____ mos. _____ ds. IF LESS than 1 day how many _____ hrs. _____ min.

8. OCCUPATION

- (a) Trade, profession or particular kind of work.
(b) General nature of industry business or establishment in which employed (or employer)

9. BIRTHPLACE Idaho
(State or Country)

10. NAME OF FATHER Frederick Romain

11. BIRTHPLACE OF FATHER Ill.
(State or Country)

12. MAIDEN NAME OF MOTHER Josephine Kauffmann

13. BIRTHPLACE OF MOTHER Ill.
(State or Country)

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Frederick Romain
(Address) Kenterville Idaho

15.

Filed March 5th 1913

Joseph E. Rains
Local Registrar
for State & City

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH March 4 1913
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from March 4 1913, to March 4 1913 that I last saw him alive on March 4 1913 and that death occurred on the date stated above, at 6:20 P.M.

The CAUSE OF DEATH* was as follows:

Congenital Pulmonary Atelectasis

(Duration) 1 1/2 months
Contributory (Secondary)

(Duration) _____ yrs. _____ mos. _____ ds.
(Signed) Henry B. B. M. D.
March 4 1913 (Address) Kenterville Idaho

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place _____ In the _____
of death _____ yrs. _____ mos. _____ ds. State _____ yrs. _____ mos. _____ ds.
Where was disease contracted,
If not at place of death?
Former or
usual residence.

19. PLACE OF BURIAL OR REMOVAL DATE OF BURIAL

Catholic Cemetery Kenterville March 5 1913

20. UNDERTAKER

ADDRESS

Joseph Mellesky Kenterville, Idaho

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Form V. S. No. 5 20M.1-16-12

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH.

Registration District No. 2101County of IdahoPrimary Registration District No. 2101City of Stites

(No. _____, _____ St.)

File No. 4392Registered No. 121

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Eva Mickelberry

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX F.4. COLOR OR RACE W.5. SINGLE, MARRIED, WIDOWED OR DIVORCED.
married
(Write the word.)6. DATE OF BIRTH Sept 16, 1882

(Month)

(Day)

(Year)

7. AGE 31 yrs. — mos. — ds.IF LESS than 1 day
how many hrs. or
..... mins.?

8. OCCUPATION

(a) Trade, profession or particular kind of work

Housewife

(b) General nature of industry business, or establishment in which employed (or employer)

9. BIRTHPLACE

(State or Country)

Montana10. NAME OF FATHER —11. BIRTHPLACE OF FATHER —

(State or Country)

12. MAIDEN NAME OF MOTHER —13. BIRTHPLACE OF MOTHER —

(State or Country)

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) H. F. Schrader M.D.(Address) from husband over telephone

15.

Filed March 17 19133Schrader

Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH March 16 1913

(Month)

(Day)

(Year)

17. I HEREBY CERTIFY, That I attended deceased from March 12 1913, to March 16 1913,
that I last saw her alive on March 16 1913,
and that death occurred on the date stated above, at 9 A M.

The CAUSE OF DEATH* was as follows:

Pulmonary Tuberculosis(Duration) 3 yrs. — mos. — ds.Contributory Child birth, Purp. sepsis
(Secondary)(Duration) — yrs. 4 mos. — ds.(Signed) H. F. Schrader M. D.3/16 1913 (Address) Stites Idaho

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death.....yrs.....mos. 3 days. In the State.....yrs.....mos. 2 days.Where was disease contracted if not at place of death? —Former or usual residence Oregon19. PLACE OF BURIAL OR REMOVAL 1. O. O. F. CemeteryDATE OF BURIAL March 18 191320. UNDERTAKER —ADDRESS None

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Form V. S. No. 5. 12½ M. 7-24-11

CERTIFICATE OF DEATH

State of Idaho

BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH.
County of Idaho
City of Reese's Bar
Salmon River

Registration District No. 10
Primary Registration District No. 2042
(No. _____, _____ St.)

File No. 4393
Registered No. 122

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME William C Caldwell

If death occurred in a hospital, institution or camp give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX male 4. COLOR OR RACE white 5. SINGLE, MARRIED, WIDOWED OR DIVORCED.
supposed single
(Write the word.)

6. DATE OF BIRTH Not known
(Month) (Day) (Year)

7. AGE 44 yrs. _____ mos. _____ ds. IF LESS than 1 day how many _____ hrs. or _____ min?

8. OCCUPATION
(a) Trade, profession or particular kind of work. Trapper
(b) General nature of industry business or establishment in which employed (or employer)

9. BIRTHPLACE Oregon
(State or Country)

10. NAME OF FATHER

11. BIRTHPLACE OF FATHER Not known
(State or Country)

12. MAIDEN NAME OF MOTHER

13. BIRTHPLACE OF MOTHER Not known
(State or Country)

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) James Graham
(Address) McCall Idaho

15. Filed Mar 29 1913
Jose L Rains
Local Registrar
for State Sub Reg?

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH March 4 1913
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I ~~attended deceased from~~
held an inquest upon deceased
at Goff Idaho
that I last saw him alive on the 29th March 1913
and that death occurred on the date stated above, at 4:10 A.M.

The CAUSE OF DEATH* was as follows:

Traumatism by firearms. Homicidal

_____ (Duration) _____ yrs. _____ mos. _____ ds.

Contributory _____
(Secondary)

_____ (Duration) _____ yrs. _____ mos. _____ ds.

(Signed) Henry B Blake M. D.

Mar 29 1913 (Address) Corner Idaho Com
Cottonwood Idaho

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place _____ In the _____
of death _____ yrs. _____ mos. _____ ds. State _____ yrs. _____ mos. _____ ds.
Where was disease contracted,
If not at place of death?
Former or
usual residence.

19. PLACE OF BURIAL OR REMOVAL DATE OF BURIAL

Cemetery at Riggins Idaho Mar 29 1913

20. UNDERTAKER ADDRESS

Homer Seander Goff Idaho.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
N. B.—Every item of information should be carefully supplied. AGE should be state EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Form V. S. No. 5. 10M. 6-20-11.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH.

Registration District No. 10

County of Idaho

Primary Registration District No. 2041

City of White Bird

(No. _____, _____ St.)

File No. 1394

Registered No. 123

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

Richard M. Henley

If death occurred in a hospital, institution or camp give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX

4. COLOR OR RACE

5. SINGLE, MARRIED, WIDOWED OR DIVORCED.

Male White Married

6. DATE OF BIRTH

August 14 1850

(g.h.) March 29 1913
(Month) (Day) (Year)

7. AGE

63 yrs. 7 mos. 15 ds.

IF LESS than 1 day
how many hrs. or
..... min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work

Farmer

(b) General nature of industry business or establishment in which employed (or employer)

9. BIRTHPLACE

(State or Country)

Mo.

10. NAME OF FATHER

William Henley

11. BIRTHPLACE OF FATHER

(State or Country)

Nashville Tenn

12. MAIDEN NAME OF MOTHER

Russell

13. BIRTHPLACE OF MOTHER

(State or Country)

Nashville Tenn

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

(Address)

R. M. Henley
White Bird Id

15.

Filed April 2 1913

Jose L. Rain
Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

March 29 1913
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from

Dec 20, 1913, to Mar 29 1913

that I last saw him alive on 23 of Mar 1913

and that death occurred on the date stated above, at 10:30 P. M.

The CAUSE OF DEATH* was as follows:

Arteriosclerosis

(Duration) 2 yrs. _____ mos. _____ ds.

Contributory (Secondary)

nephritis

(Duration) _____ yrs. 4 mos. _____ ds.

(Signed)

W. A. F. H. H. M. D.
Mar 3, 1913 (Address) White Bird Ida

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death. _____ yrs. _____ mos. _____ ds. State. _____ yrs. _____ mos. _____ ds.

Where was disease contracted.

If not at place of death?

Former or

usual residence.

19. PLACE OF BURIAL OR REMOVAL DATE OF BURIAL

White Bird Id April 13 1913

20. UNDERTAKER

ADDRESS

W. E. Graham Brangerville

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. N. B.—Every item of information should be carefully supplied. AGE should be state EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Form V. S. No. 5. 10M. 6-20-11.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH.

Registration District No. 10County of IdahoPrimary Registration District No. 1001City of Grangerille

(No. _____ St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

William Clarence WalkerFile No. 4395Registered No. 124

If death occurred in a hospital, institution or camp give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX

Male

4. COLOR OR RACE

White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED.

Single
(Write the word.)

6. DATE OF BIRTH

March131887

(Month)

(Day)

(Year)

7. AGE

25

yrs.

11

mos.

27

ds.

IF LESS than 1 day
how many _____ hrs. or
_____ min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work

Farming

(b) General nature of industry business or establishment in which employed (or employer)

9. BIRTHPLACE

(State or Country)

Missouri

10. NAME OF FATHER

Robert Newton Walker

11. BIRTHPLACE OF FATHER

(State or Country)

Missouri

12. MAIDEN NAME OF MOTHER

Mary Elizabeth Prater

13. BIRTHPLACE OF MOTHER

(State or Country)

Kentucky

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

R. N. Walker

(Address)

Grangerille Idaho

15.

Filed

Feb. 111913Essie L. Gains

Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

March 10

(Month)

(Day)

1913

(Year)

17. I HEREBY CERTIFY, That I ~~attended~~ deceased from191

to

191

I last saw him ~~alive~~ on March 10 191and that death occurred on the date stated above, at 4 P. M.

The CAUSE OF DEATH* was as follows:

Suicide by firearms
(This certificate issued by
authority of Coroner H. B. Blake)
(Duration) _____ yrs. _____ mos. _____ ds.Contributory
(Secondary)

(Duration) _____ yrs. _____ mos. _____ ds.

(Signed) Essie L. Gains M.D. M. D.Feb. 11 1913 (Address) Grangerille

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death _____ yrs. _____ mos. _____ ds. State _____ yrs. _____ mos. _____ ds.

Where was disease contracted,

If not at place of death?

Former or

usual residence.

19. PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

Crairie View CemeteryFeb. 11 1913

20. UNDERTAKER

ADDRESS

W. E. GrahamGrangerille

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Form V. S. No. 5. 12½M.7

1. PLACE OF DEATH. Registration District No. 10
 County of Idaho Primary Registration District No. 2044
 City of Grangeville (No. _____, St.)

of Idaho
 BOARD OF HEALTH
 Bureau of Vital Statistics
 File No. 4396
 Registered No. 125

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Edgar Parks

If death occurred in a hospital, institution or camp give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX Male 4. COLOR OR RACE white 5. SINGLE, MARRIED, WIDOWED OR DIVORCED. Single
 (Write the word.)

6. DATE OF BIRTH March 13 1913
 (Month) (Day) (Year)

7. AGE — yrs. — mos. 11 ds. IF LESS than 1 day how many hrs. or min?

8. OCCUPATION

(a) Trade, profession or particular kind of work. none
 (b) General nature of industry business or establishment in which employed (or employer)

9. BIRTHPLACE Idaho Co
 (State or Country)

10. NAME OF FATHER George A Parks

11. BIRTHPLACE OF FATHER Illinois
 (State or Country)

12. MAIDEN NAME OF MOTHER Pearl B Warden

13. BIRTHPLACE OF MOTHER Iowa
 (State or Country)

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
 (Informant) G. A. Parks
 (Address) Grangeville Ida

15. Filed Mar. 24 1913 Jesse L. Rains
 Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH March 24 1913
 (Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from Mar 13 1913, to Mar 24 1913
 that I last saw him alive on March 14 1913
 and that death occurred on the date stated above, at 11 A. M.
 The CAUSE OF DEATH* was as follows:

Transition

(Duration) _____ yrs. _____ mos. _____ ds.
 Contributory Premature Birth
 (Secondary)

(Duration) _____ yrs. _____ mos. _____ ds.
 (Signed) G. S. Streeter M. D.
Mar 24 1913 (Address) Grangeville Ida

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place _____ In the _____
 of death _____ yrs. _____ mos. _____ ds. State _____ yrs. _____ mos. _____ ds.
 Where was disease contracted,
 If not at place of death?
 Former or
 usual residence _____

19. PLACE OF BURIAL OR REMOVAL DATE OF BURIAL
Mt. Idaho Cemetery Mar. 25 1913

20. UNDERTAKER ADDRESS
None None

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Form V. S. No. 5. 12½ M. 7-24-

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH. Registration District No. 16
County of Boyer Primary Registration District No. 1009
City of Lewiston (No. 817, 8th Ave, 9 St.)

File No. 1397
Registered No. 29

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

Willis L. Likes

If death occurred in a hospital, institution or camp give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX M 4. COLOR OR RACE W. 5. SINGLE, MARRIED, WIDOWED OR DIVORCED. Single
(Write the word.)

6. DATE OF BIRTH 2nd June 1
(Month) (Day) (Year)

7. AGE 53 yrs. — mos. — ds. IF LESS than 1 day
how many — hrs. or — min?

8. OCCUPATION

(a) Trade, profession or particular kind of work
(b) General nature of industry business or establishment in which employed (or employer)

Farmer

9. BIRTHPLACE

(State or Country)

Indiana

10. NAME OF FATHER

Abraham Likes

11. BIRTHPLACE OF FATHER

(State or Country)

Ohio

12. MAIDEN NAME OF MOTHER

Eva Bean

13. BIRTHPLACE OF MOTHER

(State or Country)

Ohio

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

S. B. Likes

(Address)

15.

File Apr. 10 1913 S. B. Likes
Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH

March 5 1913
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from March 1912, to March 1913.

that I last saw him alive on March 5 1913
and that death occurred on the date stated above, at 7.4 M.

The CAUSE OF DEATH* was as follows:

Valvular disease of heart

(Duration) one yrs. — mos. — ds.

Contributory —
(Secondary)

(Duration) — yrs. — mos. — ds.

(Signed) M. D.

Mar. 11 1913 (Address) Lewiston Idaho

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place In the
of death — yrs. — mos. — ds. State — yrs. — mos. — ds.

Where was disease contracted,

If not at place of death?

Former or
usual residence.

19. PLACE OF BURIAL OR REMOVAL DATE OF BURIAL

Lewiston Idaho Mar 6 1913

20. UNDERTAKER ADDRESS

C. J. Vasar Lewiston

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Form V. S. No. 5. 12½ M. 7-24-11

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH.
County of *Payson*
City of *Payson*

Registration District No. *16*
Primary Registration District No. *2075*
(No. _____ St.)

File No. *4395*
Registered No. *30*

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

Hannah J. Stevens

If death occurred in a hospital, institution or camp give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX *F* 4. COLOR OR RACE *W* 5. SINGLE, MARRIED, WIDOWED OR DIVORCED.
married
(Write the word.)

6. DATE OF BIRTH

(Month) (Day) (Year)

7. AGE *70* yrs. ____ mos. ____ ds. IF LESS than 1 day
how many ____ hrs. or ____ min?

8. OCCUPATION
(a) Trade, profession or particular kind of work. *Housewife*
(b) General nature of industry business or establishment in which employed (or employer) _____

9. BIRTHPLACE *Mich*
(State or Country)

10. NAME OF FATHER

11. BIRTHPLACE OF FATHER
(State or Country)

12. MAIDEN NAME OF MOTHER

13. BIRTHPLACE OF MOTHER
(State or Country)

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) *G. O. Stevens*
(Address) *Payson, Id*

15. Filed *Apr 10* 191*3* *L. J. Perkins*
Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH *Mar. 5* 191*3*
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from *Mar. 3* 191*3*, to *Mar. 4* 191*3* that I last saw her alive on *Mar. 4* 191*3* and that death occurred on the date stated above, at *6 P. M.*

The CAUSE OF DEATH* was as follows:

Epilepsy Apoplexy

____ (Duration) ____ yrs. ____ mos. ____ ds.

Contributory (Secondary) *apoplexy*

____ (Duration) ____ yrs. ____ mos. ____ ds.

(Signed) *J. M. Lyle* M. D.

3-6 191*3* (Address) *Payson*

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place _____ In the _____
of death ____ yrs. ____ mos. ____ ds. State ____ yrs. ____ mos. ____ ds.

Where was disease contracted,
If not at place of death? _____
Former or
usual residence _____

19. PLACE OF BURIAL OR REMOVAL DATE OF BURIAL

Melrose *3-7* 191*3*

20. UNDERTAKER ADDRESS

none

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Form V. S. No. 5. 12½ M. 7-24-11

CERTIFICATE OF

1. PLACE OF DEATH. Registration District No. 12
County of Myer Primary Registration District No. 1009
City of Lewiston (No. 1210, JK St.)

BOARD OF HEALTH
Bureau of Vital Statistics
File No. 4399
Registered No. 31

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Howard Phillip Volmer

If death occurred in a hospital, institution or camp give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX Male 4. COLOR OR RACE white 5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.)
6. DATE OF BIRTH May 8 1911
(Month) (Day) (Year)
7. AGE one 9 29 IF LESS than 1 day
yrs. mos. ds. how many hrs. or min?

8. OCCUPATION

- (a) Trade, profession or particular kind of work
(b) General nature of industry business or establishment in which employed (or employer)

9. BIRTHPLACE

(State or Country)

Lewiston Myer Co

10. NAME OF FATHER

George Volmer

11. BIRTHPLACE OF FATHER

(State or Country)

Germany

12. MAIDEN NAME OF MOTHER

Mary Kilde

13. BIRTHPLACE OF MOTHER

(State or Country)

Idaho, near Moscow

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

George Volmer

(Address) Lewiston Idaho

15.

Filed

Apr 10 1913

L. J. Vassar
Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH

March

7

1913

(Month)

(Day)

(Year)

17. I HEREBY CERTIFY, That I attended deceased from

Feb 17

1913

to

March 6

1913

that I last saw him alive on March 6 1913

and that death occurred on the date stated above, at 5 A.M.

The CAUSE OF DEATH* was as follows:

Lagrippe

(Duration) yrs. mos. 17 ds.

Contributory (Secondary)

(Duration) yrs. mos. ds.

(Signed)

L. J. Vassar

M. D.

3/7 1913 (Address) Lewiston Idaho

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place

In the

of death. yrs. mos. ds. State. yrs. mos. ds.

Where was disease contracted,

If not at place of death?

Former or

usual residence.

19. PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

Lewiston

Mar 8 1913

20. UNDERTAKER

ADDRESS

C. J. Vassar

Lewiston

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Form V. S. No. [REDACTED]

MEDICAL CERTIFICATE OF DEATH

1. PLACE OF BIRTH. Registration District No. 16
County of New Pierce Primary Registration District No. 2075
City of Peck (No. _____, _____ St.)

BOARD OF HEALTH
Bureau of Vital Statistics
File No. 1401
Registered No. 32

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

Reuben Delos Rogers

If death occurred in a hospital, institution or camp give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX M. 4. COLOR OR RACE W. 5. SINGLE, MARRIED, WIDOWED OR DIVORCED. Married
(Write the word.)

6. DATE OF BIRTH December - 30 - 1893
(Month) (Day) (Year)

7. AGE 69 yrs. 2 mos. 9 ds. IF LESS than 1 day
how many _____ hrs. or _____ min?

8. OCCUPATION

(a) Trade, profession or particular kind of work. Farmer
(b) General nature of industry business or establishment in which employed (or employer)

9. BIRTHPLACE

(State or Country) New York

10. NAME OF FATHER

Orton Rogers

11. BIRTHPLACE OF FATHER

(State or Country) Connecticut N.Y.

12. MAIDEN NAME OF MOTHER

Jessie Haddrell

13. BIRTHPLACE OF MOTHER

(State or Country) New York

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Carrie L. Rogers

(Address) Peck, Idaho

15.

Filed Apr. 10 1913

2. J. Peck

Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH

March 8 1913
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from Feb. 24 1913, to March 8 1913.

that I last saw him alive on March 8 1913 and that death occurred on the date stated above, at 7:20 AM.

The CAUSE OF DEATH* was as follows:

Broncho Pneumonia

(Duration) _____ yrs. _____ mos. 14 ds.

Contributory (Secondary) Bronchial Asthma

(Duration) 25 yrs. _____ mos. _____ ds.

(Signed) J. M. Syle M. D.

2-9 1913

(Address) Peck, Idaho

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place _____ yrs. _____ mos. _____ ds. In the _____ yrs. _____ mos. _____ ds.

Where was disease contracted,

If not at place of death?

Former or usual residence.

19. PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

Peck Idaho

March 9, 1913

20. UNDERTAKER

ADDRESS

None

State of Idaho
 COUNTY of Blaine No. 1009
 City of Lewiston (St.)
 Division District No. 1009

State of Idaho
 BOARD OF HEALTH
 Bureau of Vital Statistics

File No. 4401
 Registered No. 33

If death occurred in a hospital, institution or camp give its NAME instead of street and number.

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

Leona Walters

PERSONAL AND STATISTICAL PARTICULARS

3. SEX F 4. COLOR OR RACE W 5. SINGLE, MARRIED, WIDOWED OR DIVORCED.
Married
 (Write the word.)

6. DATE OF BIRTH 3 11 1913
 (Month) (Day) (Year)

7. AGE 39 yrs. 2 mos. 8 ds. IF LESS than 1 day
 how many hrs. or
 min?

8. OCCUPATION

- (a) Trade, profession or particular kind of work
 (b) General nature of industry business or establishment in which employed (or employer)

Housewife

9. BIRTHPLACE

(State or Country)

Leavenworth Kans

10. NAME OF FATHER

not known

11. BIRTHPLACE OF FATHER

(State or Country)

" "

12. MAIDEN NAME OF MOTHER

Rose Rathbone

13. BIRTHPLACE OF MOTHER

(State or Country)

not known

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

(Address)

J. H. Walters
Cottonwood

15.

Filed

Apr 10 1913

S. J. Perkins

Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH

March 11 1913
 (Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from Feb 7th 1913, to March 11th 1913
 that I last saw her alive on March 11th 1913
 and that death occurred on the date stated above, at 1:30 P.M.

The CAUSE OF DEATH* was as follows:

Gumma of Brain

(Duration) 6 yrs. 6 mos. 0 ds.

Contributory (Secondary)

Syphilis

(Duration) unknown yrs. 0 mos. 0 ds.

(Signed)

Edgar R. White M. D.

March 12 1913 (Address) Lewiston Ida

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death yrs. 1 mos. 4 ds. In the State yrs. mos. ds.
 Where was disease contracted, If not at place of death? unknown
 Former or usual residence Cottonwood Ida

19. PLACE OF BURIAL OR REMOVAL DATE OF BURIAL

Susan E. Bruce Mar 13th 1913

20. UNDERTAKER

ADDRESS

C. J. Vassar Lewiston

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Form V. S. No. 5. 12½M.7-24-11

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics
File No. 4403
Registered No. 35

1. PLACE OF DEATH. Registration District No. 16
County of Nez Perce Primary Registration District No. 2074
City of Gifford (No. , St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME James English

If death occurred in a hospital, institution or camp give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX Male 4. COLOR OR RACE white 5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.)

6. DATE OF BIRTH March 25th 1913
(Month) (Day) (Year)

7. AGE 60 yrs. IF LESS than 1 day how many hrs. or min?

8. OCCUPATION (a) Trade, profession or particular kind of work Farmer (b) General nature of industry business or establishment in which employed (or employer)

9. BIRTHPLACE (State or Country) New York

10. NAME OF FATHER unknown

11. BIRTHPLACE OF FATHER unknown (State or Country)

12. MAIDEN NAME OF MOTHER unknown

13. BIRTHPLACE OF MOTHER unknown (State or Country)

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE (Informant) Pat N. Nagent (Address)

15. Filed 3-27-1913 1913 E.E. Watts Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH March 25th 1913
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from 191 to 191 that I last saw h alive on 191 and that death occurred on the date stated above, at M.

The CAUSE OF DEATH* was as follows:
Gunshot wound ,
Suicide.

(Duration) yrs. mos. ds.
Contributory (Secondary)
(Duration) yrs. mos. ds.
(Signed) E.E. Watts M. D.
3-27 1913 (Address) Gifford

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place In the
of death yrs. mos. ds. State yrs. mos. ds.
Where was disease contracted,
If not at place of death?
Former or
usual residence.

19. PLACE OF BURIAL OR REMOVAL DATE OF BURIAL
Gifford Ida 3-27 1913

20. UNDERTAKER ADDRESS
W.E. Stoddard Gifford

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Form V. S. No. 5. 12½ M. 7-24-11

CERTIFICATE OF DEATH

1. PLACE OF DEATH.

County of Nez PerceCity of LewistonRegistration District No. 16Primary Registration District No. 1009

(No. _____, _____ St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

Frank P. DuncanState of Idaho
BOARD OF HEALTH
Bureau of Vital StatisticsFile No. 4404Registered No. 36

If death occurred in a hospital, institution or camp give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX

Male

4. COLOR OR RACE

White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED.

Single
(Write the word.)

6. DATE OF BIRTH

unknown

(Month)

(Day)

(Year)

7. AGE

48 yrs.

— mos.

— ds.

IF LESS than 1 day
how many _____ hrs. or
_____ min?

8. OCCUPATION

(a) Trade, profession or particular kind of work.

Hotel Keeper

(b) General nature of industry business or establishment in which employed (or employer)

9. BIRTHPLACE

(State or Country)

unknown

10. NAME OF FATHER

unknown

11. BIRTHPLACE OF FATHER

(State or Country)

unknown

12. MAIDEN NAME OF MOTHER

unknown

13. BIRTHPLACE OF MOTHER

(State or Country)

unknown

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

E. L. White

(Address)

Lewiston

15.

Filed

Apr 101913J. J. Perkins

Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH

March261913

(Month)

(Day)

(Year)

17. I HEREBY CERTIFY, That I attended deceased from

Feb 261913to March 261913that I last saw him alive on March 261913and that death occurred on the date stated above, at 7:30 P. M.

The CAUSE OF DEATH* was as follows:

Uræmia.

(Duration)

yrs.

2

mos.

ds.

Contributory

(Secondary)

Chronic Parenchymatous
nephritis.

(Duration)

yrs.

6

mos.

ds.

(Signed)

March 311913

(Address)

Edgar H. White, M. D.
Lewiston, Ida.

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place

In the

of death

yrs.

mos.

ds.

State

yrs.

mos.

ds.

Where was disease contracted,

If not at place of death?

Former or

usual residence.

19. PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

LewistonApr 41913

20. UNDERTAKER

ADDRESS

O. J. VassarLewiston

N. B.—Every item of information should be carefully supplied. Age should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Form V. S. No. 5. 12½M.7-24-11

1. PLACE OF DEATH
County of McCone
City of Differs

Registration District No. 16
Primary Registration District No. 2074
(No. _____, St. _____)

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics
File No. 4405
Registered No. 37

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Lydia Jane Zigler

If death occurred in a hospital, institution or camp give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX F 4. COLOR OR RACE W. 5. SINGLE, MARRIED, WIDOWED OR DIVORCED. Widow
(Write the word.)

6. DATE OF BIRTH Oct. 25 1887
(Month) (Day) (Year)

7. AGE 75 yrs. 5 mos. 1 ds.
IF LESS than 1 day
how many hrs. or min?

8. OCCUPATION
(a) Trade, profession or particular kind of work..... Housewife
(b) General nature of industry business or establishment in which employed (or employer)

9. BIRTHPLACE
(State or Country) New York

10. NAME OF FATHER David W. Davis

11. BIRTHPLACE OF FATHER
(State or Country) Wales

12. MAIDEN NAME OF MOTHER Sally Ann Graves

13. BIRTHPLACE OF MOTHER
(State or Country) New York

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Bess Zigler
(Address) Differs, Ida.

15. Filed 8-26 1913 E. S. Watts
Apr. 10-1913 Differs Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH March 26 1913
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from March 19 1913, to March 26 1913, that I last saw h. alive on March 24, 1913 and that death occurred on the date stated above, at 12 M. The CAUSE OF DEATH* was as follows:

Inflammation of Bowels

(Duration) yrs. mos. 10 ds.
Contributory (Secondary) Faecal Impaction & Gen Bowel
(Duration) yrs. mos. 7 ds.
(Signed) A. J. Douglas M. D.
3/26 1913 (Address) Differs, Ida.

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place In the
of death..... yrs. mos. ds. State..... yrs. mos. ds.
Where was disease contracted,
If not at place of death?.....
Former or
usual residence.....

19. PLACE OF BURIAL OR REMOVAL Differs Ida DATE OF BURIAL 3/28 1913
20. UNDERTAKER Not known ADDRESS

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Form V. S. No. 5. 12½ M. 7-24-11

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics
File No. 4405
Registered No. 38

1. PLACE OF DEATH. Registration District No. 16
County of Blaine Primary Registration District No. 1009
City of Idaho (No. _____, _____ St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

Alfred B. Miller

If death occurred in a hospital, institution or camp give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX male 4. COLOR OR RACE White 5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.)

6. DATE OF BIRTH June 4 1910
(Month) (Day) (Year)

7. AGE 2 yrs. 9 mos. 23 ds. IF LESS than 1 day how many _____ hrs. or _____ min?

8. OCCUPATION

- (a) Trade, profession or particular kind of work _____
(b) General nature of industry business or establishment in which employed (or employer) _____

9. BIRTHPLACE

(State or Country) Pay Pige Idaho

10. NAME OF FATHER

Charles Miller

11. BIRTHPLACE OF FATHER

(State or Country) Indiana

12. MAIDEN NAME OF MOTHER

Clara Zernstein

13. BIRTHPLACE OF MOTHER

(State or Country) Seattle Wash

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Charles Miller

(Address) Idaho

15.

Filed Apr. 10 1918

L. J. Perkins
Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH

March 29 1913
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from _____ 191____, to _____ 191____

that I last saw h _____ alive on _____ 191____
and that death occurred on the date stated above, at _____ M.

The CAUSE OF DEATH* was as follows:

Died before I arrived. Had not been sick. From best information had one contribution and died in less than 30 minutes.

Contributory (Secondary) Unknown

(Duration) _____ yrs. _____ mos. _____ ds.

(Signed) J. B. Cross M. D.

19 (Address) Lewiston Idaho

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place _____ In the _____
of death _____ yrs. _____ mos. _____ ds. State _____ yrs. _____ mos. _____ ds.

Where was disease contracted, _____

If not at place of death? _____

Former or usual residence _____

19. PLACE OF BURIAL OR REMOVAL DATE OF BURIAL

Lewiston Mar 31 1913

20. UNDERTAKER ADDRESS

L. J. Vassar Lewiston

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Form V, S. No. 5. 12½M.7-24-11

ATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH.
County of Myer
City of Butte

Registration District No. 16
Primary Registration District No. 1509
(No. 0310, 3rd St.)

File No. 4407
Registered No. 99

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

Grant Cole

If death occurred in a hospital, institution or camp give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX M 4. COLOR OR RACE W 5. SINGLE, MARRIED, WIDOWED OR DIVORCED. Married
(Write the word.)

6. DATE OF BIRTH Oct 22 1912
(Month) (Day) (Year)

7. AGE 40 yrs. 5 mos. 8 ds. IF LESS than 1 day how many hrs. or min?

8. OCCUPATION

(a) Trade, profession or particular kind of work Fireman
(b) General nature of industry business or establishment in which employed (or employer)

9. BIRTHPLACE

(State or Country)

Iowa

10. NAME OF FATHER

J. L. Cole

11. BIRTHPLACE OF FATHER

(State or Country)

Iowa

12. MAIDEN NAME OF MOTHER

Lucy Davidson

13. BIRTHPLACE OF MOTHER

(State or Country)

N. Y.

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) C. Sams
(Address) Butte

15. Filed Apr. 10 1913 190 Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH

March 30 1913
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from Jan 1913, to March 30 1913

that I last saw him alive on March 30 1913

and that death occurred on the date stated above, at 10:15 A.M.

The CAUSE OF DEATH* was as follows:

Pulmonary Tuberculosis

(Duration) yrs. 7 mos. ds.

Contributory
(Secondary)

(Duration) yrs. mos. ds.

(Signed) C. Sams M. D.

3/31 1913 (Address) Butte

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place In the
of death yrs. mos. ds. State yrs. mos. ds.

Where was disease contracted,
If not at place of death?
Former or
usual residence.

19. PLACE OF BURIAL OR REMOVAL DATE OF BURIAL

Leaverton Ida Apr 1 1913

20. UNDERTAKER ADDRESS

C. J. Vassar Leaverton

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Form V. S. No. 5. 12½M.7-24-11

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics
File No. 140
Registered No. 17

1. PLACE OF DEATH. Registration District No. 26
County of Washington Primary Registration District No. 2114
City of Cambodge (No. _____, _____ St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Edward Blake Paymer

If death occurred in a hospital, institution or camp give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX Male 4. COLOR OR RACE Caucasian 5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.)

6. DATE OF BIRTH Sept 12 1911
(Month) (Day) (Year)

7. AGE 1 yrs. 5 mos. 17 ds. IF LESS than 1 day how many 5 hrs. or 5 min?

8. OCCUPATION

(a) Trade, profession or particular kind of work Infant
(b) General nature of industry business or establishment in which employed (or employer)

9. BIRTHPLACE

(State or Country) Cambodge Washington Co Ida.

10. NAME OF FATHER H B Paymer

11. BIRTHPLACE OF FATHER Tennessee
(State or Country)

12. MAIDEN NAME OF MOTHER

May Edwards

13. BIRTHPLACE OF MOTHER Tennessee
(State or Country)

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) H B Paymer
(Address) Cambodge Ida.

15. Filed Mar 4 1913 C O Schmitz
Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH Mar 3 1913
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from Feb 24 1913, to Mar 3 1913
that I last saw him alive on Mar 2 1913
and that death occurred on the date stated above, at 1 P.M.

The CAUSE OF DEATH* was as follows:

Pneumonia

(Duration) _____ yrs. _____ mos. 12 ds.
Contributory (Secondary) Pneumonia

(Duration) _____ yrs. _____ mos. 12 ds.
(Signed) C O Schmitz M. D.
Mar 3 1913 (Address) Cambodge Ida

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place _____ In the _____
of death _____ yrs. _____ mos. _____ ds. State _____ yrs. _____ mos. _____ ds.
Where was disease contracted, _____
If not at place of death? _____
Former or _____
usual residence _____

19. PLACE OF BURIAL OR REMOVAL DATE OF BURIAL

Cambodge Ida. Mar 4 1913
20. UNDERTAKER J A Haddon ADDRESS Cambodge Ida

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Form V. S. No. 5. 12½ M. 7-24-11

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics
File No. 4409
Registered No. 18

1. PLACE OF DEATH. Registration District No. 26
County of Washington Primary Registration District No. 2113
City of Medvale (No. _____, _____ St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Leo Walker Titworth

If death occurred in a hospital, institution or camp give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX 4. COLOR OR RACE 5. SINGLE, MARRIED, WIDOWED OR DIVORCED.

Male White Married
(Write the word.)

6. DATE OF BIRTH March 15, 1882
(Month) (Day) (Year)

7. AGE 60 yrs. 11 mos. 23 ds. IF LESS than 1 day how many _____ hrs. or _____ min?

8. OCCUPATION
(a) Trade, profession or particular kind of work. Rancher
(b) General nature of industry business or establishment in which employed (or employer)

9. BIRTHPLACE
(State or Country) Arkansas

10. NAME OF FATHER

11. BIRTHPLACE OF FATHER
(State or Country)

12. MAIDEN NAME OF MOTHER

13. BIRTHPLACE OF MOTHER
(State or Country)

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Neal Titworth
(Address) Medvale, Ida

15. Filed Mar 8, 1913 F. Aschmiff
Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH Mar 8, 1913
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from Mar 8, 1913, to Mar 1913
that I last saw him alive on Mar 8, 1913
and that death occurred on the date stated above, at 3 A.M.
The CAUSE OF DEATH* was as follows:

Gastritis acute

(Duration) _____ yrs. _____ mos. 3 ds.
Contributory inflammation of bowels
(Secondary)

(Duration) _____ yrs. _____ mos. one ds.
(Signed) F. Aschmiff M. D.
Mar 8, 1913 (Address) Medvale

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place In the
of death _____ yrs. _____ mos. _____ ds. State _____ yrs. _____ mos. _____ ds.
Where was disease contracted,
If not at place of death?
Former or
usual residence.

19. PLACE OF BURIAL OR REMOVAL DATE OF BURIAL
Medvale, Idaho Mar 10, 1913

20. UNDERTAKER ADDRESS
L. G. Ray Medvale

WRITE PLAINLY, WITH UNFADEING INK—THIS IS A PERMANENT RECORD.
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Form V. S. No. 5. 12½ M. 7-24-11

CERTIFICATE OF DEATH

1. PLACE OF DEATH. Registration District No. _____
County of Washington Primary Registration District No. 2113
City of Medvale (No. _____, St. _____)

BOARD OF HEALTH
Bureau of Vital Statistics
File No. 4411
Registered No. 19

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

Oliver Calvin

If death occurred in a hospital, institution or camp give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX 4. COLOR OR RACE 5. SINGLE, MARRIED, WIDOWED OR DIVORCED.

Female White Single
(Write the word.)

6. DATE OF BIRTH

Nov 15 1885
(Month) (Day) (Year)

7. AGE

28 yrs. 0 mos. 0 ds. IF LESS than 1 day
how many _____ hrs. or
_____ min?

8. OCCUPATION

(a) Trade, profession or particular kind of work.

Not employed

(b) General nature of industry business or establishment in which employed (or employer)

9. BIRTHPLACE

(State or Country)

Ill

10. NAME OF FATHER

John Calvin

11. BIRTHPLACE OF FATHER

(State or Country)

Ill

12. MAIDEN NAME OF MOTHER

Matilda Wheeler

13. BIRTHPLACE OF MOTHER

(State or Country)

Ill

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

Paul Williams

(Address)

Medvale

15.

Filed April 1 - 1913

T. Schmeig
Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH

Mar 10 1913
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from
Mar 6 1913, to Mar 10 1913

that I last saw him alive on Mar 10 1913
and that death occurred on the date stated above, at 11 P.M.

The CAUSE OF DEATH* was as follows:

Septic infection caused
by criminal abortion

(Duration) _____ yrs. _____ mos. 8 ds.

Contributory (Secondary)

Leucitis

(Duration) _____ yrs. _____ mos. 2 ds.

(Signed)

F. Schmeig

M. D.

April 1 1913 (Address) Medvale

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place _____ In the _____
of death _____ yrs. _____ mos. _____ ds. State _____ yrs. _____ mos. _____ ds.

Where was disease contracted,

If not at place of death?

Former or

usual residence.

19. PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

Paul Ill1913

20. UNDERTAKER

L. G. Ray

ADDRESS

Medvale, Ill

Form V. S. No. 5 20M.1-16-12

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH.

Registration District No. 26County of WashingtonPrimary Registration District No. 1010City of Wenatchee(No. East Galloway Ave St.)File No. 4411Registered No. 20

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

Oliver H. Gearhart

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX

4. COLOR OR RACE

5. SINGLE, MARRIED, WIDOWED OR DIVORCED.

M.W.Single
(Write the word.)

6. DATE OF BIRTH

3 - 10 - 1913
(Month) (Day) (Year)

7. AGE

— yrs. 3 mos. 3 ds.IF LESS than 1 day
how many hrs. or
..... mins.

8. OCCUPATION

(a) Trade, profession or particular kind of work

(b) General nature of industry business, or establishment in which employed (or employer)

none

9. BIRTHPLACE

(State or Country)

Wenatchee Idaho

10. NAME OF FATHER

Earnest J. Gearhart

11. BIRTHPLACE OF FATHER

(State or Country)

Ill

12. MAIDEN NAME OF MOTHER

Clara E. Ford

13. BIRTHPLACE OF MOTHER

(State or Country)

Ohio

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

Re. J. Gearhart

(Address)

Wenatchee, Idaho

15.

Filed

March 121913

Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH

March - 13 - 1913
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from

March 10 1913, to March 13 1913,that I last saw him alive on March 13 1913,and that death occurred on the date stated above, at h. M.

The CAUSE OF DEATH* was as follows:

Acute Influenza

(Duration) yrs. mos. ds.

Contributory
(Secondary)(Duration) yrs. mos. 3 ds.

(Signed)

James A. Young M. D.
3/13 1913 (Address) Wenatchee Idaho

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death yrs. mos. days. In the State yrs. mos. days.

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

Wenatchee Idaho March 14 - 1913

20. UNDERTAKER

ADDRESS

C. G. Cordelle Wenatchee Idaho

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Form V. S. No. 5. 12½M. 7-24-11

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics
File No. 4412

1. PLACE OF DEATH.
County of Washington
City of Mesa

Registration District No. East Weiser 26
Primary Registration District No. East Weiser 2112
(No. _____, _____ St.)

Registered No. 21

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME David Frank Carter

If death occurred in a hospital, institution or camp give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX male 4. COLOR OR RACE White 5. SINGLE, MARRIED, WIDOWED OR DIVORCED. married
(Write the word.)

6. DATE OF BIRTH Oct. 5 1874
(Month) (Day) (Year)

7. AGE 38 yrs. 5 mos. 14 ds. IF LESS than 1 day
how many _____ hrs. or _____ min?

8. OCCUPATION
(a) Trade, profession or particular kind of work. Farmer
(b) General nature of industry business or establishment in which employed (or employer) Ranch

9. BIRTHPLACE
(State or Country) Michigan

10. NAME OF FATHER Nathaniel T Carter

11. BIRTHPLACE OF FATHER
(State or Country) New York

12. MAIDEN NAME OF MOTHER Stedman

13. BIRTHPLACE OF MOTHER
(State or Country) Not known

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) H. W. Cooley
(Address) Weiser Ida.

15. Filed March 20th 1913 D. R. Havelthorn
Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH March 19th 1913
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from Oct 1911, to March 19th 1913
that I last saw him alive on March 17th 1913
and that death occurred on the date stated above, at 8 P. M.

The CAUSE OF DEATH* was as follows: *

Pulmonary Tuberculosis

(Duration) Several yrs. _____ mos. _____ ds.

Contributory
(Secondary) _____

(Duration) _____ yrs. _____ mos. _____ ds.

(Signed) D. R. Havelthorn M. D.
3/20/ 1913 (Address) Weiser Ida.

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place _____ In the _____
of death _____ yrs. _____ mos. _____ ds. State _____ yrs. _____ mos. _____ ds.
Where was disease contracted,
If not at place of death? _____
Former or
usual residence. _____

19. PLACE OF BURIAL OR REMOVAL DATE OF BURIAL

Weiser Mar 21 1913

20. UNDERTAKER ADDRESS

L. G. Northman Weiser

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Form V. S. No. 5. 12½ M. 7-24-11

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH. _____
County of Washington Registration District No. 26
City of Wenatchee Primary Registration District No. 1010
(No. _____, St.)

File No. 4413
Registered No. 22

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

William Gracopp

If death occurred in a hospital, institution or camp give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX Male 4. COLOR OR RACE Wh 5. SINGLE, MARRIED, WIDOWED OR DIVORCED. _____
(Write the word.)

6. DATE OF BIRTH Mar 11 1912
(Month) (Day) (Year)

7. AGE 1 yrs. 12 mos. 12 ds. IF LESS than 1 day
how many _____ hrs. or _____ min?

8. OCCUPATION
(a) Trade, profession or particular kind of work. _____
(b) General nature of industry business or establishment in which employed (or employer) _____

9. BIRTHPLACE Weiser
(State or Country)

10. NAME OF FATHER Michael F. Gracopp

11. BIRTHPLACE OF FATHER N.Y.
(State or Country)

12. MAIDEN NAME OF MOTHER Maudie Harc

13. BIRTHPLACE OF MOTHER N.Y.
(State or Country)

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Michael F. Gracopp
(Address) Weiser

15. Filed March 25 1913 M.R. Krumholz
Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH March 23 1913
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from March 21 1913, to March 22 1913
that I last saw him alive on March 22 1913
and that death occurred on the date stated above, at 11 A. M.

The CAUSE OF DEATH* was as follows:

Lobar Pneumonia

(Duration) _____ yrs. _____ mos. 3 ds.

Contributory (Secondary) _____

(Duration) _____ yrs. _____ mos. _____ ds.
(Signed) Carroll M. D.
3-24-13 (Address) Weiser Ida.

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place _____ In the _____
of death _____ yrs. _____ mos. _____ ds. State _____ yrs. _____ mos. _____ ds.
Where was disease contracted, _____
If not at place of death? _____
Former or _____
usual residence _____

19. PLACE OF BURIAL OR REMOVAL L.B. Northman DATE OF BURIAL March 1913

20. UNDERTAKER L.B. Northman ADDRESS Weiser Ida

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Form V. S. No. 5 20M.1-16-12

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH.

Registration District No. 26

County of Wash.

Primary Registration District No. 1010

City of Waiser.

(No. East Liberty St.)

File No. 1414

Registered No. 23

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

Mrs. Caroline Wideman

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX

Female

4. COLOR OR RACE

White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED.

Widow
(Write the word.)

6. DATE OF BIRTH

— — 1837
(Month) (Day) (Year)

7. AGE

76 yrs. — mos. — ds.

IF LESS than 1 day
how many hrs. or
mins.

8. OCCUPATION

(a) Trade, profession or particular kind of work

Housekeeper

(b) General nature of industry business, or establishment in which employed (or employer)

9. BIRTHPLACE

(State or Country)

State of Missouri

10. NAME OF FATHER

Stuthern

11. BIRTHPLACE OF FATHER

(State or Country)

Unknown

12. MAIDEN NAME OF MOTHER

—

13. BIRTHPLACE OF MOTHER

(State or Country)

—

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

C. C. Manly

(Address)

Waiser Idaho

15.

Filed

March 20

1913

D. B. Haworth

Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH

March - 20 - 1913
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from 3-15-13 1913, to 3-20 1913,

that I last saw her alive on 3-19 1913,

and that death occurred on the date stated above, at 7 a.m.

The CAUSE OF DEATH* was as follows:

Pneumonia

(Duration) 9 yrs. — mos. — ds.

Contributory (Secondary)

Exhaustion

(Duration) X yrs. — mos. — ds.

(Signed)

Ernest O. Finney, M. D.

3/20 1913 (Address) Waiser Idaho

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death — yrs. — mos. — days. In the State — yrs. — mos. — days.

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

Waiser 3/21 1913

20. UNDERTAKER

ADDRESS

Waiser Waiser Idaho

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Form V. S. No. 5. 12½M. 7-24-11

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics
File No. 4415
Registered No. 24

1. PLACE OF DEATH. Registration District No. 26
County of Washington Primary Registration District No. 2113
City of Medvale (No. _____, _____ St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME William Harrison Towell

If death occurred in a hospital, institution or camp give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX Male 4. COLOR OR RACE White 5. SINGLE, MARRIED, WIDOWED OR DIVORCED. Married
(Write the word.)

6. DATE OF BIRTH January 28 1863
(Month) (Day) (Year)

7. AGE 50 yrs. 1 mos. 25 ds. IF LESS than 1 day how many _____ hrs. or _____ min?

8. OCCUPATION
(a) Trade, profession or particular kind of work. Rancher
(b) General nature of industry business or establishment in which employed (or employer)

9. BIRTHPLACE
(State or Country) Iowa

10. NAME OF FATHER Alexander Towell

11. BIRTHPLACE OF FATHER
(State or Country) Indiana

12. MAIDEN NAME OF MOTHER Emily Fletcher

13. BIRTHPLACE OF MOTHER
(State or Country) Miss.

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Otho Towell
(Address) Medvale

15. Filed Mar 24 1913 F. A. Schmitz
Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH Mar 24 1913
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from Sept 9 1911 to Mar 24 1913
that I last saw him alive on Mar 20 1913
and that death occurred on the date stated above, at 5 A.M.

The CAUSE OF DEATH* was as follows:
Diabetes mellitus

..... (Duration) 2 yrs. mos. ds.
Contributory Branitis
(Secondary)

..... (Duration) 2 yrs. mos. ds.
(Signed) F. A. Schmitz M. D.
Mar 24 1913 (Address) Medvale

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place In the
of death yrs. mos. ds. State yrs. mos. ds.
Where was disease contracted,
If not at place of death?
Former or
usual residence.

19. PLACE OF BURIAL OR REMOVAL DATE OF BURIAL
Medvale Mar 24 1913

20. UNDERTAKER ADDRESS
L. G. Kay Medvale

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Form V. S. No. 5. 12½ M. 7-24-11

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH. Registration District No.
County of Washington Primary Registration District No. 2114
City of Cambridge (No., St.)

File No. 4415
Registered No. 25

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

Mary Jane Norton

If death occurred in a hospital, institution or camp give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX Female 4. COLOR OR RACE W. 5. SINGLE, MARRIED, WIDOWED OR DIVORCED. married
(Write the word.)

6. DATE OF BIRTH October 30 1866
(Month) (Day) (Year)

7. AGE 46 yrs. 5 mos. 1 ds. IF LESS than 1 day
how many hrs. or min?

8. OCCUPATION

(a) Trade, profession or particular kind of work. Housewife
(b) General nature of industry business or establishment in which employed (or employer)

9. BIRTHPLACE

(State or Country) Illinois

10. NAME OF FATHER Raphael M. Smith

11. BIRTHPLACE OF FATHER Indiana
(State or Country)

12. MAIDEN NAME OF MOTHER Thompson

13. BIRTHPLACE OF MOTHER Kentucky
(State or Country)

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) John Norton
(Address) Cambridge Idaho

15.

Filed March 31 1913 N. R. Beaulieu
Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH March 31 1913
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from May 1910, to Mar 29 1913
that I last saw her alive on Mar 30 1913

and that death occurred on the date stated above, at 12 M.

The CAUSE OF DEATH* was as follows:

Cancer of Stomach

(Duration) 2 yrs. 9 mos. 29 ds.

Contributory
(Secondary)

(Duration) 2 yrs. 9 mos. 29 ds.

(Signed) C. V. Schuyler M. D.

Mar 31 1913 (Address) Cambridge Idaho

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; (2) whether ACCIDENTAL, SUICIDAL OR HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place In the
of death yrs. mos. ds. State yrs. mos. ds.

Where was disease contracted,

If not at place of death?

Former or
usual residence.

19. PLACE OF BURIAL OR REMOVAL DATE OF BURIAL

Cambridge Idaho April 5 1913

20. UNDERTAKER

Jas Heidebaum

ADDRESS

Cambridge

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Form, V. S. No. 5. 12½ M. 7-24-11

CERTIFICATE OF DEATH

PLACE OF DEATH
County of Clearwater
City of Near Peck

Registration District No. 16
Primary Registration District No. 2075
(No. _____ St.)

BOARD OF HEALTH
Bureau of Vital Statistics
File No. 4417
Registered No. 15

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

Chris Belete

If death occurred in a hospital, institution or camp give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX M 4. COLOR OR RACE W 5. SINGLE, MARRIED, WIDOWED OR DIVORCED. Single
(Write the word.)

6. DATE OF BIRTH Nov 7 1879
(Month) (Day) (Year)

7. AGE 13 yrs. 2 mos. 14 ds. IF LESS than 1 day
how many _____ hrs. or _____ min?

8. OCCUPATION Farmer
(a) Trade, profession or particular kind of work.
(b) General nature of industry business or establishment in which employed (or employer)

9. BIRTHPLACE Germany
(State or Country)

10. NAME OF FATHER Dont know

11. BIRTHPLACE OF FATHER Germany
(State or Country)

12. MAIDEN NAME OF MOTHER Dont know

13. BIRTHPLACE OF MOTHER Germany
(State or Country)

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Fred Dieter
(Address) Gilbert Ida

15. Filed April 8 1913 J. M. Lyle
Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH Jan 21 1913
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from Jan. 19 1913, to Jan. 19 1913
that I last saw him alive on Jan 19 1913
and that death occurred on the date stated above, at _____ M.

The CAUSE OF DEATH* was as follows:

Pneumonia

_____ (Duration) _____ yrs. _____ mos. 3 ds.

Contributory (Secondary) apoplexy

_____ (Duration) _____ yrs. _____ mos. 5 ds.

(Signed) J. M. Lyle M. D.
Jan. 24 1913 (Address) Peck

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place _____ In the _____
of death _____ yrs. _____ mos. _____ ds. State _____ yrs. _____ mos. _____ ds.
Where was disease contracted,
If not at place of death?
Former or
usual residence.

19. PLACE OF BURIAL OR REMOVAL DATE OF BURIAL

Gilbert Ida Jan 23 1913

20. UNDERTAKER ADDRESS

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Form V. S. No. 5 20M.1-16-12

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH. Registration District No. 17
County of Clearwater Primary Registration District No. 2078
City of Prosser (No. _____ St.)
If death occurs away from usual residence, give facts called for under special information.

File No. 4417
Registered No. 16

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX Male 4. COLOR OR RACE White 5. SINGLE, MARRIED, WIDOWED OR DIVORCED. Married
(Write the word.)

6. DATE OF BIRTH July 11 1861
(Month) (Day) (Year)

7. AGE 57 yrs. 8 mos. 20 ds.
IF LESS than 1 day
how many _____ hrs. or
_____ mins.

8. OCCUPATION
(a) Trade, profession or particular kind of work Farmer
(b) General nature of industry business, or establishment in which employed (or employer)

9. BIRTHPLACE Mo
(State or Country)

10. NAME OF FATHER James Pratt

11. BIRTHPLACE OF FATHER N. Y.
(State or Country)

12. MAIDEN NAME OF MOTHER ?

13. BIRTHPLACE OF MOTHER Ky
(State or Country)

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Mrs. Jessie Pratt

(Address) Prosser, Ida

15. Apr 1 1913

Filed Apr 1 1913 J. M. Gair
Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH March 1 1913
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from May 1 1899 to Mar 1 1913,
that I last saw him alive on Mar 1 1913,
and that death occurred on the date stated above, at 10 P. M.

The CAUSE OF DEATH* was as follows:

Valvular Heart Disease

(Duration) 3 yrs. 9 mos. 7 ds.

Contributory Insanity
(Secondary)

(Duration) 3 yrs. 9 mos. 7 ds.

(Signed) J. M. Gair M. D.

Apr 1 1913 (Address) Prosser, Ida

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death. _____ yrs. _____ mos. _____ days. In the State. _____ yrs. _____ mos. _____ days.

Where was disease contracted if not at place of death? _____

Former or usual residence. _____

19. PLACE OF BURIAL OR REMOVAL DATE OF BURIAL

Silbert, Ida Mar 3 1913

20. UNDERTAKER ADDRESS

J. S. Hogue Prosser, Ida

MARGIN RESERVED FOR BINDING
WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Form V. S. No. 5 20M.1-16-12

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH.

Registration District No. 17

County of Charwater

Primary Registration District No. 3078

City of Crofton

(No. _____ St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

Dorothy Marie Sargent

Registered No. 17

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX

4. COLOR OR RACE

5. SINGLE, MARRIED, WIDOWED OR DIVORCED.

Female White

Single

6. DATE OF BIRTH

Nov 29 1910

March 21 1913
(Month) (Day) (Year)

7. AGE

2 yrs. 3 mos. 21 ds.

IF LESS than 1 day
how many _____ hrs. or
_____ mins.?

8. OCCUPATION

(a) Trade, profession or particular kind of work

(b) General nature of industry business, or establishment in which employed (or employer)

9. BIRTHPLACE

(State or Country)

Spokey, Wash.

10. NAME OF FATHER

Elder J. Sargent

11. BIRTHPLACE OF FATHER

(State or Country)

Norway

12. MAIDEN NAME OF MOTHER

Louisa Taylor

13. BIRTHPLACE OF MOTHER

(State or Country)

Canada

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

E. J. Sargent

(Address)

Crofton, Ida

15.

Filed

Apr 10 1913

J. M. Sargent
Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH

March 21 1913
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from

March 1 1913 to March 21 1913

that I last saw her alive on March 9 1913

and that death occurred on the date stated above, at 10 A.M.

The CAUSE OF DEATH* was as follows:

Tubercular Meningitis

(Duration) _____ yrs. 2 mos. _____ ds.

Contributory
(Secondary)

(Duration) _____ yrs. _____ mos. _____ ds.

(Signed) Earl W. Forswell M. D.

19. (Address) Crofton Ida

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death _____ yrs. _____ mos. _____ days. In the State _____ yrs. _____ mos. _____ days.

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

Crofton

Mar 22 1913

20. UNDERTAKER

ADDRESS

John Hogue

Crofton

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Form V. S. No. 5. 12½ M. 7-24-11

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics
File No. 4421
Registered No. 18

1. PLACE OF DEATH. Registration District No. 17
County of Cassia Primary Registration District No. 4078
City of Drifino (No. _____, St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

Elizabeth Adamson

If death occurred in a hospital, institution or camp give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX Female 4. COLOR OR RACE White 5. SINGLE, MARRIED, WIDOWED OR DIVORCED. Widowed
(Write the word.)

6. DATE OF BIRTH May 10 1889
(Month) (Day) (Year)

7. AGE 73 yrs. 10 mos. 21 ds. IF LESS than 1 day
how many _____ hrs. or _____ min?

8. OCCUPATION

(a) Trade, profession or particular kind of work None
(b) General nature of industry business or establishment in which employed (or employer)

9. BIRTHPLACE

(State or Country) Indiana

10. NAME OF FATHER

John Johnson

11. BIRTHPLACE OF FATHER

(State or Country) Ky.

12. MAIDEN NAME OF MOTHER

Dorothy Brainerd

13. BIRTHPLACE OF MOTHER

(State or Country) Ind.

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Mrs. Minnie C. Cio

(Address) Drifino, Ida

15.

Filed April 1 1913

M. J. Fairly
Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH

March 31 1913
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from March 1 1913 to March 31 1913

that I last saw him alive on March 30 1913 and that death occurred on the date stated above, at 10 M.

The CAUSE OF DEATH* was as follows:

Chronic Gout

(Duration) 4 yrs. _____ mos. _____ ds.

Contributory (Secondary) Old age

(Duration) 5 yrs. _____ mos. _____ ds.

(Signed) J. M. Fairly M. D.

Apr 1 1913 (Address)

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place _____ In the _____
of death _____ yrs. _____ mos. _____ ds. State _____ yrs. _____ mos. _____ ds.

Where was disease contracted,

If not at place of death?

Former or

usual residence.

19. PLACE OF BURIAL OR REMOVAL DATE OF BURIAL

Drifino, Idaho Apr 2 1913

20. UNDERTAKER

ADDRESS

J. H. Hogue Drifino, Ida
M. E. Stoddard

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Form V. S. No. 5 20M.1-16-12

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH.

Registration District No. 17

County of Blaine

Primary Registration District No. 2078

City of Russell

(No. _____, _____ St.)

File No. 1421

Registered No. 19

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Unnamed

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX

4. COLOR OR RACE

5. SINGLE, MARRIED, WIDOWED OR DIVORCED.

Female White

Single
(Write the word.)

6. DATE OF BIRTH

March 31 1913
(Month) (Day) (Year)

7. AGE

_____ yrs. _____ mos. _____ ds.

IF LESS than 1 day
how many _____ hrs. or
_____ mins.

8. OCCUPATION

(a) Trade, profession or particular kind of work
(b) General nature of industry business, or establishment in which employed (or employer)

none

9. BIRTHPLACE

(State or Country)

Idaho

10. NAME OF FATHER

Joe P. Johnson

11. BIRTHPLACE OF FATHER

(State or Country)

Idaho

12. MAIDEN NAME OF MOTHER

Ida Montgomery

13. BIRTHPLACE OF MOTHER

(State or Country)

Idaho

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

(Address)

J. P. Johnson
Russell

15.

Filed

March 31 1913

Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH

March 31 1913
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from March 31 1913, to March 31 1913.

that I last saw him alive on March 31 1913.

and that death occurred on the date stated above, at 6 P.M.

The CAUSE OF DEATH* was as follows:

Pruritus

(Duration) _____ yrs. _____ mos. _____ ds.

Contributory (Secondary)

Pruritus

(Duration) _____ yrs. _____ mos. _____ ds.

(Signed)

March 31 1913 (Address) Idaho

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death _____ yrs. _____ mos. _____ days. In the State _____ yrs. _____ mos. _____ days.

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

Russell, Idaho

March 31 1913

20. UNDERTAKER

ADDRESS

none

WRITE PLAINLY, WITH UNFADE INK—THIS IS A PERMANENT RECORD. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Form V. S. No. 5. 10M. 6-20-11.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics
File No. 4422
Registered No. 10

1. PLACE OF DEATH.

Registration District No. 20County of EmeryPrimary Registration District No. 2020City of Mountain Home

(No. _____)

St.)

Registered No. 10

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

Walter Milton Robert Lewis

If death occurred in a hospital, institution or camp give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX

Male

4. COLOR OR RACE 5. SINGLE, MARRIED, WIDOWED OR DIVORCED.

White

(Write the word.)

6. DATE OF BIRTH

Apr 16 1911
(Month) (Day) (Year)

7. AGE

1 yrs. 10 mos. 25 ds.

IF LESS than 1 day
how many hrs. or
..... min.?

8. OCCUPATION

- (a) Trade, profession or particular kind of work
(b) General nature of industry business or establishment in which employed (or employer)

9. BIRTHPLACE

(State or Country)

Mountain Home Idaho

10. NAME OF FATHER

Thomas M Lewis

11. BIRTHPLACE OF FATHER

(State or Country)

Canada Ontario

12. MAIDEN NAME OF MOTHER

Sadie E Emis

13. BIRTHPLACE OF MOTHER

(State or Country)

Minnesota

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

Thos. M. Davis

(Address)

Mt. Home

15.

Filed March 10th 1913

Rev. Mather
Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

Mich 10 1913
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from

Mich 6 1913 to Mich 10 1913

that I last saw him alive on Mich 10 1913,
and that death occurred on the date stated above, at 2:30 A.M.

The CAUSE OF DEATH* was as follows:

Bronchial Pneumonia

(Duration) yrs. mos. ds.

Contributory
(Secondary)

(Duration) yrs. mos. 8 ds.

(Signed) W. L. Fragin M. D.

3-10-1913 (Address) Inter Home

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death yrs. mos. ds. In the State of yrs. mos. ds.

Where was disease contracted.

If not at place of death?

Former or

usual residence

19. PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

Mt. HomeMarch 11th 1913

20. UNDERTAKER

ADDRESS

McConen Mt. Home

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Form V. S. No. 5. 10M. 6-20-11.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics
File No. 4423
Registered No. 12

1. PLACE OF DEATH. Registration District No. 20
County of Elmore Primary Registration District No. 2020
City of Atlanta (No. 1 St.)

If death occurred in a hospital, institution or camp give its NAME instead of street and number.
2. FULL NAME Thuman E Endicott

PERSONAL AND STATISTICAL PARTICULARS

3. SEX Male 4. COLOR OR RACE White 5. SINGLE, MARRIED, WIDOWED OR DIVORCED. Single
(Write the word.)

6. DATE OF BIRTH

(Month) (Day) (Year)

7. AGE 25 about yrs. — mos. — ds. IF LESS than 1 day how many — hrs. or — min.

8. OCCUPATION

(a) Trade, profession or particular kind of work Mail Carrier
(b) General nature of industry business or establishment in which employed (or employer)

9. BIRTHPLACE

(State or Country)

10. NAME OF FATHER

11. BIRTHPLACE OF FATHER

(State or Country)

12. MAIDEN NAME OF MOTHER

13. BIRTHPLACE OF MOTHER

(State or Country)

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Robt Morris(Address) W. Home Podge

15.

Filed March 26th 1913

B. W. Mathis
Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

March 19 1913
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from 191 to 191

that I last saw h — alive on 191, and that death occurred on the date stated above, at — M.

The CAUSE OF DEATH* was as follows:

knocked by snow slide
rolled on Rocky Bar
Atlanta track

(Duration) — yrs. — mos. — ds.

Contributory (Secondary)

(Duration) — yrs. — mos. — ds.

(Signed) H. H. H. H. H.

3/26 1913 (Address) Mountain
Coroner Home

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death — yrs. — mos. — ds. In the State — yrs. — mos. — ds.

Where was disease contracted,

If not at place of death?

Former or

usual residence

19. PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

Mountain Mar 27 1913

20. UNDERTAKER

ADDRESS

W. H. H. H. W. H. H. H.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Form V. S. No. 5. 10M. 6-20-11.

CERTIFICATE OF DEATH

1. PLACE OF DEATH.

Registration District No. 20County of ElmorePrimary Registration District No. 2020City of Mountain Home

(No. _____ St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

Felicia OrbeState of Idaho
BOARD OF HEALTH
Bureau of Vital StatisticsFile No. 1424Registered No. 11

If death occurred in a hospital, institution or camp give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX

Female

4. COLOR OR RACE 5. SINGLE, MARRIED, WIDOWED OR DIVORCED.

Spanish

(Write the word.)

6. DATE OF BIRTH

Feb 21

(Month)

(Day)

1913

(Year)

7. AGE

1 yrs.2 mos.24 ds.IF LESS than 1 day
how many hrs. or
min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work

(b) General nature of industry business or establishment in which employed (or employer)

9. BIRTHPLACE

(State or Country)

Mountain Home

10. NAME OF FATHER

Spain Justo Orbe

11. BIRTHPLACE OF FATHER

(State or Country)

Spain

12. MAIDEN NAME OF MOTHER

Margarita Meneca

13. BIRTHPLACE OF MOTHER

(State or Country)

Spain

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

Gabriel Echeverste

(Address)

Mountain Home

15.

Filed March 23rd 1913B. W. Mather

Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

March

(Month)

23rd

(Day)

1913

(Year)

17. I HEREBY CERTIFY, That I attended deceased from

191 , to191 that I last saw h..... alive on..... 191 ,

and that death occurred on the date stated above, at..... M.

The CAUSE OF DEATH* was as follows:

accidental - suffocated under bed clothes sudden (Duration) yrs. mos. ds.

Contributory

(Secondary)

..... (Duration) yrs. mos. ds.

(Signed)

3/23 1913

(Address)

Mountain Home

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place

of death..... yrs. mos. ds.

In the

Where was disease contracted,

If not at place of death?

Former or

usual residence

19. PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

M. CowenMarch 24th 1913

20. UNDERTAKER

ADDRESS

Mountain HomeMountain Home

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Form V. S. No. 5 20M.1-16-12

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH.

Registration District No.

County of Ada

Primary Registration District No.

City of Boise(No. 410, State St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME William RobertsFile No. 4425Registered No. 90

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX

Male

4. COLOR OR RACE

Black Negro

5. SINGLE, MARRIED, WIDOWED OR DIVORCED.

Married
(Write the word.)

6. DATE OF BIRTH

(Month) (Day) (Year)

7. AGE

46 yrs. mos. ds.IF LESS than 1 day
how many hrs. or
mins.

8. OCCUPATION

(a) Trade, profession or particular kind of work

Severon

(b) General nature of industry business, or establishment in which employed (or employer)

9. BIRTHPLACE

(State or Country)

Alabama

10. NAME OF FATHER

11. BIRTHPLACE OF FATHER

(State or Country)

12. MAIDEN NAME OF MOTHER

13. BIRTHPLACE OF MOTHER

(State or Country)

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

John W. Snook

(Address)

Boise

15.

Filed 3-31 1913W. C. Council
Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH

March 31 1913
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from

February 15th 1913, to March 31 1913,that I last saw h. alive on 1913,and that death occurred on the date stated above, at 2 A.M.

The CAUSE OF DEATH* was as follows:

Pulmonary Tuberculosis(Duration) hrs. mos. ds.Contributory
(Secondary)(Duration) hrs. mos. ds.

(Signed)

E. C. Coe M. D.19 (Address) Falk Bldg. Boise

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents)

At place of death Idaho State Penitentiary
1 yrs. 1 mos. 23 days. State Idaho yrs. 1 mos. 23 days.

Where was disease contracted if not at place of death?

Former or usual residence

Idaho Falls Idaho

19. PLACE OF BURIAL OR REMOVAL DATE OF BURIAL

Penitentiary Burying Ground 4/1 1913

20. UNDERTAKER

ADDRESS

Schreiber & Hidenfaden Boise

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Form V. S. No. 5 20M.1-16-12

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH.

Registration District No.

County of Ada

Primary Registration District No.

City of Boni(No. 1417 Ridemough St.)File No. 4426Registered No. 95

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

Fluence M. Kessler

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX

4. COLOR OR RACE

5. SINGLE, MARRIED, WIDOWED OR DIVORCED.

Female WhiteSingle
(Write the word.)

6. DATE OF BIRTH

April 14 1886
(Month) (Day) (Year)

7. AGE

26 yrs. 11 mos. 24 ds.IF LESS than 1 day
how many hrs. or
..... mins.?

8. OCCUPATION

(a) Trade, profession or particular kind of work

Teacher

(b) General nature of industry business, or establishment in which employed (or employer)

9. BIRTHPLACE

(State or Country)

Nebraska

10. NAME OF FATHER

John F. Kessler

11. BIRTHPLACE OF FATHER

(State or Country)

Pa.

12. MAIDEN NAME OF MOTHER

Esther Snader

13. BIRTHPLACE OF MOTHER

(State or Country)

Pa.

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

John F. Kessler

(Address)

Boni

15.

Filed 4 - 8

1913

C. S. McConnel

Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH

April 8th 1913
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from

Feb - 1911, to March 20 1913,that I last saw him alive on March 20 1913and that death occurred on the date stated above, at 10 A.M.

The CAUSE OF DEATH* was as follows:

Pulmonary Tuberculosisabout (Duration) 2 yrs. 6 mos. ds.Contributory
(Secondary)

(Duration) yrs. mos. ds.

(Signed)

J. M. Laylor M. D.Apr 8 1913 (Address) Boni Ida

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death yrs. mos. days. In the State yrs. mos. days.

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL DATE OF BURIAL

Marion Hill Cemetery 4/9 1913

20. UNDERTAKER

ADDRESS

Schreiber & Hidenfrou Boni

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Form V. S. No. 5 20M.1-16-12

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH.

Registration District No.

County of Ada

Primary Registration District No.

City of Boise(No. 204, Plume St St.)File No. 4421Registered No. 63

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

John B. Webb

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX

Male

4. COLOR OR RACE

White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED.

Married
(Write the word.)

6. DATE OF BIRTH

May 27th 1827
(Month) (Day) (Year)

7. AGE

85 yrs. 10 mos. 5 ds.

IF LESS than 1 day
how many hrs. or
..... mins.?

8. OCCUPATION

- (a) Trade, profession or particular kind of work
(b) General nature of industry business, or establishment in which employed (or employer)

Retired

9. BIRTHPLACE

(State or Country)

New York

10. NAME OF FATHER

Joseph Webb

11. BIRTHPLACE OF FATHER

(State or Country)

England

12. MAIDEN NAME OF MOTHER

Carrie Johnson

13. BIRTHPLACE OF MOTHER

(State or Country)

Michigan

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

Austin G. Walker

(Address)

Boise

15.

Filed 3-7 1913Ed M. Connel

Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH

Mar 5th 1913
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from

1911, to 1913,that I last saw him alive on Mar 4 1913and that death occurred on the date stated above, at 5:30 PM

The CAUSE OF DEATH* was as follows:

Senility

(Duration) yrs. mos. ds.

Contributory
(Secondary)

(Duration) yrs. mos. ds.

(Signed)

Mar 6 1913 (Address) Boise

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death yrs. mos. days. In the State yrs. mos. days.

Where was disease contracted if not at place of death?

Former or usual residence.

204 Plume St

19. PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

Masonic Cemetery 3/7 1913

20. UNDERTAKER

ADDRESS

Schreiber & Sidenfaden Boise, Ida

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Form V. S. No. 5 20M.1-16-12

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH.

Registration District No.

County of

Primary Registration District No.

City of

(No. 410,

St.)

File No.

Registered No.

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX

4. COLOR OR RACE

5. SINGLE, MARRIED, WIDOWED OR DIVORCED.

6. DATE OF BIRTH

7. AGE

IF LESS than 1 day
how many hrs. or mins.?

8. OCCUPATION

(a) Trade, profession or particular kind of work

(b) General nature of industry business, or establishment in which employed (or employer)

9. BIRTHPLACE

(State or Country)

10. NAME OF FATHER

11. BIRTHPLACE OF FATHER

(State or Country)

12. MAIDEN NAME OF MOTHER

13. BIRTHPLACE OF MOTHER

(State or Country)

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

(Address)

15.

Filed 3 - 5

1913

Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH

17. I HEREBY CERTIFY, That I attended deceased from

March 1 1913 to March 3 1913

that I last saw him alive on March 3 1913

and that death occurred on the date stated above, at 7 P.M.

The CAUSE OF DEATH* was as follows:

Chronic interstitial nephritis

(Duration) 2 yrs. mos. ds.

Contributory morphine, chronic (Secondary)

(Duration) 2 yrs. mos. ds.

(Signed) Mrs. Sallman M. D.

3-5 1913 (Address) Mt. Sallman

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death yrs. mos. days. In the State yrs. mos. days.

Where was disease contracted if not at place of death?

Former or usual residence.

19. PLACE OF BURIAL OR REMOVAL DATE OF BURIAL

Morris Hill Cemetery March 5 1913

20. UNDERTAKER ADDRESS

Schrieber & Hidenfaden Boise

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Form V. S. No. 5 20M.1-16-12

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH.

Registration District No.

County of Ada

Primary Registration District No.

City of Boise(No. 1319 16. 15-18 St.)File No. 4429Registered No. 78

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Mary B. Holsted

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX

Female

4. COLOR OR RACE

White American

5. SINGLE, MARRIED, WIDOWED OR DIVORCED.

Married
(Write the word.)

6. DATE OF BIRTH

Aug 27 1892
(Month) (Day) (Year)

7. AGE

70 yrs. 6 mos. 18 ds.

IF LESS than 1 day
how many hrs. or
..... mins.?

8. OCCUPATION

(a) Trade, profession or particular kind of work
(b) General nature of industry, business, or establishment in which employed (or employer)

House work.

9. BIRTHPLACE

(State or Country)

Wisconsin

10. NAME OF FATHER

Jacob S. Cook.

11. BIRTHPLACE OF FATHER

(State or Country)

N. York

12. MAIDEN NAME OF MOTHER

Mrs. Dockstader

13. BIRTHPLACE OF MOTHER

(State or Country)

N. York.

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

R. J. Buell(Address) 1405 N 13 St Boise Idaho

15.

Filed 3-171913Ed McCone

Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH

March 15 1913
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from

Jan 2 1913, to March 12 1913,
that I last saw him alive on March 15 1913,
and that death occurred on the date stated above, at M.

The CAUSE OF DEATH* was as follows:

Cancer of stomach

(Duration) yrs. mos. ds.

Contributory

(Secondary)

(Duration) yrs. mos. ds.

(Signed)

Geo. C. Smith M. D.

19. (Address)

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death yrs. mos. days. In the State yrs. mos. days.

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

Wornis Hill Cem.March 17 1913

20. UNDERTAKER

ADDRESS

Guy & Summers CoBoise Ida

MARGIN RESERVED FOR BINDING
WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Form V. S. No. 5 20M.1-16-12

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH.

Registration District No.

County of Ada

Primary Registration District No.

City of Boise

(No. 711-11-20 St.)

File No. 14311

Registered No. 89

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Nels C. Nelson

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX Male 4. COLOR OR RACE White 5. SINGLE, MARRIED, WIDOWED OR DIVORCED. Married
(Write the word.)

6. DATE OF BIRTH Feb 6 1847
(Month) (Day) (Year)

7. AGE 66 yrs. 1 mos. 21 ds.
IF LESS than 1 day how many hrs. or mins.?

8. OCCUPATION
(a) Trade, profession or particular kind of work Retired Farmer
(b) General nature of industry business, or establishment in which employed (or employer)

9. BIRTHPLACE Denmark
(State or Country)

10. NAME OF FATHER Hans C. Nelson

11. BIRTHPLACE OF FATHER Denmark
(State or Country)

12. MAIDEN NAME OF MOTHER not obtainable

13. BIRTHPLACE OF MOTHER Denmark
(State or Country)

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) H. P. Nelson
(Address) 1705 N. 19th

15. Filed 3-28 1913 W. M. Connelley
Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH Mar 27 1913
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from Apr 1st 1912, to Mar 27 1913, that I last saw him alive on Mar 25 1913, and that death occurred on the date stated above, at 4 P.M.

The CAUSE OF DEATH* was as follows:
Valvular heart disease
present 14 years ago
(Duration) yrs. mos. ds.

Contributory Bronchitis
(Secondary)
(Duration) yrs. mos. ds.
(Signed) E. J. Brown M. D.
8-28-1913 (Address) Boise Ida.

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death yrs. mos. days. In the State yrs. mos. days.

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL Atlantic Iowa DATE OF BURIAL Mar 28 1913

20. UNDERTAKER Fry & Summers Co ADDRESS Boise Ida.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Form V. S. No. 5 20M.1-16-12

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH

Registration District No.

County of Ada

Primary Registration District No.

City of Boise

(No. 410, State Idaho St.)

File No. 4431

Registered No. 74

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Stephen Francis Regan, M.D. Lousa
If death occurred in a hospital, in Idaho or Idaho state, in NAME Idaho instead of Idaho and Idaho.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX

4. COLOR OR RACE

5. SINGLE, MARRIED, WID-
OWED OR DIVORCED.

Male white Married (Write the word.)

6. DATE OF BIRTH

December 25 1841
(Month) (Day) (Year)

7. AGE

71 yrs. 7 mos. 16 ds.

IF LESS than 1 day
how many hrs. or
..... mins.?

8. OCCUPATION

(a) Trade, profession or
particular kind of work Retired
(b) General nature of industry
business, or establishment in
which employed (or employer)

9. BIRTHPLACE

New York

10. NAME OF
FATHER

Morgan Regan

11. BIRTHPLACE
OF FATHER

Ireland
(State or Country)

12. MAIDEN NAME
OF MOTHER

Mary Burke

13. BIRTHPLACE
OF MOTHER

Ireland
(State or Country)

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Morgan D. Regan

(Address) Boise Idaho

15.

Filed 3 - 14 1913 E. S. M. C. B.
Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

March 13 1913
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from

Nov 20 1912, to March 13 1913,

that I last saw him alive on March 13 1913,

and that death occurred on the date stated above, at M.

The CAUSE OF DEATH* was as follows:

apoplexy

(Duration) yrs. mos. ds.

Contributory

(Secondary)

(Duration) yrs. mos. ds.

(Signed) E. S. M. C. B. M. D.

19. (Address)

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death yrs. mos. days. In the State yrs. mos. days.

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

Masonic Cemetery March 15 1913

20. UNDERTAKER

ADDRESS

Schreiber & Hidenpader Boise

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Form V. S. No. 5 20M.1-16-12

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH.

Registration District No.

County of Ada

Primary Registration District No.

City of Boise

(No. 113, No. 16 — St.)

File No. 4432

Registered No. 70

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

Pauline Mitchell

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX

Female

4. COLOR OR RACE

White American

5. SINGLE, MARRIED, WIDOWED OR DIVORCED

Married
(Write the word.)

6. DATE OF BIRTH

Feb 27 1875
(Month) (Day) (Year)

7. AGE

38 yrs. — mos. 12 ds.

IF LESS than 1 day
how many hrs. or
..... mins.?

8. OCCUPATION

(a) Trade, profession or particular kind of work

House (Wife)

(b) General nature of industry, business, or establishment in which employed (or employer)

9. BIRTHPLACE

(State or Country)

Quincy Ill.

10. NAME OF FATHER

Wm Sherman

11. BIRTHPLACE OF FATHER

(State or Country)

Germany

12. MAIDEN NAME OF MOTHER

Henrietta Jones

13. BIRTHPLACE OF MOTHER

(State or Country)

Germany

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

C. E. Sumner

(Address)

Boise Ida

15.

Filed 3 - 10 1913 C. S. McConnell

Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

March 9th 1913
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from

March 8 1913, to March 9 1913,

that I last saw her alive on March 8 1913,

and that death occurred on the date stated above, at 6 P.M.

The CAUSE OF DEATH* was as follows:

Pulmonary Tuberculosis

(Duration) 2 yrs. — mos. — ds.

Contributory (Secondary) Empyema of lungs

(Duration) 1 yrs. — mos. — ds.

(Signed) Swenson M. D.

19. (Address) Boise Ida

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death. yrs. mos. days. In the State. yrs. mos. days.

Where was disease contracted if not at place of death?

Former or usual residence.

19. PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

Morris Hill Ceme. March 11 1913

20. UNDERTAKER

ADDRESS

Fry & Summers Boise Ida

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Form V. S. No. 5 20M.1-16-12

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH

Registration District No.

County of Ada

Primary Registration District No.

City of Boise(No. 3/4 Miles West of Boise)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

Clara J. PaineFile No. 4433Registered No. 6

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX

4. COLOR OR RACE

5. SINGLE, MARRIED, WID-
OWED OR DIVORCED.FemaleWhiteMarried
(Write the word.)

6. DATE OF BIRTH

Feb. 28th 1874
(Month) (Day) (Year)

7. AGE

38 yrs. 4 mos. — ds.IF LESS than 1 day
how many hrs. or
..... mins.?

8. OCCUPATION

(a) Trade, profession or
particular kind of workHousekeeper(b) General nature of industry
business, or establishment in
which employed (or employer)

9. BIRTHPLACE

(State or Country)

Miss10. NAME OF
FATHERIsaac Christman11. BIRTHPLACE
OF FATHER

(State or Country)

Not obtainable12. MAIDEN NAME
OF MOTHERK. Lavelle13. BIRTHPLACE
OF MOTHER

(State or Country)

Not obtainable

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

E. O. Payne

(Address)

Ara Dell Ranch

15.

Filed 3 - 11913G. M. Council
Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

Feb 28th 1913
(Month) (Day) (Year)17. I HEREBY CERTIFY, That I attended deceased from
Feb 24 1913, to Feb 28 1913
that I last saw her alive on Feb 28 1913
and that death occurred on the date stated above, at 4 P.M.

The CAUSE OF DEATH* was as follows:

Pneumonia Embolus

(Duration) yrs. mos. ds.

Contributory
(Secondary)Abd. Operation

(Duration) yrs. mos. ds.

(Signed)

W. S. Titus M. D.3-1 1913 (Address) Boise*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1)
MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.18. LENGTH OF RESIDENCE (For Hospitals, Institutions,
Transients or Recent Residents.)At place St Lukes Hospital
of death yrs. mos. days. In the State yrs. mos. days.Where was disease contracted
if not at place of death?Former or
usual residence. near Ara Dell Ranch

19. PLACE OF BURIAL OR REMOVAL DATE OF BURIAL

Marriott Hill Cemetery 3-1 1913

20. UNDERTAKER

ADDRESS

Schreiber & Vidupaden Boise

Titus

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Form V. S. No. 5 20M.1-16-12

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH.

Registration District No.

County of Ada

Primary Registration District No.

City of Boise

(No. 1137 River St.)

File No. 4434

Registered No. 75

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Lara Maria Homan

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX Female 4. COLOR OR RACE White 5. SINGLE, MARRIED, WIDOWED OR DIVORCED. Married
(Write the word.)

6. DATE OF BIRTH Feb 13 1873
(Month) (Day) (Year)

7. AGE 40 yrs. 1 mos. 1 ds.
IF LESS than 1 day how many hrs. or mins.?

8. OCCUPATION
(a) Trade, profession or particular kind of work Housekeeper
(b) General nature of industry business, or establishment in which employed (or employer)

9. BIRTHPLACE New York
(State or Country)

10. NAME OF FATHER Not obtainable

11. BIRTHPLACE OF FATHER Not obtainable
(State or Country)

12. MAIDEN NAME OF MOTHER Not obtainable

13. BIRTHPLACE OF MOTHER Not obtainable
(State or Country)

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Lara Homan
(Address) Boise Idaho

15.

Filed 3-15 1913 Ed McConnell
Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH Mar 18 1913
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from 3-11 1913, to 3-14 1913, that I last saw her alive on 3-14 1913, and that death occurred on the date stated above, at 3 A.M.

The CAUSE OF DEATH* was as follows:

Pneumonia
(Duration) yrs. mos. 3 ds.

Contributory (Secondary)
(Duration) yrs. mos. ds.
(Signed) W.B. Titus M. D.
3-15 1913 (Address) Boise

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death yrs. mos. days. In the State yrs. mos. days.

Where was disease contracted if not at place of death?

Former or usual residence 1137 River St Boise Idaho

19. PLACE OF BURIAL OR REMOVAL Harriet Hill Cemetery DATE OF BURIAL 3/18 1913

20. UNDERTAKER Schreiber & Gladenfaden ADDRESS Boise Idaho

Dr. Titus

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Form V. S. No. 5 20M.1-16-12

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH.

Registration District No.

County of Ada

Primary Registration District No.

City of Eagle(No. near Eagle, Idaho St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

Joseph JohnsonFile No. 4435Registered No. 94

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX

Male

4. COLOR OR RACE

Wht5. SINGLE, MARRIED, WID-
OWED OR DIVORCED.Single
(Write the word.)

6. DATE OF BIRTH

Mar 22nd 1913
(Month) (Day) (Year)

7. AGE

 yrs. mos. ds.IF LESS than 1 day
how many hrs. or
 mins.?

8. OCCUPATION

(a) Trade, profession or
particular kind of worknone(b) General nature of industry
business, or establishment in
which employed (or employer)

9. BIRTHPLACE

(State or Country)

Ada County Idaho10. NAME OF
FATHERWalter H Johnson11. BIRTHPLACE
OF FATHER

(State or Country)

Iowa12. MAIDEN NAME
OF MOTHERMatilda E Julion13. BIRTHPLACE
OF MOTHER

(State or Country)

France

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

W. H. Johnson

(Address)

Eagle.

15.

Filed 191 Dr. Callaway Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH

Mar 22nd 1913
(Month) (Day) (Year)17. I HEREBY CERTIFY, That I attended deceased from
March 22 - 1913, to March 22 - 1913,
that I last saw him alive on 191 ,
and that death occurred on the date stated above, at M.

The CAUSE OF DEATH* was as follows:

Stillborn due to pressure
on cord. (Duration) yrs. mos. ds.Contributory
(Secondary) (Duration) yrs. mos. ds.(Signed) M. Ellen Conway M. D.3/24/1913 (Address) Boise, Idaho*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1)
MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.18. LENGTH OF RESIDENCE (For Hospitals, Institutions,
Transients or Recent Residents.)At place
of death yrs. mos. days. In the
State yrs. mos. days.Where was disease contracted
if not at place of death?Former or
usual residence

19. PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

St Johns Cemetery3/24 1913

20. UNDERTAKER

ADDRESS

Schreiber & KidugadenBoise, Idaho

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Form V. S. No. 5, 20M.1-16-12

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH

Registration District No.

County of Ada

Primary Registration District No.

City of Boise(No. 112 E. Barnock St.)File No. 4436Registered No. 86

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

Cecilia Ann Shaw

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX

Female

4. COLOR OR RACE

White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED.

Married
(Write the word.)

6. DATE OF BIRTH

Dec31st1853

(Month)

(Day)

(Year)

7. AGE

59 yrs. 2 mos. 25 ds.IF LESS than 1 day
how many hrs. or
..... mins.?

8. OCCUPATION

(a) Trade, profession or particular kind of work

Housekeeper

(b) General nature of industry, business, or establishment in which employed (or employer)

9. BIRTHPLACE

(State or Country)

Delaware Co. Ind.

10. NAME OF FATHER

James Powell

11. BIRTHPLACE OF FATHER

(State or Country)

Ind

12. MAIDEN NAME OF MOTHER

Emma Powell

13. BIRTHPLACE OF MOTHER

(State or Country)

Ind

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

H. T. Shaw

(Address)

Boise, Idaho

15.

Filed 3 - 27 1913C. J. Powell
Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH

Mar26th1913

(Month)

(Day)

(Year)

17. I HEREBY CERTIFY, That I attended deceased from

Mar 19th1913to Mar 26th1913that I last saw her alive on Mar 26th 1913and that death occurred on the date stated above, at 10 A.M.

The CAUSE OF DEATH* was as follows:

Carcinoma of Liver

(Duration) yrs. mos. ds.

Contributory
(Secondary)

(Duration) yrs. mos. ds.

(Signed)

James L. Stewart M. D.Mar 19 1913

(Address)

Boise

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents)

At place of death

St Luke's Hospital

In the

Hospital

yrs. mos. days.

State

yrs. mos. days.

Where was disease contracted if not at place of death?

Former or usual residence

Hstick Ada Co. Ida

19. PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

Morris Hill Cemetery3/28 1913

20. UNDERTAKER

ADDRESS

Schreiber & Vidensfaden Boise, Ida

Form V. S. No. 5 20M.1-16-12

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH.

Registration District No.

County of Ada

Primary Registration District No.

City of Boise(No. 808, N. 10th St.)File No. 4437Registered No. 83

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Albert Augustus Jessup, Jr. St Lukes Hospital
If death occurred in a hospital, institution or camp, give its NAME Instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX

Male

4. COLOR OR RACE

White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED.

(Write the word.)

6. DATE OF BIRTH

March
(Month)19th
(Day)1913
(Year)

7. AGE

✓ yrs. ✓ mos. Two ds.IF LESS than 1 day
how many hrs. or
..... mins.?

8. OCCUPATION

(a) Trade, profession or particular kind of work

(b) General nature of industry business, or establishment in which employed (or employer)

9. BIRTHPLACE

(State or Country)

Boise Ada County Idaho

10. NAME OF FATHER

Albert Augustus Jessup

11. BIRTHPLACE OF FATHER

(State or Country)

Salem Oregon

12. MAIDEN NAME OF MOTHER

Phoebe Elizabeth Barnes

13. BIRTHPLACE OF MOTHER

(State or Country)

Montana

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

Albert A. Jessup

(Address)

808 N. 10th St
Boise Idaho

15.

Filed 3 22 1913B S M Council
Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH

March211913

(Month)

(Day)

(Year)

17. I HEREBY CERTIFY, That I attended deceased from

March 19 1913, to March 21 1913,that I last saw him alive on March 20th 1913and that death occurred on the date stated above, at 10 AM

The CAUSE OF DEATH* was as follows:

Bronchopneumonia(Duration) yrs. mos. 1 ds.Contributory
(Secondary)

(Duration) yrs. mos. ds.

(Signed)

James L. Stewart D.
3/21/13 (Address) Boise Idaho

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place St Lukes Hosp. in the
of death yrs. mos. 0 days. State yrs. mos. days.Where was disease contracted
if not at place of death?Former or
usual residence

19. PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

Masonic Cemetery3/22 1913

20. UNDERTAKER

ADDRESS

Schreibers BienenfadenBoise, Ida

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Form V. S. No. 5 20M.1-16-12

CERTIFICATE OF DEATH

1. PLACE OF DEATH

Registration District No.

County of Ada

Primary Registration District No.

City of Boise

(No. 121 Main St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Baby Stontemyer

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

No. 4438

Registered No. 85

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX

male

4. COLOR OR RACE

white

5. SINGLE, MARRIED, WIDOWED OR DIVORCED.

Single
(Write the word.)

6. DATE OF BIRTH

March 24 1913
(Month) (Day) (Year)

7. AGE

..... yrs. mos. 0 ds.

IF LESS than 1 day
how many .. 8 .. hrs. or
..... mins.

8. OCCUPATION

(a) Trade, profession or particular kind of work

none

(b) General nature of industry business, or establishment in which employed (or employer)

9. BIRTHPLACE

(State or Country) Boise Idaho

10. NAME OF FATHER

B. G. Stontemyer

11. BIRTHPLACE OF FATHER

(State or Country) Louisiana

12. MAIDEN NAME OF MOTHER

Laurina P. Sonna

13. BIRTHPLACE OF MOTHER

(State or Country) Pennsylvania

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) B. G. Stontemyer

(Address) 121 Main St. Boise Idaho

15.

Filed 3 - 25 1913 Edna Cornwell
Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

Mar 25th 1913
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from birth — 1913, to March 25 1913,

that I last saw him alive on March 25 1913

and that death occurred on the date stated above, at 9 A.M.

The CAUSE OF DEATH* was as follows:

could not be determined
Seemed Normal and lived
about - 8 hours after birth
(Duration) yrs. mos. ds.

Contributory possibly - hemorrhage
(Secondary) from cord may have had some
(Duration) yrs. mos. ds.

(Signed) J. M. Taylor M. D.

Mar 25 1913 (Address) Boise

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death yrs. mos. days. In the State yrs. mos. days.

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL

Masonic Cemetery

DATE OF BURIAL

3/25 1913

20. UNDERTAKER

Schreiber & Hildebrand

ADDRESS

Boise, Idaho

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Form V. S. No. 5 20M.1-16-12

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH.

Registration District No.

County of Ada

Primary Registration District No.

City of Boise(No. 1137, River St.)File No. 4439Registered No. 76

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Baby Homan

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX

4. COLOR OR RACE

5. SINGLE, MARRIED, WIDOWED OR DIVORCED.

6. DATE OF BIRTH

7. AGE

IF LESS than 1 day
how many hrs. or
..... mins.?

8. OCCUPATION

(a) Trade, profession or particular kind of work

(b) General nature of industry business, or establishment in which employed (or employer)

9. BIRTHPLACE

(State or Country)

10. NAME OF FATHER

11. BIRTHPLACE OF FATHER

(State or Country)

12. MAIDEN NAME OF MOTHER

13. BIRTHPLACE OF MOTHER

(State or Country)

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

(Address)

15.

Filed 3 - 16 19131913C. S. McConnel
Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH

17. I HEREBY CERTIFY, That I attended deceased from

3/14 1913, to 3/16 1913,that I last saw her alive on 3/15 1913,and that death occurred on the date stated above, at 6 A.M.

The CAUSE OF DEATH* was as follows:

fractureofleg(Duration) yrs. mos. 2 ds.

Contributory (Secondary)

(Duration) yrs. mos. 2 ds.(Signed) W. Stittus M. D.19. (Address) Boise Idaho

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death yrs. mos. days. In the State yrs. mos. days.

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

Marion Hill Cemetery 3/16 1913

20. UNDERTAKER

ADDRESS

Schneider & Widengaden Boise, Idaho

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Form V. S. No. 5 20M.1-16-12

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH.

Registration District No.

County of Ada

Primary Registration District No.

City of Boise

(No. 623; Hayes St.)

File No. 4441

Registered No. 69

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Hugh R. Jones

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX Male 4. COLOR OR RACE White 5. SINGLE, MARRIED, WIDOWED OR DIVORCED. Single
(Write the word.)

6. DATE OF BIRTH May 18th 1895
(Month) (Day) (Year)

7. AGE 17 yrs. 9 mos. 21 ds. IF LESS than 1 day how many hrs. or mins.?

8. OCCUPATION
(a) Trade, profession or particular kind of work Student
(b) General nature of industry business, or establishment in which employed (or employer)

9. BIRTHPLACE Boise Co. Idaho
(State or Country)

10. NAME OF FATHER Jeremiah D Jones

11. BIRTHPLACE OF FATHER American
(State or Country)

12. MAIDEN NAME OF MOTHER Clara Ostner

13. BIRTHPLACE OF MOTHER American
(State or Country)

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) J. D. Jones
(Address) Boise Idaho.

15.

Filed 3 - 10 1913 C. S. McConnell
Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH Mar 8th 1913
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from 191... to 191... that I last saw him alive on Mar 8 1913, and that death occurred on the date stated above, at 40 M. The CAUSE OF DEATH* was as follows:

Septic & Toxic
Cardiac Distention
(Duration) yrs. mos. 7 ds.

Contributory (Secondary)
(Duration) yrs. mos. ds.
(Signed) James T. Stewart M. D.
19... (Address) Boise Idaho

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death yrs. mos. days. In the State yrs. mos. days.

Where was disease contracted if not at place of death?

Former or usual residence 623 Hayes, Boise, Idaho

19. PLACE OF BURIAL OR REMOVAL Morris Hill Cemetery DATE OF BURIAL 3/10 1913

20. UNDERTAKER Schreiber & Widengraden ADDRESS Boise, Idaho

MARGIN RESERVED FOR BINDING
WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Form V. S. No. 5 20M.1-16-12

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH

Registration District No.

County of Ada

Primary Registration District No.

City of Boise

(No. 410 State St.)

File No. 4441

Registered No. 64

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Elna Clinton Osborn

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX

Male

4. COLOR OR RACE

White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED.

Single
(Write the word.)

6. DATE OF BIRTH

1879
(Month) (Day) (Year)

7. AGE

33 yrs. — mos. — ds.

IF LESS than 1 day
how many hrs. or
..... mins.?

8. OCCUPATION

(a) Trade, profession or particular kind of work.

Inmate Idaho State Prison

(b) General nature of industry business, or establishment in which employed (or employer)

9. BIRTHPLACE

(State or Country)

Washington

10. NAME OF FATHER

not obtainable

11. BIRTHPLACE OF FATHER

(State or Country)

not obtainable

12. MAIDEN NAME OF MOTHER

not obtainable

13. BIRTHPLACE OF MOTHER

(State or Country)

not obtainable

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

John Snook

(Address)

Boise

15.

Filed 3 - 7 1913

Ed M. Council

Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH

Mar 6 1913
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from

Feb 20 1913, to March 6 1913,

that I last saw him alive on March 5 1913,

and that death occurred on the date stated above, at 6 A.M.

The CAUSE OF DEATH* was as follows:

Acute Bright's disease

(Duration) yrs. mos. ds.

Contributory
(Secondary)

(Duration) yrs. mos. ds.

(Signed)

Geo. C. Calkins M. D.

19. (Address)

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death St. Alphonsus Hospital
..... yrs. mos. 3 days. State yrs. mos. days.

Where was disease contracted if not at place of death?

Former or usual residence

Idaho State Prison (Boise)

19. PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

Spokane Wash

3/7 1913

20. UNDERTAKER

ADDRESS

Schreiber & Chidenfaden

Boise, Idaho

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Form V. S. No. 5 20M.1-16-12

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH

Registration District No.

County of Ada

Primary Registration District No.

City of Boise(No. 110, East Baumgardner St.)File No. 4442Registered No. 73

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

Soren P. Jensen

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX

Male

4. COLOR OR RACE

White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED.

Married
(Write the word.)

6. DATE OF BIRTH

Aug 26 1865
(Month) (Day) (Year)

7. AGE

47 yrs. 6 mos. 15 ds.

IF LESS than 1 day
how many hrs. or
..... mins.?

8. OCCUPATION

(a) Trade, profession or particular kind of work

Contractor

(b) General nature of industry business, or establishment in which employed (or employer)

9. BIRTHPLACE

(State or Country)

Denmark

10. NAME OF FATHER

Pasmore Jensen

11. BIRTHPLACE OF FATHER

(State or Country)

Denmark

12. MAIDEN NAME OF MOTHER

Annie Sorens

13. BIRTHPLACE OF MOTHER

(State or Country)

Denmark

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

Nelda Jensen

(Address)

Roberts Ill.

15.

Filed 3 - 14 1913

C. S. McConnell
Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH

March 13 1913
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from

March 1913, to March 13 1913,

that I last saw him alive on March 13 1913,

and that death occurred on the date stated above, at 9 A.M.

The CAUSE OF DEATH* was as follows:

Chronic nephritis(Duration) 3 yrs. mos. ds.Contributory
(Secondary)

(Duration) yrs. mos. ds.

(Signed)

James H. Stewart M. D.(Address) Boise Idaho

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death yrs. mos. days. In the State yrs. mos. days.

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

Morris Hill CemeteryMarch 16 1913

20. UNDERTAKER

ADDRESS

Schreibers & SidenfadenBoise

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Form V. S. No. 5 20M.1-16-12

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH

Registration District No.

County of

Primary Registration District No.

City of

(No. 42, State St.)

File No.

Registered No.

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX

4. COLOR OR RACE

5. SINGLE, MARRIED, WIDOWED OR DIVORCED.

Male

White

Widower
(Write the word.)

6. DATE OF BIRTH

Not obtainable

(Month)

(Day)

(Year)

7. AGE

about

46 yrs. mos. ds.

IF LESS than 1 day
how many hrs. or
mins.?

8. OCCUPATION

(a) Trade, profession or particular kind of work

Engineering

(b) General nature of industry, business, or establishment in which employed (or employer)

U. S. R. S.

9. BIRTHPLACE

(State or Country)

Wisconsin

10. NAME OF FATHER

Not obtainable

11. BIRTHPLACE OF FATHER

(State or Country)

Wisconsin

12. MAIDEN NAME OF MOTHER

13. BIRTHPLACE OF MOTHER

(State or Country)

Wisconsin

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

Mrs. W. E. Fenderson

(Address)

Boise, Ida.

15.

Filed

3 - 27

1913

E. S. McCune

Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

March 26

1913

(Month)

(Day)

(Year)

17. HEREBY CERTIFY, That I attended deceased from

3/26

1913, to

3/26

1913

that I last saw him alive on

3/26 1913

and that death occurred on the date stated above, at P. A. M.

The CAUSE OF DEATH* was as follows:

Acute Brights Disease

(Duration) yrs. mos. ds.

Contributory
(Secondary)

(Duration) yrs. mos. ds.

(Signed)

And a Physician

2/7/1913 (Address) John Bldg

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death yrs. mos. days. In the State yrs. mos. days.

Where was disease contracted if not at place of death?

Former or usual residence.

19. PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

Argyle Wisconsin

March 26 1913

20. UNDERTAKER

ADDRESS

Schreiber & Sidenfeller

Boise

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Form V. S. No. 5 20M.1-16-12

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH. Registration District No. _____
County of Ada Primary Registration District No. _____
City of Boise (No. 217, State _____ St.)

File No. 444
Registered No. 05

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME William Frederick Templeton

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX Male 4. COLOR OR RACE White 5. SINGLE, MARRIED, WIDOWED OR DIVORCED. Married
(Write the word.)

6. DATE OF BIRTH May 7 1853
(Month) (Day) (Year)

7. AGE 39 yrs. 10 mos. 0 ds. IF LESS than 1 day how many hrs. or mins.?

8. OCCUPATION
(a) Trade, profession or particular kind of work Stationary Engineer
(b) General nature of industry business, or establishment in which employed (or employer) _____

9. BIRTHPLACE (State or Country) Pennsylvania

10. NAME OF FATHER John Templeton

11. BIRTHPLACE OF FATHER (State or Country) England

12. MAIDEN NAME OF MOTHER Elizabeth Ainscow

13. BIRTHPLACE OF MOTHER (State or Country) England

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Charles L. Chalcraft
(Address) 208 1/2 St. Boise, Ida.

15. Filed 3-8 1913 E. S. McConnel
Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH 3 7 1913
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from Jan 1 1913 to 3/7 1913
that I last saw him alive on 12/5 1913

and that death occurred on the date stated above, at 10 A.M.
The CAUSE OF DEATH* was as follows:

Diabetic Militis

(Duration) _____ yrs. _____ mos. _____ ds.

Contributory (Secondary) _____

(Duration) _____ yrs. _____ mos. _____ ds.

(Signed) And a Copy to M. D.

3/7 1913 (Address) Talk Bldg

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death. _____ yrs. _____ mos. _____ days. In the State. _____ yrs. _____ mos. _____ days.

Where was disease contracted if not at place of death? _____

Former or usual residence. _____

19. PLACE OF BURIAL OR REMOVAL Morris Hill Cemetery DATE OF BURIAL 3/7 1913

20. UNDERTAKER Schreiber & Hidenforn ADDRESS Boise

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Form V. S. No. 5 20M.1-16-12

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH.

Registration District No.

County of Ada

Primary Registration District No.

City of Boise(No. 410 State Idaho St.)File No. 4445Registered No. 66

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Charles Olsen

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX

Male

4. COLOR OR RACE

White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED.

Single
(Write the word.)

6. DATE OF BIRTH

Not obtainable
(Month) (Day) (Year)

7. AGE

about
60 yrs. — mos. — ds.IF LESS than 1 day
how many hrs. or
..... mins.?

8. OCCUPATION

(a) Trade, profession or particular kind of work

Miner

(b) General nature of industry business, or establishment in which employed (or employer)

9. BIRTHPLACE

(State or Country)

Sweden

10. NAME OF FATHER

not obtainable

11. BIRTHPLACE OF FATHER

(State or Country)

not obtainable

12. MAIDEN NAME OF MOTHER

not obtainable

13. BIRTHPLACE OF MOTHER

(State or Country)

not obtainable

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

Sister M. Truitt

(Address)

Boise, Idaho

15.

Filed

3-81913C. M. Connel

Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

Mar 7 1913
(Month) (Day) (Year)17. I HEREBY CERTIFY, That I attended deceased from March 5 1913, to March 7 1913, that I last saw him alive on March 6 1913, and that death occurred on the date stated above, at 9:30 A.M.

The CAUSE OF DEATH* was as follows:

Chronic parenchymatous nephritis(Duration) ? yrs. mos. ds.Contributory Chronic myocarditis
(Secondary)(Duration) ? yrs. mos. ds.

(Signed)

M. H. Fallman M. D.3/7 193 (Address) Boise Idaho

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents)

At place St. Alphonsus Hospital In the
of death yrs. mos. 7 days. State yrs. mos. days.

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

Morris Hill Cemetery3/8 1913

20. UNDERTAKER

ADDRESS

Schreibler & HidenfaderBoise

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Form V. S. No. 5 20M.1-16-12

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH.

Registration District No.

County of Ada

Primary Registration District No.

City of Boise(No. 410 State Idaho St.)File No. 4446Registered No. 62

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Robert Roland Moss

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX

Male

4. COLOR OR RACE

White5. SINGLE, MARRIED, WID-
OWED OR DIVORCED.Married
(Write the word.)

6. DATE OF BIRTH

June 17th 1849
Month Day Year

7. AGE

63 yrs. 9 mos. 17 ds.IF LESS than 1 day
how many hrs. or
..... mins.?

8. OCCUPATION

(a) Trade, profession or
particular kind of workFarmer(b) General nature of industry
business, or establishment in
which employed (or employer)

9. BIRTHPLACE

(State or Country)

Iowa10. NAME OF
FATHERWilliam Moss11. BIRTHPLACE
OF FATHER

(State or Country)

Am.12. MAIDEN NAME
OF MOTHERHenny Roland13. BIRTHPLACE
OF MOTHER

(State or Country)

Am.

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Mrs. Delia Moss(Address) Ada Co., Idaho

15.

Filed 3 - 6 1913 Edm McConnel
Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH

May 4 1913
(Month) (Day) (Year)17. I HEREBY CERTIFY, That I attended deceased from
March 1913, to May 4 1913,that I last saw him alive on May 4 1913,and that death occurred on the date stated above, at Idaho.

The CAUSE OF DEATH* was as follows:

Nephritis(Duration) 9 yrs. mos. ds.Contributory
(Secondary)

(Duration) yrs. mos. ds.

(Signed)

John A. Stewart M. D.
March 1913 (Address) Boise, Idaho

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions,
Transients or Recent Residents.)At place of death. yrs. mos. 2 days. In the Staphouse Hospital State. yrs. mos. days.Where was disease contracted
if not at place of death?Former or
usual residence 3 Miles West of Boise

19. PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

Moria Hill Cemetery March 6, 1913

20. UNDERTAKER

ADDRESS

Schubert & Lidrup Boise

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Form V. S. No. 5 20M.1-16-12

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics
File No. 1447

Registered No. 28

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

1. PLACE OF DEATH

Registration District No. 1

County of Ada

Primary Registration District No. 2004

City of near Collister

(No. North St St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Arthur C Wattles

PERSONAL AND STATISTICAL PARTICULARS

3. SEX

M

4. COLOR OR RACE

Wht

5. SINGLE, MARRIED, WID-
OWED OR DIVORCED.

Divorced
(Write the word.)

6. DATE OF BIRTH

Nov 26 1896
(Month) (Day) (Year)

7. AGE

36 yrs. 3 mos. 25 ds.

IF LESS than 1 day
how many hrs. or
..... mins.?

8. OCCUPATION

(a) Trade, profession or
particular kind of work

Invalid.

(b) General nature of industry
business, or disestablishment in
which employed (or employer)

9. BIRTHPLACE

(State or Country)

Michigan

10. NAME OF
FATHER

Chas. M. Wattles

11. BIRTHPLACE
OF FATHER

(State or Country)

Mich

12. MAIDEN NAME
OF MOTHER

Ella Abrams

13. BIRTHPLACE
OF MOTHER

(State or Country)

Mich

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

C M Wattles
Collister

(Address)

15.

Filed March 21 1913

Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

Mar 20 1913
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from

March 1903 to March 20 1913

that I last saw him alive on March 17 1913

and that death occurred on the date stated above, at 7 P.M.

The CAUSE OF DEATH* was as follows:

Rheumatic Deformans

(Duration) 10 yrs. — mos. — ds.

Contributory
(Secondary)

(Duration) — yrs. — mos. — ds.

(Signed)

Stuart B. Beck M. D.
March 1913 (Address) Bosse Ida

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death.....yrs.....mos.....days. In the State.....yrs.....mos.....days.

Where was disease contracted if not at place of death?

Former or usual residence.....near Collister Stat

19. PLACE OF BURIAL DATE OF BURIAL

Collister Cemetery 3/22 1913

20. UNDERTAKER

ADDRESS

Schreiber & Sidergala Boise, Idaho

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. N. B.—Every item of information should be carefully supplied. AGE should be state EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Form V. S. No. 5. 10M. 6-20-11.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics
No. 1448

1. PLACE OF DEATH.

Registration District No. 1

County of Boise

Primary Registration District No. 2004

City of Armonah

(No. , St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

J. M. George

Registered No. 24

If death occurred in a hospital, institution or camp give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX

M

4. COLOR OR RACE

W

5. SINGLE, MARRIED, WIDOWED OR DIVORCED.

Married
(Write the word.)

6. DATE OF BIRTH

Unknown

(Month) (Day) (Year)

7. AGE

Unknown

IF LESS than 1 day

yrs. mos. ds. how many hrs. or min.

8. OCCUPATION

Labourer at Armonah dam

- (a) Trade, profession or particular kind of work
(b) General nature of industry business or establishment in which employed (or employer)

9. BIRTHPLACE

(State or Country)

Unknown

10. NAME OF FATHER

"

11. BIRTHPLACE OF FATHER

"

(State or Country)

12. MAIDEN NAME OF MOTHER

"

13. BIRTHPLACE OF MOTHER

(State or Country)

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

H. E. Shaw M.D.

(Address)

Armonah

15.

Filed

March 22 1913

1913

H. E. Shaw

Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

March

18

1913

(Month)

(Day)

(Year)

17. I HEREBY CERTIFY, That I attended deceased from

Feb 28

1913

to March 18

1913

that I last saw him alive on Mar 17 1913

and that death occurred on the date stated above, at 3:44 M.

The CAUSE OF DEATH* was as follows:

Apoplexy a few days before admission
in Hospital Jan 17/13

(Duration) yrs. 2 mos. ds.

Contributory (Secondary)

Diabetes Mellitus

Chronic Nephritis

(Duration) yrs. mos. ds.

(Signed)

H. E. Shaw M. D.

Mar 18 1913 (Address) Armonah

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place Armonah In the Hospital

of death yrs. mos. ds. State yrs. mos. ds.

Where was disease contracted, Apoplexy a few days before admission

If not at place of death? Former or usual residence.

19. PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

Harris Hill Cemetery

3/21 1913

20. UNDERTAKER

ADDRESS

Schreiber & Sidenfaden Boise

RESERVED FOR BINDING

NOTE: Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Form V. S. No. 5 20M.1-16-12

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH.

Registration District No. 1

County of Ada

Primary Registration District No. 2004

City of Boise

(No. So End of 9th St St.)

File No. 4449

Registered No. 25

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Nancy C. Montgomery

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX

F

4. COLOR OR RACE

Wht

5. SINGLE, MARRIED, WIDOWED OR DIVORCED.

Married
(Write the word.)

6. DATE OF BIRTH

July 24 1874
(Month) (Day) (Year)

7. AGE

38 yrs. 8 mos. 28 ds.

IF LESS than 1 day
how many hrs. or
..... mins.?

8. OCCUPATION

(a) Trade, profession or particular kind of work

Housekeeper

(b) General nature of industry, business, or establishment in which employed (or employer)

9. BIRTHPLACE

(State or Country)

Kansas

10. NAME OF FATHER

John E. Hubbard

11. BIRTHPLACE OF FATHER

(State or Country)

America

12. MAIDEN NAME OF MOTHER

Jane Lester

13. BIRTHPLACE OF MOTHER

(State or Country)

American

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

J. Green

(Address)

Boise

15.

Filed March 22 1913

J. M. Taylor

Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH

Mar 20 1913
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from Dec 10 1912, to March 1 1913, that I last saw him alive on Feb 5 1913, and that death occurred on the date stated above, at 9 A.M.

The CAUSE OF DEATH* was as follows:

Pulmonary Tuberculosis

(Duration) yrs. 6 mos. ds.

Contributory (Secondary) Non Pneumonia

(Duration) yrs. mos. ds.

(Signed) A. L. Hume M. D.

19. (Address) Boise Idaho

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death yrs. mos. days. In the State yrs. mos. days.

Where was disease contracted if not at place of death?

Former or usual residence Boise, Idaho

19. PLACE OF BURIAL OR REMOVAL DATE OF BURIAL

Dry Creek Cemetery 3/22 1913

20. UNDERTAKER

ADDRESS

Schreiber & Widney Boise Idaho

MARGIN RESERVED FOR BINDING
WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Form V. S. No. 5 20M.1-16-12

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH

Registration District No. 1

County of

Primary Registration District No. 2004

City of

(No. Sundee Ave St.)

File No. 44511

Registered No. 26

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Mary F Wright

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX

4. COLOR OR RACE

5. SINGLE, MARRIED, WIDOWED OR DIVORCED.

6. DATE OF BIRTH

7. AGE

IF LESS than 1 day
how many hrs. or mins.?

8. OCCUPATION

(a) Trade, profession or particular kind of work

(b) General nature of industry business, or establishment in which employed (or employer)

9. BIRTHPLACE

(State or Country)

10. NAME OF FATHER

11. BIRTHPLACE OF FATHER

(State or Country)

12. MAIDEN NAME OF MOTHER

13. BIRTHPLACE OF MOTHER

(State or Country)

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

(Address)

15.

Filed

1917

Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH

17. I HEREBY CERTIFY, That I attended deceased from

that I last saw her alive on

and that death occurred on the date stated above, at 8 A.M.

The CAUSE OF DEATH* was as follows:

(Duration) yrs. mos. ds.

Contributory (Secondary)

(Duration) yrs. mos. ds.

(Signed) M. D.

(Address)

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death yrs. mos. days. In the State yrs. mos. days.

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

20. UNDERTAKER

ADDRESS

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Form V. S. No. 5 20M.1-16-12

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH.

Registration District No. 1

County of Adams

Primary Registration District No. 2993

File No. 1451

City of

(No. near Source Station St.)

Registered No. 27

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

Christine Campbell

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX

4. COLOR OR RACE

5. SINGLE, MARRIED, WIDOWED OR DIVORCED.

Female White

Married
(Write the word.)

6. DATE OF BIRTH

June 2nd 1884
(Month) (Day) (Year)

7. AGE

25 yrs. 4 mos. 18 ds.

IF LESS than 1 day
how many hrs. or
mins.?

8. OCCUPATION

(a) Trade, profession or

particular kind of work

(b) General nature of industry

business, or establishment in

which employed (or employer)

Housekeeper

9. BIRTHPLACE

(State or Country)

Whiteside Co. Ill

10. NAME OF FATHER

James A Robertson

11. BIRTHPLACE OF FATHER

(State or Country)

Glasgow, Scotland

12. MAIDEN NAME OF MOTHER

Christine McFarlane

13. BIRTHPLACE OF MOTHER

(State or Country)

Wallacetown Ont.

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

Lester M. Campbell

(Address)

Nampa Idaho

15.

Filed

Mar 20 1913

J. M. Taylor
Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH

March 20th 1913
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from
Jan 21 1913, to March 20 1913,
that I last saw her alive on Mar 20 1913,

and that death occurred on the date stated above, at 1 P. M.

The CAUSE OF DEATH* was as follows:

Puerperal septic
pyemia

(Duration) yrs. two mos. two ds.

Contributory
(Secondary)

(Duration) yrs. mos. ds.

(Signed)

J. H. Murray M. D.

Mar 24 1913 (Address) Nampa Idaho

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death yrs. mos. days. In the State yrs. mos. days.

Where was disease contracted if not at place of death?

Former or usual residence.

19. PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

Morris Hill Cemetery

3/22 1913

20. UNDERTAKER

ADDRESS

Schreber & Widengaden

Boise Ida

Burial permit from city health officer

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Form V. S. No. 5 20M.1-16-12

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH

Registration District No. 1

County of Ada

Primary Registration District No. 2004

City of Boise

(No. Soldiers Home St.)

File No. 4452

Registered No. 28

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Samuel Friend

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX

Male

4. COLOR OR RACE

White American

5. SINGLE, MARRIED, WIDOWED OR DIVORCED.

(Write the word.)

6. DATE OF BIRTH

Not obtainable

(Month) (Day) (Year)

7. AGE

67 yrs. — mos. — ds.

IF LESS than 1 day
how many hrs. or
..... mins.?

8. OCCUPATION

- (a) Trade, profession or particular kind of work
(b) General nature of industry business, or establishment in which employed (or employer)

Civil War Veteran

9. BIRTHPLACE

(State or Country)

Not obtainable

10. NAME OF FATHER

11. BIRTHPLACE OF FATHER

(State or Country)

12. MAIDEN NAME OF MOTHER

13. BIRTHPLACE OF MOTHER

(State or Country)

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) E. G. Brunel

(Address) Soldiers' Home

15.

Filed Mar 31 1913

J. M. Layton
Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

Mar 30 1913
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from

March 20 1913, to March 30 1913

that I last saw him alive on March 30 1913,

and that death occurred on the date stated above, at 6.4 A.M.

The CAUSE OF DEATH* was as follows:

Bright's disease

(Duration) yrs. mos. ds.

Contributory
(Secondary)

(Duration) yrs. mos. ds.

(Signed) E. G. Brunel M. D.

19. (Address)

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death yrs. mos. days. In the State yrs. mos. days.

Where was disease contracted if not at place of death?

Former or usual residence.

19. PLACE OF BURIAL OR REMOVAL

Military Cemetery

DATE OF BURIAL

Mar 31 1913

20. UNDERTAKER

Fry & Summers Co

ADDRESS

Boise

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSI-
CIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact state-
ment of OCCUPATION is very important. See instructions on back of certificate.

Form V. S. No. 5 20M.1-16-12

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH.

Registration District No.

County of *Ada*

Primary Registration District No. *2003*

City of

(No. near *Noridian* St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

Mary Ellen Olsen

File No. *1453*

Registered No. *29*

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX

F

4. COLOR OR RACE

W.

5. SINGLE, MARRIED, WID-
OWED OR DIVORCED.

Single
(Write the word.)

6. DATE OF BIRTH

Jan 20th 1913
(Month) (Day) (Year)

7. AGE

2 yrs. *3* mos. *3* ds.

IF LESS than 1 day
how many hrs. or
..... mins.?

8. OCCUPATION

(a) Trade, profession or
particular kind of work

none

(b) General nature of industry
business, or establishment in
which employed (or employer)

9. BIRTHPLACE

(State or Country)

Ada County Idaho

10. NAME OF
FATHER

Varman Olsen

11. BIRTHPLACE
OF FATHER

(State or Country)

Idaho

12. MAIDEN NAME
OF MOTHER

Ora M Cox

13. BIRTHPLACE
OF MOTHER

(State or Country)

Idaho

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

N. Olsen

(Address)

Ada Co Idaho.

15.

Filed *3-22-* 1913

C. L. Sutton
Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH

3 22 1913
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from
Mar 3rd 1913 to *3/22 1913*

that I last saw him alive on *3/18 1913*

and that death occurred on the date stated above, at *10 AM*

The CAUSE OF DEATH* was as follows:

Mal assimilation

(Duration) yrs. mos. ds.

Contributory
(Secondary)

(Duration) yrs. mos. ds.

(Signed) *Fred A. Tuttle* M. D.

3/22 1913 (Address) *Fish Bldg*

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death yrs. mos. days. In the State yrs. mos. days.

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

Cadwell Cemetery

Mar 23 1913

20. UNDERTAKER

ADDRESS

Schreibers Sidenfaden

Boise

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Form V. S. No. 5 20M.1-16-12

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH.

Registration District No.

County of *Bonner*

Primary Registration District No. *7*

City of *Idaho Falls*

(No. St.)

File No. *4454*

Registered No.

If death occurs away from usual residence, give facts called for under special information.

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME *William Jergen*

PERSONAL AND STATISTICAL PARTICULARS

3. SEX

Male

4. COLOR OR RACE

White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED.

Single
(Write the word.)

6. DATE OF BIRTH

Nov 2 9/12
(Month) (Day) (Year)

7. AGE

5 yrs. *16* mos. *16* ds.

IF LESS than 1 day
how many hrs. or
..... mins.?

8. OCCUPATION

- (a) Trade, profession or particular kind of work
(b) General nature of industry, business, or establishment in which employed (or employer)

none

9. BIRTHPLACE

(State or Country)

Idaho

10. NAME OF FATHER

Jacob Jergen

11. BIRTHPLACE OF FATHER

(State or Country)

Germany

12. MAIDEN NAME OF MOTHER

Mrs. Schemm

13. BIRTHPLACE OF MOTHER

(State or Country)

Germany

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

(Address)

Joseph Jergen
Idaho Falls

15.

Filed

Nov 18 1913
T. J. Jergen
Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH

Mar 18 1913
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from

Mar 15 1913 to *Mar 18 1913*

that I last saw him alive on *Mar 15 1913*

and that death occurred on the date stated above, at *109 M.*

The CAUSE OF DEATH* was as follows:

Malnutrition

(Duration) yrs. *2* mos. ds.

Contributory (Secondary)

Enlarged Thyroid

(Duration) yrs. mos. *10* ds.

(Signed)

W. D. M. D.
Mar 18 1913 (Address) *Idaho Falls, Ida.*

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death yrs. mos. days. In the State yrs. mos. days.

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL DATE OF BURIAL

Idaho Falls *Mar 19 1913*

20. UNDERTAKER ADDRESS

T. J. Jergen *Idaho Falls*

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. PHYSICIANS' Every item of information should be carefully supplied. AGE should be state EXACTLY. Exact state-ment of OCCUPATION is very important. See instructions on back of certificate.

Form V. S. No. 5. 10M. 6-20-11.

CERTIFICATE OF DEATH

1. PLACE OF DEATH

County of BonvilleCity of Idaho Falls

Registration District No.

Primary Registration District No.

(No., St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

George Lederal AdamsState of Idaho
BOARD OF HEALTH
Bureau of Vital StatisticsFile No. 4455

Registered No.

If death occurred in a hospital, institution or camp give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX

Male

4. COLOR OR RACE

White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED.

Single
(Write the word.)

6. DATE OF BIRTH

March181913

(Month)

(Day)

(Year)

7. AGE

2 yrs. 7 mos. 21 ds.IF LESS than 1 day
how many hrs. or
..... min.?

8. OCCUPATION

(a) Trade, profession, or particular kind of work
(b) General nature of industry business, or establishment in which employed (or employer)none

9. BIRTHPLACE

(State or Country)

Idaho

10. NAME OF FATHER

George W. Adams

11. BIRTHPLACE OF FATHER

(State or Country)

Idaho

12. MAIDEN NAME OF MOTHER

Edna Lorde

13. BIRTHPLACE OF MOTHER

(State or Country)

Utah

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

(Address)

E. L. Lorde
R. 3 Idaho Falls, Idaho,

15.

Filed

Apr 17 1913

Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

Mar181913

(Month)

(Day)

(Year)

17. I HEREBY CERTIFY, That I attended deceased from

March 16 1913, to Mar 18 1913that I last saw him alive on March 17 1913,and that death occurred on the date stated above, at 12:30 AM.

The CAUSE OF DEATH* was as follows:

Acute Laryngitis
no glandular swelling, whatever
but spasm of larynx to bifurcation
of bronchial tube.
(Duration) yrs. mos. 3 ds.Contributory
(Secondary)Acute inflammation in trachea(Duration) yrs. mos. 2 ds.(Signed) L. W. Pendleton M. D.1913 (Address) Idaho Falls, Idaho

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place In the
of death yrs. mos. ds. State yrs. mos. ds.

Where was Disease contracted,

If not at place of death?

Former or
usual residence.

19. PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

Idaho Falls, Idaho Mar 19 1913

20. UNDERTAKER

ADDRESS

L. W. Pendleton Idaho Falls

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Form V. S. No. 5 20M.1-16-12

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH.

Registration District No. 7County of BonervillePrimary Registration District No. 2027City of Lincoln (No. _____, St.)File No. 4456Registered No. 18

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME John Maynard Bray

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX

Male

4. COLOR OR RACE

White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED.

Child
(Write the word.)

6. DATE OF BIRTH

January 31 1911
(Month) (Day) (Year)

7. AGE

2 yrs. 8 mos. 8 ds.

IF LESS than 1 day
how many _____ hrs. or
_____ mins.?

8. OCCUPATION

(a) Trade, profession or particular kind of work
(b) General nature of industry business, or establishment in which employed (or employer)

Child

9. BIRTHPLACE

(State or Country)

Lincoln Idaho

10. NAME OF FATHER

Albert Bray

11. BIRTHPLACE OF FATHER

(State or Country)

Mississippi

12. MAIDEN NAME OF MOTHER

Johanna Lee

13. BIRTHPLACE OF MOTHER

(State or Country)

Utah

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

Albert Bray

(Address)

Raymond

15.

Filed Mar. 21 1913

E. Bennett
Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH

March 8 1913
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from

_____ 191____, to _____ 191____,
that I last saw him _____ alive on _____ 191____,

and the death occurred on the date stated above, at _____ M.

The CAUSE OF DEATH* was as follows:

Immediate death from
falling into boiler of hot water
accidental -

(Duration) _____ yrs. _____ mos. _____ ds.

Contributory
(Secondary)

(Duration) _____ yrs. _____ mos. _____ ds.

(Signed)

John C. Miller
Idaho Falls

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death _____ yrs. _____ mos. _____ days. In the State _____ yrs. _____ mos. _____ days.

Where was disease contracted if not at place of death?

Former or usual residence _____

19. PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

Lincoln Idaho 3/11 1913

20. UNDERTAKER

ADDRESS

E. Bennett Idaho

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics1. PLACE OF DEATH. Registration District No. 7
County of Bannock Primary Registration District No. 2027
City of Idaho Falls (No. _____ St.)File No. 4457
Registered No. 19

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Lester W. Clark

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX Male 4. COLOR OR RACE White 5. SINGLE, MARRIED, WIDOWED OR DIVORCED. Child
(Write the word.)6. DATE OF BIRTH January 13 1913
(Month) (Day) (Year)7. AGE 1 yrs. 30 mos. 30 ds.
IF LESS than 1 day how many hrs. or mins.?8. OCCUPATION Child
(a) Trade, profession or particular kind of work
(b) General nature of industry, business, or establishment in which employed (or employer)9. BIRTHPLACE Idaho
(State or Country)10. NAME OF FATHER David R. Clark11. BIRTHPLACE OF FATHER Utah
(State or Country)12. MAIDEN NAME OF MOTHER Mary Ward13. BIRTHPLACE OF MOTHER Utah
(State or Country)

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) David R. Clark
(Address) Idaho Falls15. Filed March 27 1913 E. B. Bennett
Dep. Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH March 12 1913
(Month) (Day) (Year)17. I HEREBY CERTIFY, That I attended deceased from Jan 13, 1913 to Mar. 12, 1913
that I last saw him alive on Mar. 11, 1913
and that death occurred on the date stated above, at Idaho Falls.

The CAUSE OF DEATH* was as follows:

44 Swollen thyroid and thymus.
(Duration) yrs. 2 mos. ds.Contributory (Secondary)
(Duration) yrs. mos. ds.(Signed) John D. Miller M. D.
19 (Address) Idaho Falls

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL OR HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death yrs. mos. days. In the State yrs. mos. days.

Where was disease contracted if not at place of death?

Former or usual residence.

19. PLACE OF BURIAL OR REMOVAL Idaho, Ida DATE OF BURIAL 3/14 191320. UNDERTAKER E. B. Bennett ADDRESS Idaho Falls

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
N. B.—Every item of information should be carefully supplied. AGE should be state EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Form V. S. No. 5. 10M. 6-20-11.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics
File No. 4459

1. PLACE OF DEATH.
County of Shoshone
City of Wallace

Registration District No. 28
Primary Registration District No. 1011
(No. _____, _____ St.)

Registered No. 19

If death occurs away from usual residence, give facts called for under special information.

If death occurred in a hospital, institution or camp give its NAME instead of street and number.

2. FULL NAME William Edward Joseph Coyle

PERSONAL AND STATISTICAL PARTICULARS

3. SEX male 4. COLOR OR RACE white 5. SINGLE, MARRIED, WIDOWED OR DIVORCED. single
(Write the word.)

6. DATE OF BIRTH Jan 6 1897
(Month) (Day) (Year)

7. AGE 16 yrs. 1 mos. 24 ds. IF LESS than 1 day how many _____ hrs. or _____ min.

8. OCCUPATION

- (a) Trade, profession or particular kind of work
(b) General nature of industry business or establishment in which employed (or employer)

Student

9. BIRTHPLACE

(State or Country)

Idaho

10. NAME OF FATHER

James Coyle

11. BIRTHPLACE OF FATHER

(State or Country)

Ireland

12. MAIDEN NAME OF MOTHER

Mary Roche

13. BIRTHPLACE OF MOTHER

(State or Country)

Ireland

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Mrs James Coyle
(Address) 426 Cedar St. Wallace

15. 3/3 3/3 1913 F. Leo Jimsley
Filed _____ Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH Mar 2 1913
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from Jan 1 1913, to Mar 1 1913, that I last saw him alive on Mar 1 1913, and that death occurred on the date stated above, at 130 A.M.

The CAUSE OF DEATH* was as follows:

Cerebral tumor of right hemisphere(Duration) _____ yrs. 2 mos. _____ ds.

Contributory (Secondary)

none

(Duration) _____ yrs. _____ mos. _____ ds.

(Signed) Dr. M. D. M. D.
Mar 3 1913 (Address) Wallace, Ida

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death _____ yrs. _____ mos. _____ ds. In the State _____ yrs. _____ mos. _____ ds.
Where was disease contracted,
If not at place of death?
Former or usual residence.

19. PLACE OF BURIAL OR REMOVAL DATE OF BURIAL

Wallace Ida Mar 4 1913

20. UNDERTAKER ADDRESS

Hardy Huderlakings, Wallace

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Form V. S. No. 5 20M.1-16-12

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH.

Registration District No. 28

County of Shoshone

Primary Registration District No. 1011-

City of Wallace

(No. Providence Hospital St.)

File No. 4464

Registered No. 21

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Infant Charles Thurman
If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX

4. COLOR OR RACE

5. SINGLE, MARRIED, WIDOWED OR DIVORCED.

Male

White

(Write the word.)

6. DATE OF BIRTH

3 2 1913
(Month) (Day) (Year)

7. AGE

1 yrs. 1 mos. 1 ds.

IF LESS than 1 day
how many 0 hrs. or
0 mins?

8. OCCUPATION

(a) Trade, profession or particular kind of work none
(b) General nature of industry business, or establishment in which employed (or employer)

9. BIRTHPLACE

(State or Country) Wallace, Idaho

10. NAME OF FATHER

Charles Thurman

11. BIRTHPLACE OF FATHER

(State or Country) Kansas

12. MAIDEN NAME OF MOTHER

Nellie Pittman

13. BIRTHPLACE OF MOTHER

(State or Country) Missouri

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Charles Thurman

(Address) Burke St.

15.

Filed MAY 5 1913 F. J. Lander
Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH

3 2 1913
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from Mar 1 1913, to Mar 2 1913,

that I last saw him alive on 1913

and that death occurred on the date stated above, at M.

The CAUSE OF DEATH was as follows:

premature birth

(Duration) 0 yrs. 0 mos. 0 ds.

Contributory (Secondary)

None

(Duration) 0 yrs. 0 mos. 0 ds.

(Signed)

Drs. Mowery

M. D.

3/2 1913 (Address) Wallace, Idaho.

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death 0 yrs. 0 mos. 0 days. In the State 0 yrs. 0 mos. 0 days.

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

Wallace, Idaho.

3/7 1913

20. UNDERTAKER

ADDRESS

Bruce C. Worstell

Wallace,

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. N. B.—Every item of information should be carefully supplied. AGE should be state EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Form V. S. No. 5. 10M. 6-20-11.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics
File No. 1461
Registered No. 21

1. PLACE OF DEATH. Registration District No. 28
County of Shoshone Primary Registration District No. 101
City of Wallace (No. _____, St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Andrew Anderson

If death occurred in a hospital, institution or camp give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX Male 4. COLOR OR RACE White 5. SINGLE, MARRIED, WIDOWED OR DIVORCED. married
(Write the word.)

6. DATE OF BIRTH April 9 1859
(Month) (Day) (Year)

7. AGE 55 yrs. mos. ds. IF LESS than 1 day how many hrs. or min.)

8. OCCUPATION
(a) Trade, profession or particular kind of work Miner
(b) General nature of industry business or establishment in which employed (or employer)

9. BIRTHPLACE Sweden
(State or Country)

10. NAME OF FATHER Andrew Anderson

11. BIRTHPLACE OF FATHER Sweden
(State or Country)

12. MAIDEN NAME OF MOTHER Unknown

13. BIRTHPLACE OF MOTHER Sweden
(State or Country)

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Hanna Anderson
(Address) Mullan Idaho

15. March 8 1913 F. Leo Ziegler
Filed Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH March 7 1913
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from Feb 27 1913 to March 7 1913
that I last saw him alive on March 6 1913
and that death occurred on the date stated above, at 3:30 PM

The CAUSE OF DEATH* was as follows:

Cirrhosis of liver

(Duration) 2 yrs. mos. ds.

Contributory (Secondary)

(Duration) _____ yrs. mos. ds.

(Signed) D. H. Mowbray
March 8 1913 (Address) Wallace

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death _____ yrs. mos. ds. State _____ yrs. mos. ds.
Where was disease contracted, If not at place of death?
Former or usual residence _____

19. PLACE OF BURIAL OR REMOVAL Mullan Idaho DATE OF BURIAL March 9 1913

20. UNDERTAKER Hard Undertaking Co ADDRESS Wallace

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Form V. S. No. 5 20M.1-16-12

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH.

Registration District No. 28

County of Shoshone

Primary Registration District No. 104

City of Wallace

(No. 320, Cedar Street St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Edward S Bohon

File No. 1462

Registered No. 23

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX

Male

4. COLOR OR RACE

White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED.

married
(Write the word.)

6. DATE OF BIRTH

9 12 1864
(Month) (Day) (Year)

7. AGE

45 yrs. 6 mos. 0 ds.

IF LESS than 1 day
how many hrs. or
mins.

8. OCCUPATION

(a) Trade, profession or particular kind of work

merchant

(b) General nature of industry, business, or establishment in which employed (or employer)

liquor business

9. BIRTHPLACE

(State or Country)

Missouri

10. NAME OF FATHER

Bohon

11. BIRTHPLACE OF FATHER

(State or Country)

Kentucky

12. MAIDEN NAME OF MOTHER

13. BIRTHPLACE OF MOTHER

(State or Country)

Kentucky

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

Mrs. S. E. Bohon

(Address)

Wallace, Ida

15.

Filed

Nov 17, 1913

H. Leo Taylor

Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH

3 12 1913
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from

— 191—, to — 191—,

that I last saw him alive on Mar 3 1913

and that death occurred on the date stated above, at 10:34 M.

The CAUSE OF DEATH* was as follows:

a self-inflicted gunshot wound to forehead
suicidal intent

(Duration) 1 yrs. 0 mos. 0 ds.

Contributory (Secondary)

Intoxication
Brooding

(Duration) 1 yrs. 0 mos. 0 ds.

(Signed)

Chas R. Mowery, Coroner

3/14/1913 (Address) Wallace, Ida

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death — yrs. — mos. — days. In the State — yrs. — mos. — days.

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

Wallace, Ida, 3/14 1913

20. UNDERTAKER

ADDRESS

B. E. Wawtlett, Wallace, Ida

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. N. B.—Every item of information should be carefully supplied. AGE should be state EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Form V. S. No. 5. 10M. 6-20-11.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. **PLACE OF DEATH.** Registration District No. 28
County of Shoshone Primary Registration District No. 1011
City of Wallace (No. _____, _____ St.) Registered No. 23

If death occurs away from usual residence, give facts called for under special information.

2. **FULL NAME** Helmer Bowman

If death occurred in a hospital, institution or camp give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. **SEX** male 4. **COLOR OR RACE** white 5. **SINGLE, MARRIED, WIDOWED OR DIVORCED** single
(Write the word)

6. **DATE OF BIRTH** _____
(Month) (Day) (Year)

7. **AGE** 23 yrs. _____ mos. _____ ds. IF LESS than 1 day how many _____ hrs. or _____ min.?

8. **OCCUPATION**
(a) Trade, profession or particular kind of work _____
(b) General nature of industry business or establishment in which employed (or employer) machinist

9. **BIRTHPLACE** (State or Country) Mo.

10. **NAME OF FATHER** Joe Bowman

11. **BIRTHPLACE OF FATHER** (State or Country) Kentucky

12. **MAIDEN NAME OF MOTHER** Sarah Huitt

13. **BIRTHPLACE OF MOTHER** (State or Country) Mo.

14. **THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE**
(Informant) Frank Bowman
(Address) Mullan Idaho

15. Mar. 15, 1913 Dr. Leo Dringley
Filed _____ Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. **DATE OF DEATH** Mar 14 1913
(Month) (Day) (Year)

17. **I HEREBY CERTIFY**, That I attended deceased from Mar 7, 1913, to Mar 14, 1913 that I last saw him alive on Mar 14, 1913 and that death occurred on the date stated above, at 11 A. M.

The **CAUSE OF DEATH*** was as follows:
Cerebral Men-
ingitis

(Duration) _____ yrs. _____ mos. 12 ds.

Contributory (Secondary) none

(Duration) _____ yrs. _____ mos. _____ ds.

(Signed) Dr. M. D. Mullan (Address) Wallace

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. **LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)**
At place _____ yrs. _____ mos. _____ ds. In the _____ State _____ yrs. _____ mos. _____ ds.
Where was disease contracted, _____
If not at place of death? _____
Former or usual residence _____

19. **PLACE OF BURIAL OR REMOVAL** Mullan **DATE OF BURIAL** Mar 14, 1913

20. **UNDERTAKER** Ward's Undertaking Co. Wallace **ADDRESS**

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Form V. S. No. 5. 10M. 6-20-11.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH.

Registration District No. 28County of ShoshonePrimary Registration District No. 1011City of Wallace

(No. _____, St.)

Registered No. 24

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

Dean Goupill

If death occurred in a hospital, institution or camp give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX

male

4. COLOR OR RACE

white

5. SINGLE, MARRIED, WIDOWED OR DIVORCED.

single
(Write the words)

6. DATE OF BIRTH

_____.
(Month) (Day) (Year)

7. AGE

35 yrs. — mos. — ds.

IF LESS than 1 day
how many hrs. or
min.?

8. OCCUPATION

- (a) Trade, profession or particular kind of work
(b) General nature of industry business or establishment in which employed (or employer)

mill man

9. BIRTHPLACE

(State or Country)

unknown

10. NAME OF FATHER

11. BIRTHPLACE OF FATHER

(State or Country)

12. MAIDEN NAME OF MOTHER

13. BIRTHPLACE OF MOTHER

(State or Country)

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

Wards Undertaking Co

(Address)

By H. Thompson
Wallace, Idaho

15.

Filed March 18 1913H. Res. J. J. J.

Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

May

(Month)

14

(Day)

31913
(Year)

17. I HEREBY CERTIFY, That I attended deceased from

_____ 1913, to _____ 1913that I last saw him alive on _____ 1913and that death occurred on the date stated above, at 9:12 A.M.

The CAUSE OF DEATH* was/as follows

Due to fracture of skull & cervical vertebrae

(Duration)

Instant yrs. mos. ds.

Contributory (Secondary)

(Duration)

None yrs. mos. ds.

(Signed)

Chas. R. Mowery
Mar 18 1913 (Address) Wallace, Idaho

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place

of death.

Where was disease contracted,

If not at place of death?

Former or

usual residence.

In the

ds. State.

yrs. mos. ds.

19. PLACE OF BURIAL OR REMOVAL

Wallace

DATE OF BURIAL

Mar 18 1913

20. UNDERTAKER

Wards Undertaking Co

ADDRESS

Form V. S. No. 5 20M.1-16-12

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH.

Registration District No. 28County of ShoshonePrimary Registration District No. 1011-City of Wallace(No. Providence Hospital St.)File No. 4465Registered No. 25

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME J. C. Connors

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX

male

4. COLOR OR RACE

white

5. SINGLE, MARRIED, WIDOWED OR DIVORCED.

single
(Write the word.)

6. DATE OF BIRTH

(Month)

(Day)

(Year)

7. AGE

38

yrs. mos. ds.

IF LESS than 1 day
how many hrs. or
mins.?

8. OCCUPATION

(a) Trade, profession or
particular kind of work miner(b) General nature of industry
business, or establishment in
which employed (or employer)

9. BIRTHPLACE

(State or Country)

not known

10. NAME OF
FATHER

"

"

11. BIRTHPLACE
OF FATHER

"

"

(State or Country)

12. MAIDEN NAME
OF MOTHER

"

"

13. BIRTHPLACE
OF MOTHER

"

"

(State or Country)

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

R. H. Kingsbury

(Address)

Wallace, Idaho.

15.

Filed

Mar 221913F. Leo Quinley

Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH

3

(Month)

17

(Day)

1913

(Year)

17. I HEREBY CERTIFY, That I attended deceased from

March 17 1913, to March 17 1913,that I last saw him alive on March 17 1913and that death occurred on the date stated above, at 9 P. M.

The CAUSE OF DEATH* was as follows:

Lobar Pneumonia

(Duration) yrs. mos. ds.

Contributory

(Secondary)

(Duration) yrs. mos. ds.

(Signed)

F. Leo Quinley

M. D.

Mar 20 1913 (Address) Wallace, Idaho

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death Providence Hosp In the
yrs. mos. 1 days. State yrs. mos. days.Where was disease contracted
if not at place of death?Former or
usual residence

19. PLACE OF BURIAL OR REMOVAL

Wallace, Idaho.

DATE OF BURIAL

March 22 1913

20. UNDERTAKER

Brace & Mortimer

ADDRESS

Wallace

Form V. S. No. 5 20M.1-16-12

CERTIFICATE OF DEATH

 State of Idaho
 BOARD OF HEALTH
 Bureau of Vital Statistics

1. PLACE OF DEATH.

Registration District No. 28County of ShoshonePrimary Registration District No. 1011City of Wallace(No. Wallace Hospital St.)File No. 4466Registered No. 26

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Carl Anderson

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX

Male

4. COLOR OR RACE

White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED.

Single
(Write the word.)

6. DATE OF BIRTH

(Month)

(Day)

(Year)

7. AGE

48

yrs. mos. ds.

 IF LESS than 1 day
 how many hrs. or mins.?

OCCUPATION

(a) Trade, profession or particular kind of work

Tailor

(b) General nature of industry business, or establishment in which employed (or employer)

9. BIRTHPLACE

(State or Country)

Norway

10. NAME OF FATHER

Omar Anderson

11. BIRTHPLACE OF FATHER

(State or Country)

Norway

12. MAIDEN NAME OF MOTHER

Christine Christopherson

13. BIRTHPLACE OF MOTHER

(State or Country)

Norway

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

J. E. St. Jean

(Address)

Wallace Id.

15.

Filed

Mar 22,1913T. Leodingley

Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

3111913

(Month)

(Day)

(Year)

17. I HEREBY CERTIFY, That I attended deceased from

Jan 1 1913 to Mar 11 1913that I last saw him alive on Mar 10 1913and that death occurred on the date stated above, at 3:30 P.M.

The CAUSE OF DEATH* was as follows:

Pulmonary Tuberculosis
Lois(Duration) indefinite yrs. mos. ds.Contributory (Secondary) Exposure & Alcohol(Duration) 1 yrs. mos. ds.(Signed) Dr. Mowery M. D.3/11/13 (Address) Wallace Idaho

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death. yrs. mos. days. In the State. yrs. mos. days.

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

Wallace Id.Mar 23 1913

20. UNDERTAKER

ADDRESS

W. W. VestellWallace Id.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Form V. S. No. 5. 12½ M. 7-24-11

1. PLACE OF DEATH. Registration
County of Blaine Lake Primary Registration District No. 2093
City of Lamar (No. _____, _____ St.)

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

File No. 4467

Registered No. 18

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Nicholas Egli

If death occurred in a hospital, institution or camp give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX Male 4. COLOR OR RACE White 5. SINGLE, MARRIED, WIDOWED OR DIVORCED. Widowed
(Write the word.)

6. DATE OF BIRTH October 15 1883
(Month) (Day) (Year)

7. AGE 79 yrs. 4 mos. 29 ds. IF LESS than 1 day how many _____ hrs. or _____ min?

8. OCCUPATION Farmer
(a) Trade, profession or particular kind of work
(b) General nature of industry business or establishment in which employed (or employer)

9. BIRTHPLACE Switzerland
(State or Country)

10. NAME OF FATHER Joseph Egli

11. BIRTHPLACE OF FATHER Switzerland
(State or Country)

12. MAIDEN NAME OF MOTHER Annie Hanne

13. BIRTHPLACE OF MOTHER Switzerland
(State or Country)

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) J. W. Casey
(Address) Lamar Idaho

15. Filed 4-7- 1913 Joseph Egli
Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH Mar 4 1913
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from Mar 2 1913, to Mar 4 1913, that I last saw him alive on Mar 2 1913 and that death occurred on the date stated above, at 9 P. M. The CAUSE OF DEATH* was as follows:
General Debility

(Duration) _____ yrs. _____ mos. _____ ds.
Contributory Frozen foot
(Secondary)
2 days (Duration) _____ yrs. _____ mos. _____ ds.
(Signed) S. F. Ashley M. D.
3/6 1913 (Address) Mar 4

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place _____ In the _____
of death _____ yrs. _____ mos. _____ ds. State _____ yrs. _____ mos. _____ ds.
Where was disease contracted,
If not at place of death? _____
Former or
usual residence. _____

19. PLACE OF BURIAL OR REMOVAL DATE OF BURIAL

Lamar Id 3-4 1913
20. UNDERTAKER ADDRESS

Form V. S. No. 5. 12½ M. 7-24-11

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH. Registration District No. 27
 County of Beauregard Primary Registration District No. 2092
 City of Paris (No. _____, St.)

File No. 446
 Registered No. 16

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

Frances Lewis

If death occurred in a hospital, institution or camp give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX Female 4. COLOR OR RACE White 5. SINGLE, MARRIED, WIDOWED OR DIVORCED. single
 (Write the word.)
 6. DATE OF BIRTH Feb. 27 - 1913
 (Month) (Day) (Year)

7. AGE _____ yrs. _____ mos. 24 ds. IF LESS than 1 day how many _____ hrs. or _____ min?

8. OCCUPATION

(a) Trade, profession or particular kind of work. none
 (b) General nature of industry business or establishment in which employed (or employer)

9. BIRTHPLACE

(State or Country) Idaho

10. NAME OF FATHER

Frank Lewis

11. BIRTHPLACE OF FATHER

(State or Country) Idaho

12. MAIDEN NAME OF MOTHER

Pollie Shepherd

13. BIRTHPLACE OF MOTHER

(State or Country) England

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Frank Lewis
 (Address) Paris Idaho

15.

Filed 7-3-191W. Hayward
Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH

Mar. 20 1913
 (Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from Mar. 18 - 1913, to Mar 20 - 1913
 that I last saw her alive on Mar 20 1913
 and that death occurred on the date stated above, at _____ M.

The CAUSE OF DEATH* was as follows:

Acute Bacterial Pneumonia

_____ (Duration) _____ yrs. _____ mos. _____ ds.

Contributory
 (Secondary) none

_____ (Duration) _____ yrs. _____ mos. 3 ds.

(Signed) W. Hayward M. D.
3/22 - 1913 (Address) Paris Idaho

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place _____ In the _____
 of death _____ yrs. _____ mos. _____ ds. State _____ yrs. _____ mos. _____ ds.
 Where was disease contracted, _____
 If not at place of death? _____
 Former or _____
 usual residence _____

19. PLACE OF BURIAL OR REMOVAL DATE OF BURIAL

Paris Idaho 3-22 1913

20. UNDERTAKER ADDRESS

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Form V. S. No. 5. 12½ M. 7-24-11

CERTIFICATE OF DEATH

1. PLACE OF DEATH. Registration District No. 24
County of Bear Lake Primary Registration District No. 2092
City of Paris Idaho (No. _____, St.)

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics
File No. 4469
Registered No. 17

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

Ralph W. Jones

If death occurred in a hospital, institution or camp give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX Male 4. COLOR OR RACE White 5. SINGLE, MARRIED, WIDOWED OR DIVORCED. Single
(Write the word.)

6. DATE OF BIRTH July 25 1912
(Month) (Day) (Year)

7. AGE 8 yrs. 2 mos. 2 ds. IF LESS than 1 day how many hrs. or min?

8. OCCUPATION

(a) Trade, profession or particular kind of work. none
(b) General nature of industry business or establishment in which employed (or employer)

9. BIRTHPLACE

(State or Country) Idaho

10. NAME OF FATHER

Earl Jones

11. BIRTHPLACE OF FATHER

(State or Country) Idaho

12. MAIDEN NAME OF MOTHER

Cassie Wright

13. BIRTHPLACE OF MOTHER

(State or Country) Idaho

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Chas Jones
(Address) Paris Idaho

15.

Filed 4-7-1913

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH

March 20 1913
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from Mar 16 1913, to Mar 20 1913

that I last saw him alive on Mar 19 1913 and that death occurred on the date stated above, at 6 P.M.

The CAUSE OF DEATH* was as follows:

Acute Bronchial Pneumonia

(Duration) _____ yrs. _____ mos. 4 ds.

Contributory (Secondary) none

(Duration) _____ yrs. _____ mos. _____ ds.

(Signed) J. W. Hayward M. D.
3/20 1913 (Address) Paris Idaho

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; (2) whether ACCIDENTAL, SUICIDAL OR HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place _____ In the _____
of death _____ yrs. _____ mos. _____ ds. State _____ yrs. _____ mos. _____ ds.

Where was disease contracted,

If not at place of death?

Former or

usual residence.

19. PLACE OF BURIAL OR REMOVAL DATE OF BURIAL

Paris Idaho 3-22 1913

20. UNDERTAKER

ADDRESS

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Form V. S. No. 5 20M.1-16-12

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH

Registration District No. 23

County of Twin Falls

Primary Registration District No. 2087

City of

(No.

St.)

Registered No.

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Ruth Dingley

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX F

4. COLOR OR RACE W.

5. SINGLE, MARRIED, WIDOWED OR DIVORCED. Single (write the word.)

6. DATE OF BIRTH Feb. 11 1913

(Month)

(Day)

(Year)

7. AGE

yrs.

mos. 10

ds.

IF LESS than 1 day
how many hrs. or
mins.?

8. OCCUPATION

(a) Trade, profession or particular kind of work

(b) General nature of industry business, or establishment in which employed (or employer)

9. BIRTHPLACE

(State or Country) Twin Falls County

10. NAME OF FATHER A. M. Dingley

11. BIRTHPLACE OF FATHER Missouri

(State or Country)

12. MAIDEN NAME OF MOTHER Amy Wilford

13. BIRTHPLACE OF MOTHER Wash.

(State or Country)

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Lemuel D. Galls

(Address) Lemuel Dingley

15.

Filed 3-6 1913

3

Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH

(Month) 3

(Day) 5

1913 (Year)

17. I HEREBY CERTIFY, That I attended deceased from

Mar 3 1913, to Mar 3 1913

that I last saw her alive on Mar 3 1913

and that death occurred on the date stated above, at 3 P. M.

The CAUSE OF DEATH* was as follows:

Tuberculosis

(Duration) yrs. mos. 5 ds.

Contributory (Secondary)

(Duration) yrs. mos. ds.

(Signed) H. G. Fike M. D.

3/6/1913 (Address) Twin Falls, Idaho

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death yrs. mos. days. In the State yrs. mos. days.

Where was disease contracted if not at place of death?

Former or usual residence.

19. PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

Twin Falls 3-6 1913

20. UNDERTAKER

ADDRESS

Charles J. Crooby Twin Falls

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Form V. S. No. 5. 12 1/2 M. 7-24-11

1. PLACE OF DEATH.
County of *Twinn Falls.*
City of *W. S. E. Bull.*

Registration District No. *2-13*
Primary Registration District No. *2087*
(No. _____, St.)

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics
File No. *4471*

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME *Alice Klaude McKibben*

Registered No. _____
If death occurred in a hospital, institution or camp give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX *F.* 4. COLOR OR RACE *White* 5. SINGLE, MARRIED, WIDOWED OR DIVORCED. *single*
(Write the word.)

6. DATE OF BIRTH *Mar 30 1913*
(Month) (Day) (Year)

7. AGE *9 yrs. 9 mos. 14 ds.* IF LESS than 1 day how many _____ hrs. or _____ min?

8. OCCUPATION
(a) Trade, profession or particular kind of work. *house*
(b) General nature of industry business or establishment in which employed (or employer)

9. BIRTHPLACE
(State or Country) *Bull Ida*

10. NAME OF FATHER *Walter McKibben*

11. BIRTHPLACE OF FATHER
(State or Country) *Ohio*

12. MAIDEN NAME OF MOTHER *Blanch Price*

13. BIRTHPLACE OF MOTHER
(State or Country) *Wis.*

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) *W. C. McKibben*
(Address) *Bull Ida*

15. Filed *3-31* 191*3* *J. H. Murphy*
Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH *Mar 30 1913*
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from *his physical* 191*3*
that I last saw him *attended by Christian Scriver* 191*3*
alive on *Mar 30*
and that death occurred on the date stated above, at _____ M.

The CAUSE OF DEATH was as follows:
whooping Cough.

(Duration) _____ yrs. *1* mos. *7* ds.
Contributory (Secondary)

(Duration) _____ yrs. _____ mos. _____ ds.
(Signed) *J. H. Murphy* M. D.
3-31 191*3* (Address) *Bull.*

The above is true to the best of my knowledge.
C. L. Blystone
J. L. Humphreys
Witness

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Form V. S. No. 5 20M.1-1

DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics
File No. 4472

1. PLACE OF DEATH. Registration District No. 2087
County of Twin Falls Primary Registration District No. 23
City of Buhl (No. St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Albert Clarence Stoddard

Registered No.

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX M. 4. COLOR OR RACE W. 5. SINGLE, MARRIED, WIDOWED OR DIVORCED. Single (Write the word.)

6. DATE OF BIRTH Oct. 12 1910 (Month) (Day) (Year)

7. AGE 2 yrs. 5 mos. ds. IF LESS than 1 day how many hrs. or mins.?

8. OCCUPATION (a) Trade, profession or particular kind of work (b) General nature of industry business, or establishment in which employed (or employer) Ruby

9. BIRTHPLACE Buhl - Ida. (State or Country)

10. NAME OF FATHER Joseph Stoddard

11. BIRTHPLACE OF FATHER England (State or Country)

12. MAIDEN NAME OF MOTHER Laura Morford

13. BIRTHPLACE OF MOTHER Beaver Falls Pa. (State or Country)

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE (Informant) Laura Stoddard (Address) Buhl Ida

15. Filed 3-13 1913 J. H. Murphy Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH Mar 12 1913 (Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from Mar 3 1913, to Mar 12 1913, that I last saw him alive on Mar 3 1913, and that death occurred on the date stated above, at 1:15 P.M.

The CAUSE OF DEATH* was as follows:

Tubercular Cerebrospinal meningitis

(Duration) yrs. 1 mos. 10 ds. Contributory (Secondary)

(Duration) yrs. mos. ds. (Signed) W. H. Christy M. D. 3/13 1913 (Address) Buhl Ida

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death. yrs. mos. days. In the State. yrs. mos. days.

Where was disease contracted if not at place of death?

Former or usual residence.

19. PLACE OF BURIAL OR REMOVAL DATE OF BURIAL H. B. Edwards Twin Falls 3-14 1913

20. UNDERTAKER ADDRESS Vacker

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Form V. S. No. 5 20M.1-16-12

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH

Registration District No.

23

County of

Twin Falls

Primary Registration District No.

2087

File No.

4473

City of

Buhl

(No.

St.)

Registered No.

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

Geraldine Lois Osgood

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX

F

4. COLOR OR RACE

White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED.

Single
(Write the word.)

6. DATE OF BIRTH

Sept. 27th 1912

(Month)

(Day)

(Year)

7. AGE

5 yrs. 18 mos. ds.

IF LESS than 1 day
how many hrs. or
..... mins.?

8. OCCUPATION

(a) Trade, profession or particular kind of work

(b) General nature of industry, business, or establishment in which employed (or employer)

Baby

9. BIRTHPLACE

(State or Country)

Buhl

10. NAME OF FATHER

M. B. Osgood

11. BIRTHPLACE OF FATHER

(State or Country)

Maine

12. MAIDEN NAME OF MOTHER

Alberta Sherman

13. BIRTHPLACE OF MOTHER

(State or Country)

South Dakota

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

M. B. Osgood
Buhl

(Address)

15.

Filed

3/17

191

J. H. Murphy

Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH

Mar 17

(Month)

(Day)

1913

17. I HEREBY CERTIFY, That I attended deceased from

Mar 17

1913, to

Mar 18

1913

that I last saw him alive on

191

and that death occurred on the date stated above, at 59 M.

The CAUSE OF DEATH* was as follows:

Baby was found dead in bed Cause unknown probably valvular heart disease

(Duration)

yrs.

mos.

ds.

Contributory

(Secondary)

(Duration)

yrs.

mos.

ds.

(Signed)

Chas. M. H. Barber M. D.

3/17 1913

(Address)

Buhl Ida

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place

of death

yrs.

mos.

days.

In the

State

yrs.

mos.

days.

Where was disease contracted if not at place of death?

Former or

usual residence

19. PLACE OF BURIAL OR REMOVAL

Buhl

DATE OF BURIAL

3-18

1913

20. UNDERTAKER

J. B. Evans

ADDRESS

Buhl Ida

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Form V. S. No. 5 20M.1-16-12

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH.

Registration District No. 23County of Twin FallsPrimary Registration District No. 2084City of Kimberly

(No. _____, _____ St.)

File No. 4474

Registered No. _____

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME George Everett Peterson

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX

Male

4. COLOR OR RACE

White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED.

— (Write the word.) —

6. DATE OF BIRTH

Nov. 9th, 1912

(Month)

(Day)

(Year)

7. AGE

4 yrs. 22 mos. 22 ds.IF LESS than 1 day
how many _____ hrs. or
_____ mins.?

8. OCCUPATION

(a) Trade, profession or particular kind of work _____

(b) General nature of industry, business, or establishment in which employed (or employer) _____

9. BIRTHPLACE

(State or Country)

Kimberly

10. NAME OF FATHER

J. E. Peterson

11. BIRTHPLACE OF FATHER

(State or Country)

Mass.

12. MAIDEN NAME OF MOTHER

Maud Blair

13. BIRTHPLACE OF MOTHER

(State or Country)

Iowa.

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) W. E. Peterson(Address) Kimberly

15.

Filed Apr 1191 3John H. Engle
Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH

Mar30191 3

(Month)

(Day)

(Year)

17. I HEREBY CERTIFY, That I attended deceased from

Mar. 28 1913, to Mar. 31 1913that I last saw him alive on Mar. 30 1913and that death occurred on the date stated above, at 4 P. M.

The CAUSE OF DEATH* was as follows:

acute pleuro-pneumonia(Duration) 2 yrs. 2 mos. 2 ds.Contributory
(Secondary) Cough(Duration) 10 yrs. 10 mos. 10 ds.(Signed) John J. White M. D.Mar 3, 1913 (Address) Kimberly

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death. _____ yrs. _____ mos. _____ days. In the State. _____ yrs. _____ mos. _____ days.

Where was disease contracted if not at place of death? _____

Former or usual residence _____

19. PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

KimberlyApr 2 1913

20. UNDERTAKER

ADDRESS

Kimberly Twin Falls

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Form V. S. No. 5 20M.1-16-12

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH.

Registration District No. 23County of Twin FallsPrimary Registration District No. 2083City of Hansen

(No. _____, St.)

File No. 4475

Registered No. _____

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Wm Clark Killion

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX

Male

4. COLOR OR RACE

White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED.

Single (Write the word.)

6. DATE OF BIRTH

Aug 30 1905
(Month) (Day) (Year)

7. AGE

7 yrs. 7 mos. 9 ds.IF LESS than 1 day
how many hrs. or
..... mins.?

8. OCCUPATION

(a) Trade, profession or particular kind of work

(b) General nature of industry business, or establishment in which employed (or employer)

9. BIRTHPLACE

(State or Country) Sheridan, Mo.

10. NAME OF FATHER

Chas. A. Killion

11. BIRTHPLACE OF FATHER

(State or Country) Iowa

12. MAIDEN NAME OF MOTHER

Zella M. Kirkpatrick

13. BIRTHPLACE OF MOTHER

(State or Country) Grand City, Mo.

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) C. D. Weaver(Address) Twin Falls, Id

15.

Filed 3-10 1913John H. Ogden
Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH

Mar. 9 1913
(Month) (Day) (Year)17. I HEREBY CERTIFY, That I attended deceased from Feb. 14 1913 to Mar. 9 1913that I last saw him alive on Mar. 9 1913
and that death occurred on the date stated above, at 11:30.

The CAUSE OF DEATH* was as follows:

Broncho-pneumonia(Duration) yrs. mos. 28 ds.Contributory
(Secondary)

(Duration) yrs. mos. ds.

(Signed) C. D. Weaver M. D.19 (Address) Twin Falls, Id

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death yrs. mos. days. In the State yrs. mos. days.

Where was disease contracted if not at place of death?

Former or usual residence.

19. PLACE OF BURIAL OR REMOVAL

Twin Falls

DATE OF BURIAL

3-10 1913

20. UNDERTAKER

ADDRESS

Charles J. Crosby Twin Falls

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Form V. S. No. 5 20M.1-16-12		CERTIFICATE OF DEATH		State of Idaho BOARD OF HEALTH Bureau of Vital Statistics	
1. PLACE OF DEATH.		Registration District No. <u>23</u>		File No. <u>4475</u>	
County of <u>Twin Falls</u>		Primary Registration District No. <u>2086</u>		Registered No. _____	
City of _____		(No. _____, _____ St.)		If death occurred in a hospital, institution or camp, give its NAME instead of street and number.	
If death occurs away from usual residence, give facts called for under special information.					
2. FULL NAME <u>Elisaha Dannels</u>					
PERSONAL AND STATISTICAL PARTICULARS			MEDICAL CERTIFICATE OF DEATH.		
3. SEX	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED OR DIVORCED.	16. DATE OF DEATH		
Male	White	Single (Write the word.)	<u>March 7th</u> 191 <u>3</u>		
6. DATE OF BIRTH			(Month) (Day) (Year)		
<u>Oct. 11, 1861</u>					
(Month) (Day) (Year)			17. I HEREBY CERTIFY, That I attended deceased from <u>Feb 17</u> 191 <u>3</u> , to <u>March 2</u> 191 <u>3</u> , that I last saw him alive on <u>Feb 17</u> 191 <u>3</u> , and that death occurred on the date stated above, at <u>7 A.M.</u>		
7. AGE	IF LESS than 1 day how many _____ hrs. or _____ mins.?		The CAUSE OF DEATH* was as follows:		
<u>51</u> yrs. <u>4</u> mos. <u>19</u> ds.			<u>Valvular Heart Disease</u>		
8. OCCUPATION			(Duration) <u>2</u> yrs. _____ mos. _____ ds.		
(a) Trade, profession or particular kind of work <u>Farmer</u>			Contributory <u>Chronic Nephritis</u>		
(b) General nature of industry business, or establishment in which employed (or employer) _____			(Secondary)		
9. BIRTHPLACE			(Duration) <u>1</u> yrs. _____ mos. _____ ds.		
(State or Country) <u>Paulding Co., Ohio</u>			(Signed) <u>H. C. Wilson</u> M. D.		
10. NAME OF FATHER			<u>Feb 3, 1913</u> (Address) <u>Twin Falls, Idaho</u>		
<u>Johnathan Dannels</u>			*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.		
11. BIRTHPLACE OF FATHER			18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)		
(State or Country) <u>Homes Co., Ohio</u>			At place of death _____ yrs. _____ mos. _____ days. In the State _____ yrs. _____ mos. _____ days.		
12. MAIDEN NAME OF MOTHER			Where was disease contracted if not at place of death? _____		
<u>Mrs. Nellie Dannels</u>			Former or usual residence _____		
13. BIRTHPLACE OF MOTHER			19. PLACE OF BURIAL OR REMOVAL DATE OF BURIAL		
(State or Country) <u>Mich.</u>			<u>Twin Falls</u> <u>Mar 3</u> 191 <u>3</u>		
14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE			20. UNDERTAKER ADDRESS		
(Informant) <u>Albert Ball</u>			<u>Chas. J. Conley</u> <u>Twin Falls</u>		
(Address) <u>Twin Falls Co.</u>					
15. Filed <u>3-3</u> 191 <u>3</u> <u>John H. Sledge</u> Local Registrar					

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Form V. S. No. 5 20M.1-16-12

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH.
County of **Twin Falls**
City of **Twin Falls** (No. _____, _____ St.)
Registration District No. **23**
Primary Registration District No. **2085**

File No. **447**
Registered No. _____

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME **Mary Martha Hagar**

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX **Female** 4. COLOR OR RACE **White** 5. SINGLE, MARRIED, WIDOWED OR DIVORCED. **Single** (Write the word.)

6. DATE OF BIRTH **Jan. 11, 1913**
(Month) (Day) (Year)

7. AGE **1** yrs. **19** mos. **19** ds.
IF LESS than 1 day how many hrs. or mins.?

8. OCCUPATION
(a) Trade, profession or particular kind of work
(b) General nature of industry, business, or establishment in which employed (or employer)

9. BIRTHPLACE **Twin Falls**
(State or Country)

10. NAME OF FATHER **L.G. Hagar**

11. BIRTHPLACE OF FATHER **Avoca, Wisc.**
(State or Country)

12. MAIDEN NAME OF MOTHER **Bertha Mary Tott**

13. BIRTHPLACE OF MOTHER **Orange City, Iowa**
(State or Country)

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) **Leroy G. Hagar**
(Address) **Twin Falls**

15. Filed **3-3** 1913 **John H. Hughes** Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH **March 2nd** 191**3**
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from **Feb 26** 191**3**, to **March 2** 191**3**, that I last saw her alive on **March 2** 191**3**, and that death occurred on the date stated above, at **6 P.M.**
The CAUSE OF DEATH* was as follows:

Pneumonia
(Duration) yrs. mos. **5** ds.
Contributory (Secondary)
(Duration) yrs. mos. ds.
(Signed) **John F. Coughlin** M. D.
3-3 191**3** (Address) **Twin Falls**

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death. yrs. mos. days. In the State. yrs. mos. days.
Where was disease contracted if not at place of death?
Former or usual residence.

19. PLACE OF BURIAL OR REMOVAL **Twin Falls** DATE OF BURIAL **3/4** 191**3**

20. UNDERTAKER **Charles J. Crosby** ADDRESS **Twin Falls**

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Form V. S. No. 5 20M.1-16-12

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH
County of Twins Falls
City of " "

Registration District No. 23
Primary Registration District No. 2085
(No. " " St.)

File No. 4478
Registered No. " "

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Johanna Swanson

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX Female 4. COLOR OR RACE White 5. SINGLE, MARRIED, WIDOWED OR DIVORCED. Widow

6. DATE OF BIRTH Jan. 15 1830
(Month) (Day) (Year)

7. AGE 83 yrs. 1 mos. 25 ds.
IF LESS than 1 day how many hrs. or mins.?

8. OCCUPATION
(a) Trade, profession or particular kind of work House Wife
(b) General nature of industry, business, or establishment in which employed (or employer)

9. BIRTHPLACE Sweden
(State or Country)

10. NAME OF FATHER Anderson

11. BIRTHPLACE OF FATHER Sweden
(State or Country)

12. MAIDEN NAME OF MOTHER Johnson

13. BIRTHPLACE OF MOTHER Sweden
(State or Country)

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Peter Swanson
(Address) Twins Falls

15. Filed 3-12 1913 John H. Hargrave
Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH March 10 1913
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from Jan 8 1913, to March 10 1913, that I last saw h. or alive on Jan 8 1913, and that death occurred on the date stated above, at M.

The CAUSE OF DEATH* was as follows:

Chronic Pneumonia

(Duration) 2 yrs. 2 mos. 25 ds.

Contributory (Secondary)

(Duration) " " yrs. " " mos. " " ds.

(Signed) H. Wilson M. D.

March 11 1913 (Address) Twins Falls, Idaho

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death " " yrs. " " mos. " " days. In the State " " yrs. " " mos. " " days.

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL Twins Falls DATE OF BURIAL 3/12 1913

20. UNDERTAKER J. J. Grosvane ADDRESS Twins Falls

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Form V. S. No. 5 20M.1-16-12

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH Registration District No. 23
County of Dubin Falls Primary Registration District No. 2085
City of " (No. " St.)

File No. 4471
Registered No. "

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Emil A. Peterson

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX Male 4. COLOR OR RACE White 5. SINGLE, MARRIED, WIDOWED OR DIVORCED. Single

6. DATE OF BIRTH

About 55 yrs old
(Month) (Day) (Year)

7. AGE

Unknown
yrs. mos. ds.

IF LESS than 1 day
how many hrs. or
mins.?

8. OCCUPATION

(a) Trade, profession or particular kind of work
(b) General nature of industry business, or establishment in which employed (or employer)

Merchant & Reveryman

9. BIRTHPLACE

(State or Country)

Sweden

10. NAME OF FATHER

No record

11. BIRTHPLACE OF FATHER

(State or Country)

"

12. MAIDEN NAME OF MOTHER

"

13. BIRTHPLACE OF MOTHER

(State or Country)

"

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

(Address)

W. F. Thumeyer
Hollister

15.

Filed

3-6

1913

Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH

March 5th 1913
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from
Jan 1913, to Mar 5 1913

that I last saw him alive on Mar. 4 1913

and that death occurred on the date stated above, at 5:30 M.

The CAUSE OF DEATH* was as follows:

Cerebrosis Fever

Probably 2 yrs from history

(Duration) yrs. mos. ds.

Contributory
(Secondary)

(Duration) yrs. mos. ds.

(Signed)

J. R. Morgan

M. D.

Mar. 7, 1913 (Address) Dubin Falls

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death. yrs. mos. days. In the State. yrs. mos. days.

Where was disease contracted if not at place of death?

Former or usual residence.

19. PLACE OF BURIAL OR REMOVAL DATE OF BURIAL

Chicago Ill

1913

20. UNDERTAKER

ADDRESS

Charles J. Crosby Dubin Falls

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Form V. S. No. 5 20M.1-16-12

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH.

Registration District No. 23

County of Twin Falls

Primary Registration District No. 2085

File No. 4480

City of Twin Falls

(No. _____, _____ St.)

Registered No. _____

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Patrick T. Corcoran

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX

Male

4. COLOR OR RACE

White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED.

Married
(Write the word.)

6. DATE OF BIRTH

February 11th 1847
(Month) (Day) (Year)

7. AGE

66 yrs. 1 mos. 3 ds.

IF LESS than 1 day
how many _____ hrs. or
_____ mins.?

8. OCCUPATION

(a) Trade, profession or particular kind of work Farmer
(b) General nature of industry business, or establishment in which employed (or employer) _____

9. BIRTHPLACE

(State or Country) Edinburgh, Scotland

10. NAME OF FATHER

Thomas Corcoran

11. BIRTHPLACE OF FATHER

(State or Country) Ireland

12. MAIDEN NAME OF MOTHER

Katherine McEvoy

13. BIRTHPLACE OF MOTHER

(State or Country) Ireland

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Margaret Corcoran

(Address) Twin Falls

15.

Filed 3-17 1913 John H. Bogle
Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH

3 14 1913
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from 8/12/1912 to 12/17/1912, that I last saw him alive on 12/17/1912

and that death occurred on the date stated above, at 10 P.M.

The CAUSE OF DEATH* was as follows:

Angina pectoris

304 (Duration) 304 yrs. _____ mos. _____ ds.

Contributory (Secondary)

(Duration) _____ yrs. _____ mos. _____ ds.

(Signed) W. G. Pike M. D.

3/17/1913 (Address) Twin Falls, Ida

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death _____ yrs. _____ mos. _____ days. In the State _____ yrs. _____ mos. _____ days.

Where was disease contracted if not at place of death?

Former or usual residence _____

19. PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

Twin Falls 3-18 1913

20. UNDERTAKER

ADDRESS

Charles J. Crosby Twin Falls

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Form V. S. No. 5 20M.1-16-12

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH.

Registration District No. 23County of Twin FallsPrimary Registration District No. 2085File No. 4481

City of _____

(No. _____, _____ St.)

Registered No. _____

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Mrs. Lurania Barnes

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX

4. COLOR OR RACE

5. SINGLE, MARRIED, WID-
OWED OR DIVORCED.

Female

White

(Write the word.)

6. DATE OF BIRTH

Oct. 20th, 1848

(Month)

(Day)

(Year)

7. AGE

64 yrs. 5 mos. X ds.IF LESS than 1 day
how many hrs. or
..... mins.?

8. OCCUPATION

(a) Trade, profession or
particular kind of work

Housewife

(b) General nature of industry
business, or establishment in
which employed (or employer)

9. BIRTHPLACE

(State or Country)

Ohio

10. NAME OF
FATHER

Hubbard Smith

11. BIRTHPLACE
OF FATHER

(State or Country)

Ohio

12. MAIDEN NAME
OF MOTHER

Mary Phillips

13. BIRTHPLACE
OF MOTHER

(State or Country)

Ill.

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

Geo. Barnes (son)

(Address)

Rock Creek,

15.

Filed

3-241913John H. Coughlin
Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH

March 21 1913
(Month) (Day) (Year)17. I HEREBY CERTIFY, That I attended deceased from
Jan 24th 1913, to March 21 1913,that I last saw him alive on March 21 1913,and that death occurred on the date stated above, at 12:15 P.

The CAUSE OF DEATH* was as follows:

Auto-intoxication of Heart.(Duration) yrs. mos. 1 ds.

Contributory

(Secondary)

(Duration) yrs. mos. ds.

(Signed)

Amos L. McFarland M. D.3/24 1913 (Address) Twin Falls Id.

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions,
Transients or Recent Residents.)

At place

of death yrs. mos. days.

In the

State yrs. mos. days.

Where was disease contracted
if not at place of death?Former or
usual residence

19. PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

Twin Falls 3-24 1913

20. UNDERTAKER

ADDRESS

John H. Coughlin Twin Falls

MARGIN RESERVED FOR BINDING
WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Form V. S. No. 5 20M.1-16-12

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH.

Registration District No. 23

County of Twin Falls

Primary Registration District No. 2085

City of Twin Falls

(No. _____, St.)

File No. 4482

Registered No. _____

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Mrs. Mary A. Lingo

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX

Female

4. COLOR OR RACE

White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED.

Widowed
(Write the word.)

6. DATE OF BIRTH

Feb. 10th, 1843

(Month) (Day) (Year)

7. AGE

70 yrs. 1 mos. 14 ds.

IF LESS than 1 day
how many hrs. or
..... mins.?

8. OCCUPATION

(a) Trade, profession or particular kind of work

None

(b) General nature of industry business, or establishment in which employed (or employer)

9. BIRTHPLACE

(State or Country)

Ind.

10. NAME OF FATHER

Hiram Burton

11. BIRTHPLACE OF FATHER

(State or Country)

Maine

12. MAIDEN NAME OF MOTHER

Sibil Dudley

13. BIRTHPLACE OF MOTHER

(State or Country)

Maine

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Mrs. Emma L. Ciddley

(Address) 351-5th Ave North

15.

Filed 3-24 1913

John P. Lougher
Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH

March 24th 1913
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from

March 4 1913 to March 24 1913
that I last saw her alive on March 22 1913

and that death occurred on the date stated above, at 12:40 M.

The CAUSE OF DEATH* was as follows:

Dyspepsia and Diarrhea

(Duration) 15 yrs. _____ mos. _____ ds.

Contributory
(Secondary)

(Duration) _____ yrs. _____ mos. _____ ds.

(Signed) W. H. Wilson M. D.

3-24-13 (Address) Twin Falls, Idaho

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death yrs. mos. days. In the State yrs. mos. days.

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL DATE OF BURIAL

Ammonia, Id. 1913

20. UNDERTAKER ADDRESS

James J. Lougher Twin Falls

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Form V. S. No. 5 20M.1-16-12

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics
File No. 4483

1. PLACE OF DEATH.

Registration District No. 23

County of Twins Falls

Primary Registration District No. 2085

City of " "

(No. " " St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Adaline I. Smith

Registered No. " "

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX

4. COLOR OR RACE

5. SINGLE, MARRIED, WIDOWED OR DIVORCED.

Female

White

Married (Use word.)

6. DATE OF BIRTH

Dec.

13

1855

(Month)

(Day)

(Year)

7. AGE

57 yrs. 3 mos. 11 ds.

IF LESS than 1 day how many hrs. or mins.?

8. OCCUPATION

(a) Trade, profession or particular kind of work

House work

(b) General nature of industry business, or establishment in which employed (or employer)

9. BIRTHPLACE

(State or Country)

Ohio

10. NAME OF FATHER

Jonathon Nisbitt

11. BIRTHPLACE OF FATHER

(State or Country)

Penn.

12. MAIDEN NAME OF MOTHER

Catharine Hamilton

13. BIRTHPLACE OF MOTHER

(State or Country)

Penn.

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

Mrs. L. M. Bailey

(Address)

Twins Falls Ida.

15.

Filed

3-24

1913

John H. Englem
Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH

March

24

1913

(Month)

(Day)

(Year)

17. I HEREBY CERTIFY, That I attended deceased from

March 10 1913, to March 24 1913,

that I last saw her alive on March 24 1913

and that death occurred on the date stated above, at 3 P.M.

The CAUSE OF DEATH* was as follows:

Septicaemia following punctured wound of thumb.

(Duration) yrs. mos. 14 ds.

Contributory

(Secondary)

(Duration) yrs. mos. ds.

(Signed)

H. W. Wilson M. D.

Mar. 23 1913 (Address) Twins Falls Ida.

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death yrs. mos. days. In the State yrs. mos. days.

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

Charlton Maus

191

20. UNDERTAKER

ADDRESS

J. F. Grosman Twins Falls

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Form V. S. No. 5 20M.1-16-12

CERTIFICATE OF DEATH

State of Idaho
BUREAU OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH
County of *Thom Fall*
City of " " (No. , St.)

Registration District No. *23*
Primary Registration District No. *2085*

File No. *4484*
Registered No. _____

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME *Preston C Parry*

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX *M* 4. COLOR OR RACE *W* 5. SINGLE, MARRIED, WIDOWED OR DIVORCED *Single*
(Write the word.)

6. DATE OF BIRTH
(Month) *1* (Day) (Year)

7. AGE *35* yrs. mos. ds. IF LESS than 1 day how many hrs. or mins.

8. OCCUPATION
(a) Trade, profession or particular kind of work *machinist*
(b) General nature of industry business, or establishment in which employed (or employer)

9. BIRTHPLACE
(State or Country) *Pa.*

10. NAME OF FATHER

11. BIRTHPLACE OF FATHER
(State or Country)

12. MAIDEN NAME OF MOTHER

13. BIRTHPLACE OF MOTHER
(State or Country)

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) *W L Pruebe*
(Address) *Swiss Falls*

15. Filed *Apr 4* 1913 *John H. Bue*
Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH *Mar 26* 1913
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from *191* to *191*, that I last saw him alive on *191*, and that death occurred on the date stated above, at *5 P. M.*

The CAUSE OF DEATH* was as follows:
Hemorrhage of Lungs

(Duration) yrs. mos. ds.
Contributory (Secondary) *Tuberculosis*
or more

(Duration) *8* yrs. mos. ds.
(Signed) *Charles J. Crosby* M.D.
3-27-13 (Address) *Thom Falls* coroner

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death. yrs. mos. days. In the State. yrs. mos. days.

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL *Thom Falls* DATE OF BURIAL *4-3* 1913

20. UNDERTAKER *Charles J. Crosby* ADDRESS *Thom Falls*

WRITE PLAINLY, WITH UNFADEING INK—THIS IS A PERMANENT RECORD.
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Form V. S. No. 5. 10M. 6-20-11.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH
County of Bannock
City of McCammon (No. _____ St.)
Registration District No. 11
Primary Registration District No. 2047

File No. 4485
Registered No. 15

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

Cecil Lewis

If death occurred in a hospital, institution or camp give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX Male 4. COLOR OR RACE White 5. SINGLE, MARRIED, WIDOWED OR DIVORCED. Infant
(Write the word.)

6. DATE OF BIRTH May - 24th 1912
(Month) (Day) (Year)

7. AGE 8 mos. 14 ds. IF LESS than 1 day how many hrs. or min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work
(b) General nature of industry business or establishment in which employed (or employer)

Infant

9. BIRTHPLACE

(State or Country)

McCammon Ida

10. NAME OF FATHER

William D. Lewis

11. BIRTHPLACE OF FATHER

(State or Country)

Robt - Idaho

12. MAIDEN NAME OF MOTHER

Mary Lowry

13. BIRTHPLACE OF MOTHER

(State or Country)

Idaho

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

Mr Lewis

(Address)

McCammon Ida

15.

Filed

Apr 19 1913

Cecil Kasper

Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

2 — 7 — 1913
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from

2/2 — 1913 to 2/7 — 1913

that I last saw him alive on 2/7 1913

and that death occurred on the date stated above, at 1 A.M.

The CAUSE OF DEATH* was as follows:

Pneumonia

(Duration) yrs. mos. ds.

Contributory
(Secondary)

(Duration) yrs. mos. ds.

(Signed) J. H. Cooper M. D.

April 1 1913 (Address) McCammon Ida

State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL OR HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted,

If not at place of death?

Former or

usual residence.

19. PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

McCammon Ida 2-9- 1913

20. UNDERTAKER

ADDRESS

W. W. Walker Camtella

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Form V. S. No. 5 20M.1-16-12

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH.

Registration District No. 11County of PannookPrimary Registration District No. 1047File No. 4486City of Arimo

(No. _____, _____ St.)

Registered No. 19

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

James Henderson

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX

Male

4. COLOR OR RACE

White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED.

Married

(Write the word.)

6. DATE OF BIRTH

Aug 4. 1847

(Month)

(Day)

1

(Year)

7. AGE

65 yrs. 5 mos. 25 ds.IF LESS than 1 day
how many _____ hrs. or
_____ mins.?

8. OCCUPATION

(a) Trade, profession or particular kind of work

Merchant

(b) General nature of industry business, or establishment in which employed (or employer)

9. BIRTHPLACE

(State or Country)

Scotland

10. NAME OF FATHER

Robert Henderson

11. BIRTHPLACE OF FATHER

(State or Country)

Scotland

12. MAIDEN NAME OF MOTHER

Mary Ross

13. BIRTHPLACE OF MOTHER

(State or Country)

Scotland

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Mrs. James Henderson(Address) Armo, Idaho

15.

Filed

Sept 10, 1913

1913

E. K. Kacey
Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH

January 29. th. 1913

(Month)

(Day)

191

(Year)

17. I HEREBY CERTIFY, That I attended deceased from

July 1, 1912 to January 29, 1913,that I last saw him alive on January 6, 1913,and that death occurred on the date stated above, at 6:30 A.M.

The CAUSE OF DEATH* was as follows:

Haemorrhage of the Brain

(Duration) _____ yrs. _____ mos. _____ ds.

Contributory
(Secondary)

(Duration) _____ yrs. _____ mos. _____ ds.

(Signed) J. W. Henderson M. D.92 1913 (Address) Brigham Utah

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death _____ yrs. _____ mos. _____ days. In the State _____ yrs. _____ mos. _____ days.

Where was disease contracted if not at place of death?

Former or usual residence Armo Id.

19. PLACE OF BURIAL OR REMOVAL

Armo, Cemetery

DATE OF BURIAL

Feb 2. 1913

20. UNDERTAKER

G. W. Lindquist

ADDRESS

Logan, Ut.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Form V. S. No. 5. 12½ M. 7-24-11

CERTIFICATE OF DEATH

1. PLACE OF DEATH. Registration District No. 11
County of Bannock Primary Registration District No. 2047
City of McCammon (No. _____ St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

Ellis Lewis

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

File No. 4487Registered No. 18

If death occurred in a hospital, institution or camp give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX Male 4. COLOR OR RACE White 5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.)

6. DATE OF BIRTH Feb 8, 1912
(Month) (Day) (Year)

7. AGE 1 yrs. — mos. — ds. IF LESS than 1 day how many — hrs. or — min?

8. OCCUPATION

(a) Trade, profession or particular kind of work. none
(b) General nature of industry business or establishment in which employed (or employer)

9. BIRTHPLACE

(State or Country)

McCammon, Ida.

10. NAME OF FATHER

Wm Lewis

11. BIRTHPLACE OF FATHER

(State or Country)

McCammon, Ida.

12. MAIDEN NAME OF MOTHER

Lewis - Emma

13. BIRTHPLACE OF MOTHER

(State or Country)

Okfuskee, Ida.

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

Wm Lewis

(Address)

McCammon, Ida.

15.

Filed April 19, 1913

Ellis K. Bailey
Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH

2 — 8 — 1913
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from

2/4 — 1913, to 2/8 — 1913

that I last saw him alive on 2/8 — 1913

and that death occurred on the date stated above, at 10 A.M.

The CAUSE OF DEATH* was as follows:

Broncho-Pneumonia

(Duration) — yrs. — mos. 4 ds.

Contributory (Secondary)

(Duration) — yrs. — mos. — ds.

(Signed) Wm Lewis M. D.

19 (Address) McCammon, Ida.

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place — yrs. — mos. — ds. In the — yrs. — mos. — ds.

Where was disease contracted,

If not at place of death?

Former or

usual residence.

19. PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

McCammon2-10-1913

20. UNDERTAKER

ADDRESS

W. W. WalkerPocatello

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Form V. S. No. 5 20M.1-16-12

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH.

Registration District No. 11

County of Bannock

Primary Registration District No. 1047

City of McCammon, Id.

No. St.)

File No. 4484

Registered No. 16

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Rachel A. Hall

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX Female 4. COLOR OR RACE W. 5. SINGLE, MARRIED, WIDOWED OR DIVORCED married
(Write the word.)

6. DATE OF BIRTH

May 14 1892
(Month) (Day) (Year)

7. AGE

20 yrs. 8 mos. 4 ds.

IF LESS than 1 day
how many hrs. or
mins.?

8. OCCUPATION

(a) Trade, profession or particular kind of work
(b) General nature of industry, business, or establishment in which employed (or employer)

Housewife

9. BIRTHPLACE

(State or Country)

Albin, Idaho

10. NAME OF FATHER

W. W. Lewis

11. BIRTHPLACE OF FATHER

(State or Country)

Idaho

12. MAIDEN NAME OF MOTHER

Lewis - Bertha

13. BIRTHPLACE OF MOTHER

(State or Country)

Idaho

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

Doc Hall (Husband)

(Address)

McCammon

15.

Filed

April 10

1918

Edw. Karsley
Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

2 12 1913
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from

191, to 191,

that I last saw h. alive on 191,

and that death occurred on the date stated above, at M.

The CAUSE OF DEATH* was as follows:

Breast m. d.

(Duration) yrs. mos. ds.

Contributory
(Secondary)

measles

(Duration) yrs. mos. ds.

(Signed)

J. H. Cape

M. D.

Feb 12 1913

(Address) McCammon

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death.....yrs.....mos.....days. In the State.....yrs.....mos.....days.

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL DATE OF BURIAL

McCammon, Id. 2-15 1913

20. UNDERTAKER

ADDRESS

W. W. Walker

Panhandle

Form V. S. No. 5 20M.1-16-12

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH.

Registration District No. 11

County of

Bannock Co

Primary Registration District No. 2047

City of

McCammon, Ida

No.

St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

Virgil Joe. Hall

File No.

4489

Registered No.

17

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX

Male

4. COLOR OR RACE

White

5. SINGLE, MARRIED, WID-
OWED OR DIVORCED.Single
(Write the word.)

6. DATE OF BIRTH

Aug - 23rd, 1913
5 (Month) 23 (Day) 1913 (Year)

7. AGE

yrs. 5 mos. 27 ds.

IF LESS than 1 day
how many hrs. or
..... mins.?

8. OCCUPATION

(a) Trade, profession or

particular kind of work

(b) General nature of industry

business, or establishment in

which employed (or employer)

9. BIRTHPLACE

(State or Country)

McCammon, Ida

10. NAME OF
FATHER

David R Hall

11. BIRTHPLACE
OF FATHER

(State or Country)

Malad Valley, Utah

12. MAIDEN NAME
OF MOTHER

Lorris Rachel

13. BIRTHPLACE
OF MOTHER

(State or Country)

Albion, Ida

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

Dor

(Address)

D. R. Hall

15.

Filed

April 10,

1913

Relis Karsen

Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH

2 - 20 - 1913
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from

2/20 - 1913, to 2/20 - 1913,
that I last saw him alive on 2/20 - 1913.

and that death occurred on the date stated above, at 3 P. M.

The CAUSE OF DEATH* was as follows:

Broncho-Pneumonia.

(Duration) yrs. mos. 5 ds.

Contributory

(Secondary)

measles.

(Duration) yrs. mos. ds.

(Signed)

Feb 26, 1913

(Address)

McCammon, Ida

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place

of death.....yrs.....mos.....days.

In the

State.....yrs.....mos.....days.

Where was disease contracted
if not at place of death?.....

Former or

usual residence.....

19. PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

McCammon, Ida 1/22 1913

20. UNDERTAKER

ADDRESS

W. W. Waeker

Pacutello

A stillbirth must be registered both as a birth and death. The date of death should be the date of delivery and the death certificate should further state, if known, the cause of the stillbirth and the period of utero gestation in months.

STATEMENT OF OCCUPATION.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer, Physician, Stenographer, Compositor, Architect, Locomotive engineer, Civil engineer, Stationary fireman, etc.* But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner*, (b) *Cotton mill*; (a) *Salesman*, (b) *Grocery*; (a) *Foreman*, (b) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification, as *Day laborer, Farm laborer, Laborer—Coal mine, etc.* Women at home, who are engaged in the duties of the household only (not paid *Housekeepers*, who receive a definite salary), may be entered as *Housewife, Housework, or At home*, and children, not gainfully employed, as *At school or At home*. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer (retired, 6 yrs.)* For persons who have no occupation whatever, write *None*.

STATEMENT OF CAUSE OF DEATH.—Name, first the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebro-*

spinal fever (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid Pneumonia"); *Lobar pneumonia*; *Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritoneum, etc., Carcinoma, Sarcoma, etc., of* (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles*; *Whooping cough*; *Chronic valvular heart disease*; *Chronic interstitial nephritis, etc.* The contributory (secondary or intercurrent affection need not be stated unless important. Example: *Measles* (disease causing death), 29 ds.; *Bronchopneumonia* (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "Asthenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility," ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Haemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uraemia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify as "PUERPERAL, septicemia", "PUERPERAL peritonitis," etc., all diseases resulting from childbirth or miscarriage. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning*; *Struck by railway train—accident*; *Revolver wound of head—homicide*; *Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "Contributory."

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
 Bureau of Vital Statistics
 File No. 4490
 Registered No. 20

1. **PLACE OF DEATH.** Registration District No. 11
 County of Bannock Primary Registration District No. 2098
 City of Cleveland (No. _____, _____ St.)

If death occurs away from usual residence, give facts called for under special information.

2. **FULL NAME** William McIntyre Austin

If death occurred in a hospital, institution or camp give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. **SEX** Male 4. **COLOR OR RACE** White 5. **SINGLE, MARRIED, WIDOWED OR DIVORCED.** Married
 (Write the word.)

6. **DATE OF BIRTH** July 5 1855
 (Month) (Day) (Year)

7. **AGE** 57 yrs. 8 mos. 18 ds. IF LESS than 1 day how many _____ hrs. or _____ min?

8. **OCCUPATION**
 (a) Trade, profession or particular kind of work. Farmer
 (b) General nature of industry business or establishment in which employed (or employer)

9. **BIRTHPLACE** (State or Country) North Ogden Utah

10. **NAME OF FATHER** William Austin

11. **BIRTHPLACE OF FATHER** (State or Country) Washington Co. New York

12. **MAIDEN NAME OF MOTHER** Agnes McIntyre

13. **BIRTHPLACE OF MOTHER** (State or Country) Hammond St Lawrence Co. New York

14. **THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE**
 (Informant) Mary Lundgreen
 (Address) Treasureton Idaho

15. Filed Apr 10, 1913 Edwin Kasey
 Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. **DATE OF DEATH** March 23 1913
 (Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from March 23 1913, to March 23 1913 that I last saw him alive on March 22 1913 and that death occurred on the date stated above, at 3:35 A.M.

The CAUSE OF DEATH* was as follows:
Heart failure
Valvular insufficiency

(Duration) 12 yrs. mos. ds.
 Contributory (Secondary) none

(Duration) _____ yrs. mos. ds.
 (Signed) Edwin Kasey M. D.
March 23, 1913 (Address) Schafer

State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. **LENGTH OF RESIDENCE** (For Hospitals, Institutions, Transients or Recent Residents.)

At place In the
 of death _____ yrs. mos. ds. State _____ yrs. mos. ds.
 Where was disease contracted,
 If not at place of death?
 Former or
 usual residence _____

19. **PLACE OF BURIAL OR REMOVAL** Cleveland **DATE OF BURIAL** March 26 1913

20. **UNDERTAKER** Sp Larsen **ADDRESS** Cleveland

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Form V. S. No. 5. 12½ M. 7-24-11

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH. Registration District No. 14
County of Custer Primary Registration District No. 2054
City of Mackay (No. _____, _____ St.)

File No. 4491Registered No. 45

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

Sarah Crumpton

If death occurred in a hospital, institution or camp give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX Female 4. COLOR OR RACE White 5. SINGLE, MARRIED, WIDOWED OR DIVORCED. Married
(Write the word.)

6. DATE OF BIRTH November 17 1884
(Month) (Day) (Year)

7. AGE 27 yrs. 4 mos. 13 ds. IF LESS than 1 day how many _____ hrs. or _____ min?

8. OCCUPATION

(a) Trade, profession or particular kind of work.
(b) General nature of industry business or establishment in which employed (or employer)

Housewife

9. BIRTHPLACE

(State or Country)

Utah

10. NAME OF FATHER

Joseph H. Horton

11. BIRTHPLACE OF FATHER

(State or Country)

England

12. MAIDEN NAME OF MOTHER

Mary Sprout

13. BIRTHPLACE OF MOTHER

(State or Country)

England

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

F. P. Richards

(Address)

Mackay, Idaho

15.

Filed 4/3 1913

C. J. Birtley
Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH

3 1913
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from May 15 1913, to March 30 1913

that I last saw him alive on March 30 1913

and that death occurred on the date stated above, at 4 A. M.

The CAUSE OF DEATH* was as follows:

Tubo-ovarian abscess.
Chronic Purulent Appendicitis

(Duration) _____ yrs. 3 mos. _____ ds.

Contributory (Secondary)

Surgical Shock

(Duration) _____ yrs. _____ mos. 124 hours ds.

(Signed)

F. P. Richards

M. D.

3/31 1913 (Address) Mackay, Idaho

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place _____ In the _____
of death _____ yrs. _____ mos. 1 ds. State 26 yrs. _____ mos. _____ ds.

Where was disease contracted, If not at place of death? at Mackay

Former or usual residence Utah

19. PLACE OF BURIAL OR REMOVAL DATE OF BURIAL

Shallis 2d 4-3 1913

20. UNDERTAKER ADDRESS

Chas Baker Mackay 2d

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH.

Registration District No. 31County of CassiaPrimary Registration District No. 2126City of Burley

(No. _____, _____ St.)

File No. 4492Registered No. 11

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME George R. Judd

If death occurred in a hospital, institution or camp give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX

4. COLOR OR RACE

5. SINGLE, MARRIED, WIDOWED OR DIVORCED.

Male White Single (Write the word.)

6. DATE OF BIRTH

April 2 1859
(Month) (Day) (Year)

7. AGE

57 yrs. 11 mos. ds.IF LESS than 1 day
how many _____ hrs. or
_____ min?

8. OCCUPATION

(a) Trade, profession or particular kind of work Farmer
(b) General nature of industry business or establishment in which employed (or employer)

9. BIRTHPLACE

(State or Country)

Utah

10. NAME OF FATHER

William R. Judd

11. BIRTHPLACE OF FATHER

(State or Country)

Canada

12. MAIDEN NAME OF MOTHER

Linn A Reid

13. BIRTHPLACE OF MOTHER

(State or Country)

England

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Mrs. Lillian Judd
(Address) Burley, Ida.

15.

Filed Apr 4 1913 L. B. Stockelger
Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH

March 1 1913
(Month) (Day) (Year)17. I HEREBY CERTIFY, That I attended deceased from March 1 1913, to March 1 1913that I last saw him alive on March 1 1913and that death occurred on the date stated above, at 3 A.M.

The CAUSE OF DEATH* was as follows:

Valvular Heart Disease(Duration) 1.5 yrs. mos. ds.Contributory
(Secondary)(Duration) 1.5 yrs. mos. ds.(Signed) J. C. Patterson M. D.
March 3 1913 (Address) Burley, Idaho

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place In the
of death _____ yrs. _____ mos. _____ ds. State _____ yrs. _____ mos. _____ ds.

Where was disease contracted,

If not at place of death?

Former or

usual residence.

19. PLACE OF BURIAL OR REMOVAL DATE OF BURIAL

Granville, Utah 1913

20. UNDERTAKER

ADDRESS

L. B. Stockelger Burley, Idaho

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Form V. S. No. 5. 12½ M. 7-24-11

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH. Registration District No. 31
County of Cassia Primary Registration District No. 21st
City of Burley (No. _____, _____ St.)

File No. 4493
Registered No. 172

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

Baby Custerhout

If death occurred in a hospital, institution or camp give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX 4. COLOR OR RACE 5. SINGLE, MARRIED, WIDOWED, OR DIVORCED.

Girl white Single
(Write the word.)

6. DATE OF BIRTH Nov 26 1913
(Month) (Day) (Year)

7. AGE IF LESS than 1 day
_____ yrs. 3 mos. 8 ds. how many _____ hrs. or _____ min?

8. OCCUPATION

(a) Trade, profession or particular kind of work.
(b) General nature of industry business or establishment in which employed (or employer)

At home

9. BIRTHPLACE

(State or Country)

Cassia Co. Ida.

10. NAME OF FATHER

Jesse C. Custerhout

11. BIRTHPLACE OF FATHER

(State or Country)

Unknown.

12. MAIDEN NAME OF MOTHER

Winnifred Judd.

13. BIRTHPLACE OF MOTHER

(State or Country)

Toole County Utah

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

(Address)

Roy A. Judd
Burley Ida.

15.

Filed Apr 4 1913 L. B. Fallogly
Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH

Nov 4 1913
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from Nov 26 1913, to Nov 3 1913

that I last saw her alive on Nov 3 1913

and that death occurred on the date stated above, at 109 CL

The CAUSE OF DEATH* was as follows:

Pneumonia

(Duration) _____ yrs. _____ mos. _____ ds.
Contributory (Secondary) Whooping Cough

(Duration) _____ yrs. _____ mos. _____ ds.
(Signed) J. M. Minter M. D.
Nov 6 1913 (Address) Burley Ida.

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place _____ In the _____
of death _____ yrs. _____ mos. _____ ds. State _____ yrs. _____ mos. _____ ds.

Where was disease contracted? *

If not at place of death?

Former or

usual residence.

19. PLACE OF BURIAL OR REMOVAL DATE OF BURIAL

Burley Ida. Nov 6 1913

20. UNDERTAKER

ADDRESS

L. B. Fallogly Burley Ida.

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Form V. S. No. 5. 12½ M. 7-24-11

CERTIFICATE OF DEATH

1. PLACE OF DEATH.
County of Blaine
City of Blaine

Registration District No. 31
Primary Registration District No. 21st
(No. _____, _____ St.)

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics
File No. 4494
Registered No. 13

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Ethel May Randall

If death occurred in a hospital, institution or camp give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX Girl 4. COLOR OR RACE white 5. SINGLE, MARRIED, WIDOWED OR DIVORCED. Single
(Write the word.)

6. DATE OF BIRTH Dec. 11th 1911
(Month) (Day) (Year)

7. AGE _____ yrs. _____ mos. _____ ds. IF LESS than 1 day how many _____ hrs. or _____ min?

8. OCCUPATION
(a) Trade, profession or particular kind of work. At home
(b) General nature of industry business or establishment in which employed (or employer)

9. BIRTHPLACE
(State or Country) Burley Idaho

10. NAME OF FATHER Homer A. Randall

11. BIRTHPLACE OF FATHER
(State or Country) Weber Co. Utah

12. MAIDEN NAME OF MOTHER Anna Westergaard

13. BIRTHPLACE OF MOTHER
(State or Country) Weber Co. Utah

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Homer A. Randall
(Address) Burley Ida.

15. April 4 1913
Filed Blaine
Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH March 6th 1913
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from Feb. 14th 1913, to March 6th 1913

that I last saw her alive on March 6th 1913

and that death occurred on the date stated above, at 4 P. M.

The CAUSE OF DEATH* was as follows:
Bronch. Pneumonia

(Duration) _____ yrs. _____ mos. 21 ds.

Contributory (Secondary)

(Duration) _____ yrs. _____ mos. _____ ds.

(Signed) J. C. Patterson M. D.
March 7th 1913 (Address) Burley, Idaho

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place _____ In the _____
of death _____ yrs. _____ mos. _____ ds. State _____ yrs. _____ mos. _____ ds.
Where was disease contracted,
If not at place of death? _____
Former or
usual residence _____

19. PLACE OF BURIAL OR REMOVAL DATE OF BURIAL

Burley Ida Mar. 7 1913

20. UNDERTAKER ADDRESS

J. B. Gallagher

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH.

Registration District No. 31

County of Cassia

Primary Registration District No. 2124

City of

(No.)

St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

Berta Gutschfeld

File No. 4497

Registered No. 16

If death occurred in a hospital, institution or camp give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX

4. COLOR OR RACE

5. SINGLE, MARRIED, WIDOWED OR DIVORCED.

f. white

single

(Write the word.)

6. DATE OF BIRTH

Feb 16 1913

(Month) (Day) (Year)

7. AGE

8 yrs. 6 mos. 6 ds.

IF LESS than 1 day how many hrs. or min?

8. OCCUPATION

- (a) Trade, profession or particular kind of work.
- (b) General nature of industry business or establishment in which employed (or employer)

9. BIRTHPLACE

(State or Country)

Oakley, Idaho

10. NAME OF FATHER

Fred Gutschfeld

11. BIRTHPLACE OF FATHER

(State or Country)

Idaho

12. MAIDEN NAME OF MOTHER

Ellie Doyle

13. BIRTHPLACE OF MOTHER

(State or Country)

Idaho

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

(Address)

Dr. Peterson

15.

Filed

Mar 20 1913

P. B. Strickland

Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH

Feb 22 1913

(Month)

(Day)

(Year)

17. I HEREBY CERTIFY, That I attended deceased from

Feb 22 1913, to Feb 22 1913

that I last saw her alive on Feb 22 1913

and that death occurred on the date stated above, at 8:30 M.

The CAUSE OF DEATH* was as follows:

Pneumonia

(Duration) yrs. 10 mos. 10 ds.

Contributory (Secondary)

(Duration) yrs. 10 mos. 10 ds.

(Signed)

Feb 22 1913 (Address) Oakley, Idaho

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place In the

of death yrs. mos. ds. State yrs. mos. ds.

Where was disease contracted, If not at place of death?

Former or usual residence.

19. PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

Oakley Feb 24 1913

20. UNDERTAKER

ADDRESS

Fred Gutschfeld Oakley, Idaho

WRITE PLAINLY, WITH UNFADE INK—THIS IS A PERMANENT RECORD.
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Form V. S. No. 5. 12½ M. 7-24-11

CERTIFICATE OF DEATH

1. PLACE OF DEATH.
County of Bingham
City of Blackfoot

Registration District No. 13
Primary Registration District No. 1007
(No. 432, No. Ummady St.)

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics
File No. 4498
Registered No. 25

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

Clarence Jensen

If death occurred in a hospital, institution or camp give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX Male 4. COLOR OR RACE White 5. SINGLE, MARRIED, WIDOWED OR DIVORCED. 5
(Write the word.)

6. DATE OF BIRTH Feb 8 1912
(Month) (Day) (Year)

7. AGE 1 yrs. 0 mos. 22 ds. IF LESS than 1 day how many.....hrs. or.....min?

8. OCCUPATION
(a) Trade, profession or particular kind of work. None
(b) General nature of industry business or establishment in which employed (or employer)

9. BIRTHPLACE (State or Country) Idaho

10. NAME OF FATHER Jarvis D. Jensen

11. BIRTHPLACE OF FATHER (State or Country) Utah

12. MAIDEN NAME OF MOTHER Emma J. Williams

13. BIRTHPLACE OF MOTHER (State or Country) Utah

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) P. J. Williams
(Address) Blackfoot P. O. No. 3

15. Filed Feb 2 1913 W. E. Patrick
Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH Feb 2 1913
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from Feb 28 1913, to Feb 2 1913 that I last saw him alive on Feb 1 1913 and that death occurred on the date stated above, at 11:30 M.

The CAUSE OF DEATH* was as follows:
Boone's - pneumonia

(Duration) yrs. mos. 4 ds.
Contributory (Secondary) Muscles

(Duration) yrs. mos. 7 ds.
(Signed) W. E. Patrick M. D.
Feb 2 1913 (Address) Blackfoot

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place In the of death.....yrs.....mos.....ds. State.....yrs.....mos.....ds.
Where was disease contracted, If not at place of death?..... Former or usual residence.....

19. PLACE OF BURIAL OR REMOVAL DATE OF BURIAL
H. C. Cem. Blackfoot. Feb 2 1913

20. UNDERTAKER ADDRESS
P. J. Williams

Form V. S. No. 5 20M.1-16-12

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH.

Registration District No. 18County of BinghamPrimary Registration District No. 1007City of Blackfoot(No. Upper Addition St.)File No. 449Registered No. 26

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

Elta Van Blaricom

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX

Female

4. COLOR OR RACE

White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED.

Single
(Write the word.)

6. DATE OF BIRTH

Nov 10 1902
(Month) (Day) (Year)

7. AGE

10 yrs. 3 mos. 23 ds.IF LESS than 1 day
how many hrs. or
..... mins.?

8. OCCUPATION

(a) Trade, profession or particular kind of work

Schoolgirl

(b) General nature of industry business, or establishment in which employed (or employer)

9. BIRTHPLACE

(State or Country)

Idaho

10. NAME OF FATHER

Peter B. Van Blaricom

11. BIRTHPLACE OF FATHER

(State or Country)

Canada

12. MAIDEN NAME OF MOTHER

Harriet Stander

13. BIRTHPLACE OF MOTHER

(State or Country)

Utah

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

P. B. Van Blaricom

(Address)

Blackfoot Idaho

15.

Filed

Nov 4 1913M. E. Patrie

Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH

Nov 3 1913
(Month) (Day) (Year)17. I HEREBY CERTIFY, That I attended deceased from Nov 25 1913 to Nov 3 1913that I last saw her alive on Nov 23 1913 and that death occurred on the date stated above, at 2 PM.

The CAUSE OF DEATH* was as follows:

Spasmodic croup

(Duration)

yrs. mos. 5 ds.

Contributory (Secondary)

Measles

(Duration)

yrs. mos. 10 ds.

(Signed)

M. E. Patrie M. D.Nov 13 1913 (Address) Blackfoot

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death.....yrs.....mos.....days.

In the State.....yrs.....mos.....days.

Where was disease contracted if not at place of death?.....

Former or usual residence.....

19. PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

First City CemeteryNov 5 1913

20. UNDERTAKER

ADDRESS

P. B. Van Blaricom Blackfoot

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Form V. S. No. 5 20M.1-16-12

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH.

Registration District No. 13County of BinghamPrimary Registration District No. 2053File No. 4509City of Blackfoot

(No. _____)

St. _____

Registered No. 27

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

Adam Kundert

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX

male

4. COLOR OR RACE

white

5. SINGLE, MARRIED, WIDOWED OR DIVORCED.

married
(Write the word.)

6. DATE OF BIRTH

July
(Month)12
(Day)1872
(Year)

7. AGE

41 yrs.

mos.

ds.

IF LESS than 1 day
how many hrs. or
..... mins.?

8. OCCUPATION

(a) Trade, profession or particular kind of work
(b) General nature of industry, business, or establishment in which employed (or employer)Booskeeper

9. BIRTHPLACE

(State or Country)

Iowa

10. NAME OF FATHER

Adam Kundert

11. BIRTHPLACE OF FATHER

(State or Country)

Switzerland

12. MAIDEN NAME OF MOTHER

Margaret Michler

13. BIRTHPLACE OF MOTHER

(State or Country)

Switzerland

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

Ollie Kundert

(Address)

Blackfoot

15.

Filed

Mar 11 1913W. E. Parie
Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH

Mar 1
(Month)

(Day)

1913
(Year)

17. I HEREBY CERTIFY, That I attended deceased from

Feb 22 1913 to Mar 1 1913that I last saw him alive on Mar 1 1913and that death occurred on the date stated above, at 10:30 M.

The CAUSE OF DEATH* was as follows:

General Septicemia

(Duration)

yrs.

mos.

ds.

Contributory
(Secondary)Infected ingrown toe nail

(Duration)

yrs.

mos.

7 ds.

(Signed)

H. J. Zimmerman M. D.Mar 3 1913 (Address) Blackfoot Idaho

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place

of death

yrs.

mos.

days.

In the

State

6 yrs.

mos.

days.

Where was disease contracted
if not at place of death?Former or
usual residence

19. PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

General Cem BlackfootMar 5 1913

20. UNDERTAKER

ADDRESS

E. J. PuckBlackfoot

WRITE PLAINLY
N. B.—Every item of information should be carefully supplied. CITIZENS should state CAUSE OF DEATH in plain terms, so that it may be of use in the event of OCCUPATION is very important. See instructions on back of certificate.

County of Blaine File No. 4501
City of Blackfoot (No. 28) Registered No. 28
(Butterfield)
If death occurs away from usual residence, give facts called for under special information. 2. FULL NAME Cleon Gardner
If death occurred in a hospital, institution or camp give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX Male 4. COLOR OR RACE White 5. SINGLE, MARRIED, WIDOWED OR DIVORCED. Single
(Write the word.)
6. DATE OF BIRTH March 3 1913
(Month) (Day) (Year)
7. AGE _____ yrs. _____ mos. _____ ds. IF LESS than 1 day how many _____ hrs. or _____ min?
8. OCCUPATION
(a) Trade, profession or particular kind of work. _____
(b) General nature of industry business or establishment in which employed (or employer) _____
9. BIRTHPLACE
(State or Country) Bingham Co. Idaho
10. NAME OF FATHER Albert Gardner
11. BIRTHPLACE OF FATHER Utah
(State or Country)
12. MAIDEN NAME OF MOTHER Minnie Taylor
13. BIRTHPLACE OF MOTHER Utah
(State or Country)
14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Jos. J. Gardner
(Address) _____
15. Filed Mar 7 1913 W. E. Patie
Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH

March 6 1913
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from March 3 1913, to March 6 1913
that I last saw him alive on March 6 1913
and that death occurred on the date stated above, at 8:45 P.M.

The CAUSE OF DEATH* was as follows:

Spina Bifida

(Duration) _____ yrs. _____ mos. 3 ds.

Contributory
(Secondary)

(Duration) _____ yrs. _____ mos. _____ ds.

(Signed) J. W. Metcalf M. D.

Mar 6 1913 (Address) Blackfoot, Idaho

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place _____ In the _____
of death _____ yrs. _____ mos. _____ ds. State _____ yrs. _____ mos. _____ ds.
Where was disease contracted, _____
If not at place of death? _____
Former or _____
usual residence. _____

19. PLACE OF BURIAL OR REMOVAL DATE OF BURIAL

Lincoln City Cem Blackfoot Mar 7 1913
20. UNDERTAKER E. J. Hick ADDRESS Blackfoot

1. PLACE OF DEATH.

Registration

County of Bingham

Primary Registrar

District No.

City of Blackfoot(No. 314)

St.)

File No. 4502Registered No. 29

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Annie Arnish

If death occurred in a hospital, institution or camp give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX

4. COLOR OR RACE

5. SINGLE, MARRIED, WIDOWED OR DIVORCED.

FemaleWhiteSingle
(Write the word.)

6. DATE OF BIRTH

3101901

(Month)

(Day)

(Year)

7. AGE

11 yrs. 11 mos. 29 ds.IF LESS than 1 day
how many hrs. or
min?

8. OCCUPATION

(a) Trade, profession or particular kind of work.

in School

(b) General nature of industry business or establishment in which employed (or employer)

9. BIRTHPLACE

(State or Country)

Russia

10. NAME OF FATHER

Frank Arnish

11. BIRTHPLACE OF FATHER

(State or Country)

Russia

12. MAIDEN NAME OF MOTHER

Francis Matwick

13. BIRTHPLACE OF MOTHER

(State or Country)

Russia

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Frank Arnish

(Address)

15.

Filed

Mar 10 1913W.E. Petrie

Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH

March81913

(Month)

(Day)

(Year)

17. I HEREBY CERTIFY, That I attended deceased from

March 81913to March 81913that I last saw her alive on March 1913and that death occurred on the date stated above, at M.

The CAUSE OF DEATH* was as follows:

Pneumonia

(Duration) yrs. mos. ds.

Contributory

(Secondary)

(Duration) yrs. mos. ds.

(Signed)

F. W. Mitchell

M. D.

March 8 1913 (Address) Blackfoot, Idaho

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place

In the

of death yrs. mos. ds. State yrs. mos. ds.

Where was disease contracted,

If not at place of death?

Former or

usual residence?

19. PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

Fun City Cem. BlackfootMar. 10 1913

20. UNDERTAKER

ADDRESS

E. J. LuckBlackfoot

1. PLACE OF DEATH.

County of BinghamCity of Blackfoot

Registration District No. _____

Primary Registration District No. 2053
(No. Idaho Moore Argyle St.)File No. 1511Registered No. 20

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

Otis A. Post

If death occurred in a hospital, institution or camp give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX

Male

4. COLOR OR RACE

White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED.

Married
(Write the word.)

6. DATE OF BIRTH

(Month)

(Day)

1877
(Year)

7. AGE

35 yrs.

mos.

ds.

IF LESS than 1 day
how many hrs. or
..... min.?

8. OCCUPATION

(a) Trade, profession, or particular kind of work

Farmer

(b) General nature of industry business, or establishment in which employed (or employer)

9. BIRTHPLACE

(State or Country)

Missouri

10. NAME OF FATHER

J. H. Post

11. BIRTHPLACE OF FATHER

(State or Country)

?

12. MAIDEN NAME OF MOTHER

?

13. BIRTHPLACE OF MOTHER

(State or Country)

?

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

(Address)

Francis H. PooleBlackfoot, Idaho

15.

Filed

March 13 1913
W. E. Pattee
Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

March
(Month)14
(Day)1913
(Year)

17. I HEREBY CERTIFY, That I attended deceased from

Jan 2, 1913, to March 14, 1913
that I last saw him alive on March 13, 1913,and that death occurred on the date stated above, at 6 A.M.

The CAUSE OF DEATH* was as follows:

Cerebral hemorrhage

(Duration)

3 yrs.

mos.

ds.

Contributory
(Secondary)Epilepsy

(Duration)

yrs.

mos.

ds.

(Signed)

Francis H. Poole

M. D.

March 14 1913(Address) Blackfoot

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place

In the

of death yrs. 2 mos. 12 ds. State 35 yrs. mos. ds.Where was Disease contracted, Meridian Idaho

If not at place of death?

Former or

usual residence.

""

19. PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

Meridian, Idaho191

20. UNDERTAKER

ADDRESS

E. J. PeckBlackfoot, Ida

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICAL CLANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Form V. S. No. 5. 12½ M. 7-24-11

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH. Registration District No. 13
County of Bingham Primary Registration District No. 253
City of Partridge (No. _____, _____ St.)

File No. 4504
Registered No. 31

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Thelma Rosa Taylor
If death occurred in a hospital, institution or camp give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX _____ 4. COLOR OR RACE _____ 5. SINGLE, MARRIED, WIDOWED OR DIVORCED. _____

Female white (Write the word.)

6. DATE OF BIRTH _____
_____ / _____ 1908
(Month) (Day) (Year)

7. AGE _____
5 yrs. 1 mos. 28 ds. IF LESS than 1 day
how many _____ hrs. or _____ min?

8. OCCUPATION

- (a) Trade, profession or particular kind of work. _____
(b) General nature of industry business or establishment in which employed (or employer) _____

9. BIRTHPLACE _____
(State or Country) Idaho Bingham Co

10. NAME OF FATHER _____
Edwin Taylor

11. BIRTHPLACE OF FATHER _____
(State or Country) Salt Lake Utah

12. MAIDEN NAME OF MOTHER _____
Rosa May Smith

13. BIRTHPLACE OF MOTHER _____
(State or Country) Salt Lake Utah

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Edwin Taylor
(Address) Partridge

15. _____
Filed Mar 15 1913 ME Taylor
Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH _____
Mar. 14 1913
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from _____
Mar. 10 1913, to March 14 1913
that I last saw her alive on Mar 13 1913
and that death occurred on the date stated above, at 2:45 AM.
The CAUSE OF DEATH* was as follows:

Pneumonia
(Duration) _____ yrs. _____ mos. 5 ds.
Contributory (Secondary) Measles
(Duration) _____ yrs. _____ mos. 10 ds.
(Signed) A. W. Mitchell M. D.
Mar 14 1913 (Address) Bluffton Idaho

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place _____ In the _____
of death _____ yrs. _____ mos. _____ ds. State _____ yrs. _____ mos. _____ ds.
Where was disease contracted, _____
If not at place of death? _____
Former or _____
usual residence. _____

19. PLACE OF BURIAL OR REMOVAL DATE OF BURIAL

Lin City Cem Bluffton Mar 14 1913

20. UNDERTAKER ADDRESS

E. J. Kirk Bluffton

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Form V. S. No. 5. 12½ M. 7-24-11

CERTIFICATE OF DEATH

1. PLACE OF DEATH. Registration District No. 13
County of Burgham Primary Registration District No. 1007
City of Blackfoot (No. E. Judicial St.)

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

File No. 4505
Registered No. 32

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

Wallace Cutler

If death occurred in a hospital, institution or camp give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX Male 4. COLOR OR RACE White 5. SINGLE, MARRIED, WIDOWED OR DIVORCED.

(Write the word.)

6. DATE OF BIRTH

January 16 1911
(Month) (Day) (Year)

7. AGE

2 yrs. 2 mos. 2 ds.

IF LESS than 1 day
how many..... hrs. or
..... min?

8. OCCUPATION

- (a) Trade, profession or particular kind of work.
(b) General nature of industry business or establishment in which employed (or employer)

9. BIRTHPLACE

(State or Country)

Burgham

10. NAME OF FATHER

Joseph H. Cutler

11. BIRTHPLACE OF FATHER

(State or Country)

England

12. MAIDEN NAME OF MOTHER

Mary Ann Howkey

13. BIRTHPLACE OF MOTHER

(State or Country)

Portage, Wis.

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

Joseph H. Cutler

(Address)

Blackfoot

15.

Filed Mar 18 1913

W. E. Patie
Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH

March 18 1913
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from March 10 1913, to March 18 1913.

that I last saw her alive on March 17 1913.

and that death occurred on the date stated above, at 9. 9. M.

The CAUSE OF DEATH* was as follows:

Intestinal obstruction

(Duration) yrs. mos. 1 ds.

Contributory
(Secondary)

(Duration) yrs. mos. ds.

(Signed) F. W. Mitchell M. D.

March 18 1913 (Address) Blackfoot, Idaho

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place yrs. mos. ds. In the
of death..... yrs. mos. ds. State..... yrs. mos. ds.

Where was disease contracted,

If not at place of death?

Former or

usual residence.

19. PLACE OF BURIAL OR REMOVAL DATE OF BURIAL

Portage, Wis. Mar 19 1913

20. UNDERTAKER

ADDRESS

E. J. Peck Blackfoot

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Form V. S. No. 5 20M.1-16-12

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH.

Registration District No. 13County of BinghamPrimary Registration District No. 2053City of Thomas Mars

(No. _____, St.)

File No. 4506Registered No. 33

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

Clarence H. Jackrel

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX

Male

4. COLOR OR RACE

White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED.

5
(Write the word.)

6. DATE OF BIRTH

May 29 1912
(Month) (Day) (Year)

7. AGE

9 yrs. 19 mos. 19 ds.IF LESS than 1 day
how many hrs. or
..... mins.?

8. OCCUPATION

- (a) Trade, profession or particular kind of work
(b) General nature of industry business, or establishment in which employed (or employer)

9. BIRTHPLACE

(State or Country)

Idaho

10. NAME OF FATHER

Percy P. Jackrel

11. BIRTHPLACE OF FATHER

(State or Country)

Utah

12. MAIDEN NAME OF MOTHER

Lucy Williams

13. BIRTHPLACE OF MOTHER

(State or Country)

Utah

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

(Address)

Blacksfoot RFD No. 2

15.

Filed

May 18 1913W. E. Patric

Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH

May 18 1913
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from

Investigated death
1912 to 1913that I last saw him alive on 1912and that death occurred on the date stated above, at 1:15 P. M.

The CAUSE OF DEATH* was as follows:

Pneumonia

(Duration) yrs. mos. ds.

Contributory
(Secondary)

(Duration) yrs. mos. ds.

(Signed)

W. E. Patric M. D.3-18-1913 (Address) Blacksfoot Ida

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death yrs. mos. days. In the State yrs. mos. days.

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

Thomas MarsMay 19 1913

20. UNDERTAKER

ADDRESS

BlacksfootBlacksfoot

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Form V. S. No. 5 20M.1-16-12

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH.

Registration District No. 13County of BlainePrimary Registration District No. 2053File No. 4507City of Blackfoot (No. 1 St.)Registered No. 34

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Olson Farnsworth

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX

Male

4. COLOR OR RACE

White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED.

Single
(Write the word.)

6. DATE OF BIRTH

mch231913

(Month)

(Day)

(Year)

7. AGE

— yrs. — mos. — ds.IF LESS than 1 day
how many 1/2 hrs. or
— mins.

8. OCCUPATION

(a) Trade, profession or particular kind of work

(b) General nature of industry business, or establishment in which employed (or employer)

9. BIRTHPLACE

(State or Country) Idaho

10. NAME OF FATHER

M. H. Farnsworth

11. BIRTHPLACE OF FATHER

(State or Country) Arizona

12. MAIDEN NAME OF MOTHER

Wattie May Huff

13. BIRTHPLACE OF MOTHER

(State or Country) Idaho

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Richard K Farnsworth(Address) Blackfoot

15.

Filed Mch 22 1913W. E. Petic

Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH

mch281913

(Month)

(Day)

(Year)

17. I HEREBY CERTIFY, That I attended deceased from

mch 231913

to

mch 231913that I last saw him alive on mch 23 1913and that death occurred on the date stated above, at 12:30 M.

The CAUSE OF DEATH* was as follows:

Premature Birth

(Duration)

yrs.

mos.

ds.

Contributory

(Secondary)

(Duration)

yrs.

mos.

ds.

(Signed) H. D. Simmons

M. D.

mch 23 1913 (Address) Blackfoot Idaho

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place

of death

yrs.

mos.

days.

In the

State

yrs.

mos.

days.

Where was disease contracted if not at place of death?

Former or usual residence.

19. PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

Funeral of Richard K Farnsworthmch 23 1913

20. UNDERTAKER

ADDRESS

Richard K FarnsworthBlackfoot

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Form V. S. No. 5. 12½ M. 7-24-11

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH. Registration District No. 13
County of Bingham Primary Registration District No. 2053
City of Blackfoot (No. _____, St.)

File No. 4508
Registered No. 35

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Iva Matilda Popu

If death occurred in a hospital, institution or camp give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX Female 4. COLOR OR RACE white 5. SINGLE, MARRIED, WIDOWED OR DIVORCED. Single
(Write the word.)
6. DATE OF BIRTH 5 3 1913
(Month) (Day) (Year)

7. AGE 19 yrs. 10 mos. 19 ds. IF LESS than 1 day how many hrs. or min?

8. OCCUPATION
(a) Trade, profession or particular kind of work. House work
(b) General nature of industry business or establishment in which employed (or employer)

9. BIRTHPLACE (State or Country) Limestone Utah

10. NAME OF FATHER Wm Popu

11. BIRTHPLACE OF FATHER (State or Country) Mo.

12. MAIDEN NAME OF MOTHER Matilda Cramer

13. BIRTHPLACE OF MOTHER (State or Country) Virginia

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) William Popu
(Address) _____

15. 1913 3 23 Me
Filed Me 1913 3 23 Me
Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH me 22 1913
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from me 12 1913, to me 22 1913
that I last saw her alive on me 21 1913
and that death occurred on the date stated above, at 79 M.
The CAUSE OF DEATH* was as follows:

acute dilatation of heart

(Duration) yrs. mos. ds.
Contributory (Secondary) Cholecystitis acute

(Duration) yrs. mos. ds. 9
(Signed) H. J. Simmons M. D.
me 22 1913 (Address) Blackfoot Idaho

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place In the
of death. yrs. mos. ds. State. yrs. mos. ds.
Where was disease contracted,
If not at place of death?
Former or
usual residence.

19. PLACE OF BURIAL OR REMOVAL DATE OF BURIAL
Basalt Idaho Mar 24 1913

20. UNDERTAKER ADDRESS
E. J. Runk Blackfoot

Form V. S. No. 5. 12½ M. 7-24-11

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH. Registration District No. 13
 County of Burgham Primary Registration District No. 2053
 City of Blackfoot (No. _____, _____ St.)

File No. 4509
 Registered No. 36

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

Geo Parker Jr

If death occurred in a hospital, institution or camp give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX 4. COLOR OR RACE 5. SINGLE, MARRIED, WIDOWED OR DIVORCED.

Male White (Write the word.)

6. DATE OF BIRTH

Mar 6
Mar 15 1913
 (Month) (Day) (Year)

7. AGE

IF LESS than 1 day
 how many _____ hrs. or
 _____ yrs. _____ mos. 16 ds. _____ min?

8. OCCUPATION

(a) Trade, profession or particular kind of work.
 (b) General nature of industry business or establishment in which employed (or employer)

Infant

9. BIRTHPLACE

(State or Country)

Blackfoot R F Id

10. NAME OF FATHER

Geo Parker

11. BIRTHPLACE OF FATHER

(State or Country)

Penn.

12. MAIDEN NAME OF MOTHER

Lillian Isaacson

13. BIRTHPLACE OF MOTHER

(State or Country)

Wyo

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

(Address)

George Porter

15.

Filed

Mar 24 1913

McE. Patrie
 Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH

March 23. 1913
 (Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from

March 22 1913, to March 23 1913

that I last saw h alive on March 12 1913

and that death occurred on the date stated above, at 12:30 A.M.

The CAUSE OF DEATH* was as follows:

Pneumonia

_____ (Duration) _____ yrs. _____ mos. 3 ds.

Contributory (Secondary)

measles

_____ (Duration) _____ yrs. _____ mos. 10 ds.

(Signed)

F. W. Metcalf M. D.
March 23 1913 (Address) Blackfoot Idaho

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place _____ In the _____
 of death _____ yrs. _____ mos. _____ ds. State _____ yrs. _____ mos. _____ ds.

Where was disease contracted,

If not at place of death?

Former or

usual residence.

19. PLACE OF BURIAL OR REMOVAL DATE OF BURIAL

Fun City Burial Blackfoot Mar 23 1913

20. UNDERTAKER

ADDRESS

E. J. Ruk

Blackfoot

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Form V. S. No. 5. 12½ M. 7-24-11

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH.
County of *Bingham*
City of *Blackfoot*

Registration District No. *13*
Primary Registration District No. *2053*
(No. _____, _____ St.)

File No. *1511*
Registered No. *37*

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

Patrah Christoferson

If death occurred in a hospital, institution or camp give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX 4. COLOR OR RACE 5. SINGLE, MARRIED, WIDOWED OR DIVORCED.

Female

White

Married
(Write the word.)

6. DATE OF BIRTH

3 *21* *1844*
(Month) (Day) (Year)

7. AGE

69 yrs. *0* mos. *0* ds.

IF LESS than 1 day
how many..... hrs. or
..... min?

8. OCCUPATION

(a) Trade, profession or particular kind of work.
(b) General nature of industry business or establishment in which employed (or employer)

Housewife

9. BIRTHPLACE

(State or Country)

Norway

10. NAME OF FATHER

?

11. BIRTHPLACE OF FATHER

(State or Country)

?

12. MAIDEN NAME OF MOTHER

?

13. BIRTHPLACE OF MOTHER

(State or Country)

?

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

(Address)

Francis H. Poole
Blackfoot, Ida.

15.

Filed

Mar 29 1913

W. E. Paton
Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH

March *27* *1913*
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from

March 15 *1913*, to *Mar. 27* *1913*

that I last saw her alive on *March 27* *1913*

and that death occurred on the date stated above, at *2 P. M.*

The CAUSE OF DEATH* was as follows:

Chronic convulsions

..... (Duration) yrs. mos. *2* ds.

Contributory *Chronic Intestinal Nephritis*
(Secondary)

..... (Duration) yrs. mos. ds.

(Signed) *Francis H. Poole* M. D.

Mar. 27 *1913* (Address) *Blackfoot.*

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place *16* In the
of death..... yrs. mos. ds. State..... yrs. mos. ds.

Where was disease contracted,

If not at place of death?

Former or

usual residence *Pocatello, Idaho.*

19. PLACE OF BURIAL OR REMOVAL DATE OF BURIAL

Lincoln City Cem Blackfoot *Mar 29 1913*

20. UNDERTAKER

ADDRESS

E. J. Peak.

Blackfoot.

WRITE PLAINLY, WITH UNFADING INK. THIS IS A PERMANENT RECORD. N. B.—Every item of information should be carefully supplied. AGE should be state EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Form V. S. No. 5. 10M. 6-20-11.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH. Registration District No. 29
County of Minidoka Primary Registration District No. 2115
City of Rupert (No. _____ St.)

File No. 4511Registered No. _____
If death occurred in a hospital, institution or camp give its NAME instead of street and number.

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

Theodore Bear

PERSONAL AND STATISTICAL PARTICULARS

3. SEX 4. COLOR OR RACE 5. SINGLE, MARRIED, WIDOWED OR DIVORCED.

MaleWhiteSingle
(Write the word.)

6. DATE OF BIRTH

Dec301913

(Month)

(Day)

(Year)

7. AGE

yrs. 2mos. 3ds. 3IF LESS than 1 day
how many..... hrs. or
..... min.?

8. OCCUPATION

- (a) Trade, profession or particular kind of work
(b) General nature of industry business or establishment in which employed (or employer)

9. BIRTHPLACE

(State or Country)

Burley Ida.

10. NAME OF FATHER

Geo. B. Bear

11. BIRTHPLACE OF FATHER

(State or Country)

Utah

12. MAIDEN NAME OF MOTHER

Julia Boyd

13. BIRTHPLACE OF MOTHER

(State or Country)

Nova Scotia

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

Geo. B. Bear

(Address)

Rupert Ida

15.

Filed

4/10/1913V. R. Killeen

Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

Mar.11913

(Month)

(Day)

(Year)

17. I HEREBY CERTIFY, That I attended deceased from

Mar. 1 1913, to Mar. 1 1913that I last saw him alive on Mar. 1 1913,and that death occurred on the date stated above, at 9 p.m.

The CAUSE OF DEATH* was as follows:

Malnutrition(Duration) yrs. 2 mos. 3 ds.Contributory
(Secondary)

(Duration) yrs. _____ mos. _____ ds.

(Signed) J. B. Killeen M. D.3/1 1913 (Address) Rupert

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state 1) MEANS OF INJURY; and 2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death..... yrs. _____ mos. _____ ds. State..... yrs. _____ mos. _____ ds.

Where was disease contracted.

If not at place of death?

Former or

usual residence.

19. PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

Burley3/1 1913

20. UNDERTAKER

ADDRESS

L. B. GalloglyBurley

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Form V. S. No. 5 20M.1-16-12

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH.

Registration District No.

3

County of

Primary Registration District No.

2005

City of

(No.

St.)

File No.

451

Registered No.

38

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

Recorder Morris Hudgett

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX

M.

4. COLOR OR RACE

W

5. SINGLE, MARRIED, WIDOWED OR DIVORCED.

married
(Write the word.)

6. DATE OF BIRTH

March 19th 1841
(Month) (Day) (Year)

7. AGE

71 yrs. 11 mos. 27 ds.

IF LESS than 1 day
how many hrs. or mins.?

8. OCCUPATION

(a) Trade, profession or particular kind of work

Farmer

(b) General nature of industry business, or establishment in which employed (or employer)

9. BIRTHPLACE

(State or Country)

Ohio

10. NAME OF FATHER

Clifford Mudgett

11. BIRTHPLACE OF FATHER

(State or Country)

New Hampshire

12. MAIDEN NAME OF MOTHER

Rebecca Haymaker

13. BIRTHPLACE OF MOTHER

(State or Country)

Ohio

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

George Mudgett

(Address)

Spokane Wash

15.

Filed

May 8 - 1913

1913

J. S. Meyer

Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH

Mar 19th 1913
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from

Feb 28 1913, to Mar 6th 1913,

that I last saw him alive on Mar 6th 1913,

and that death occurred on the date stated above, at 11 P.M.

The CAUSE OF DEATH* was as follows:

Arthritis deformans set in several years ago following rheumatism
uraemic Coma set in Mar 3rd 1913

(Duration) 7 yrs. 11 mos. 27 ds.

Contributory none but what are described
(Secondary)

(Duration) yrs. mos. ds.

(Signed) J. W. James M. D.

3/7-1913 (Address) Middleton

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death yrs. mos. days. In the State yrs. mos. days.

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

Middleton

3/9 1913

20. UNDERTAKER

ADDRESS

W. G. Dyer

Calhoun

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Form V. S. No. 5 20M.1-16-12

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH.

Registration District No. 3County of QueenPrimary Registration District No. 2003City of Calderwell

(No. _____)

St.)

File No. 4513Registered No. 39

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME W. H. Redsell

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX

M.

4. COLOR OR RACE

W.

5. SINGLE, MARRIED, WIDOWED OR DIVORCED.

Widowed
(Write the word.)

6. DATE OF BIRTH

November 15 1827
(Month) (Day) (Year)

7. AGE

85 yrs. 4 mos. 24 ds.IF LESS than 1 day
how many hrs. or
..... mins.?

8. OCCUPATION

(a) Trade, profession or particular kind of work

Retire Merchant

(b) General nature of industry business, or establishment in which employed (or employer)

9. BIRTHPLACE

(State or Country)

England

10. NAME OF FATHER

William Redsell

11. BIRTHPLACE OF FATHER

(State or Country)

England

12. MAIDEN NAME OF MOTHER

don't no

13. BIRTHPLACE OF MOTHER

(State or Country)

England

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Mrs. W. H. Bailey(Address) Haily Idaho

15.

Filed Mar. 10 1913John D. Meyer
Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH

Mar 9 1913
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from

Mar. 6 1913, to Mar 9 1913,that I last saw him alive on Mar 9 1913and that death occurred on the date stated above, at 12:30 P.

The CAUSE OF DEATH* was as follows:

Septicemia(Duration) yrs. mos. 7 ds.

Contributory (Secondary)

Hernia(Duration) yrs. mos. 2 ds.

(Signed)

3/10/13 (Address) Calderwell Idaho.

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death yrs. mos. days. In the State yrs. mos. days.

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

Buise Idaho 3/10 1913

20. UNDERTAKER

ADDRESS

W. Dyer Calderwell.
Idaho

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Form V. S. No. 5. 12½M.7-24-11

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH. Registration District No. 3
County of Lanyon Primary Registration District No. 2007
City of Caldwell (No. _____, _____ St.)

File No. 4511
Registered No. 40

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Frankie Trotter

If death occurred in a hospital, institution or camp give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX Male 4. COLOR OR RACE white 5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.)

6. DATE OF BIRTH Feb 8
(Month) (Day) (Year)

7. AGE 8 yrs. 0 mos. 0 ds. IF LESS than 1 day how many _____ hrs. or _____ min?

8. OCCUPATION
(a) Trade, profession or particular kind of work School Boy
(b) General nature of industry business or establishment in which employed (or employer)

9. BIRTHPLACE (State or Country) Lanyon & Idaho

10. NAME OF FATHER O. M. Trotter

11. BIRTHPLACE OF FATHER (State or Country) MO

12. MAIDEN NAME OF MOTHER Kella Palmer

13. BIRTHPLACE OF MOTHER (State or Country) Idaho

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE (Informant) James A. Trotter
(Address) Caldwell Idaho

15. Filed Mar. 14-1913 J. S. Meyer
Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH 3-13-1913
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from March 6 1913, to March 13 1913, that I last saw him alive on March 13 1913 and that death occurred on the date stated above, at 4 M. The CAUSE OF DEATH* was as follows:
Suppurative Appendicitis
acute

(Duration) _____ yrs. _____ mos. 16 ds.
Contributory (Secondary)

(Duration) _____ yrs. _____ mos. _____ ds.
(Signed) J. J. Miller M. D.
2-14-1913 (Address) Caldwell Idaho

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place In the
of death _____ yrs. _____ mos. _____ ds. State _____ yrs. _____ mos. _____ ds.
Where was disease contracted,
If not at place of death?
Former or
usual residence.

19. PLACE OF BURIAL OR REMOVAL DATE OF BURIAL

Lanyon Hill Co 3/14 1913
20. UNDERTAKER W E Platt ADDRESS Caldwell

Form V. S. No. 5 20M.1-16-12

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH.

Registration District No.

3

County of Canyon

Primary Registration District No.

1005

City of Caldwell

(No. St.)

Registered No.

41

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

Edward B. Smith

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX

M.

4. COLOR OR RACE

W5. SINGLE, MARRIED, WID-
OWED OR DIVORCED.Married
(Write the word.)

6. DATE OF BIRTH

January 1st 1856
(Month) (Day) (Year)

7. AGE

57 yrs. 3 mos. — ds.IF LESS than 1 day
how many hrs. or
..... mins.?

8. OCCUPATION

(a) Trade, profession or
particular kind of workRancher(b) General nature of industry
business, or establishment in
which employed (or employer)

9. BIRTHPLACE

(State or Country)

Kentucky10. NAME OF
FATHERJames Smith11. BIRTHPLACE
OF FATHER

(State or Country)

Kentucky
James Smith12. MAIDEN NAME
OF MOTHERMary Davis13. BIRTHPLACE
OF MOTHER

(State or Country)

Kentucky

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

John T. Sebrer

(Address)

Caldwell Ida

15.

Filed

April 1st 1913John T. Sebrer

Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH

March 30 1913
(Month) (Day) (Year)17. I HEREBY CERTIFY, That I attended deceased from
March 20th 1913 to March 30th 1913that I last saw him alive on March 30th 1913and that death occurred on the date stated above, at 1 P.M.

The CAUSE OF DEATH* was as follows:

Aortic Fibrillation(Duration) yrs. 3 mos. ds.Contributory
(Secondary)Diabetes mellitus

(Duration) yrs. mos. ds.

(Signed)

W. C. Dyer M. D.
4/1/1913 (Address) Caldwell Ida

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions,
Transients or Recent Residents.)

At place

of death yrs. mos. days.

In the

State yrs. mos. days.

Where was disease contracted
if not at place of death?Former or
usual residence

19. PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

Canyon Hill4/1 1913

20. UNDERTAKER

ADDRESS

W. C. DyerCaldwell

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Form V. S. No. 5. 10M. 6-20-11.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH.

Registration District No. 3County of CanyonPrimary Registration District No. 2004City of Parma

(No. _____ St.)

File No. 4516Registered No. 42

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

Aldice F. Pillsbury

If death occurred in a hospital, institution or camp give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX

male

4. COLOR OR RACE 5. SINGLE, MARRIED, WIDOWED OR DIVORCED.

whitesingle
(Write the word.)

6. DATE OF BIRTH

Dec 20
(Month) (Day) (Year)1847
(Year)

7. AGE

66 yrs. 2 mos. 15 ds.IF LESS than 1 day
how many _____ hrs. or
_____ min.?

8. OCCUPATION

- (a) Trade, profession or particular kind of work
(b) General nature of industry business or establishment in which employed (or employer)

Farmer

9. BIRTHPLACE

(State or Country)

N. York

10. NAME OF FATHER

David F. Pillsbury

11. BIRTHPLACE OF FATHER

(State or Country)

Vermont

12. MAIDEN NAME OF MOTHER

Harriet Hadwin

13. BIRTHPLACE OF MOTHER

(State or Country)

England

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

Frederic Pillsbury

(Address)

Parma R R 3

15.

Filed

3/8

191

3 R. Allen

Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

Mar
(Month)7
(Day)1913
(Year)

17. I HEREBY CERTIFY, That I attended deceased from

Mar. 5 1913, to Mar. 7 1913that I last saw him alive on Mar. 6 1913and that death occurred on the date stated above, at 5 A. M.

The CAUSE OF DEATH* was as follows:

Lobar Pneumonia(Duration) _____ yrs. _____ mos. 6 ds.Contributory
(Secondary)Bright's Disease(Duration) several yrs. _____ mos. _____ ds.

(Signed)

Chas. B. Allen M. D.3-7 1913 (Address) Parma, Ida.

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death _____ yrs. _____ mos. _____ ds. State _____ yrs. _____ mos. _____ ds.

Where was disease contracted?

If not at place of death?

Former or

usual residence.

19. PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

Parma3/8 1913

20. UNDERTAKER

ADDRESS

Thuttreland Co Parma

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Form V. S. No. 5 20M.1-16-12

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH.

Registration District No. 3

County of Lamy on

Primary Registration District No. 2007

City of Panna

(No. _____ St.)

File No. 4517

Registered No. 43

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

Baby Harrell

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX

M

4. COLOR OR RACE

W

5. SINGLE, MARRIED, WIDOWED OR DIVORCED.

(Write the word.)

6. DATE OF BIRTH

Dec 20 1913
(Month) (Day) (Year)

7. AGE

3 yrs. 7 mos. 7 ds.

IF LESS than 1 day
how many _____ hrs. or
_____ mins.?

8. OCCUPATION

(a) Trade, profession or particular kind of work
(b) General nature of industry, business, or establishment in which employed (or employer)

9. BIRTHPLACE

(State or Country) Leavenworth

10. NAME OF FATHER

Willis L. Harrell

11. BIRTHPLACE OF FATHER

(State or Country) Kansas

12. MAIDEN NAME OF MOTHER

Lizzie Carlisle

13. BIRTHPLACE OF MOTHER

(State or Country) Idaho

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Lester Hayshu

(Address) Panna Ida

15.

Filed Mar. 27- 1913 R. F. Cluen
Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH

March 26 1913
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from

191 to 191

that I last saw h. alive on 191

and that death occurred on the date stated above, at M.

The CAUSE OF DEATH* was as follows:

Death was due to
congenital deformity

(Duration) _____ yrs. _____ mos. _____ ds.

Contributory
(Secondary)

(Duration) _____ yrs. _____ mos. _____ ds.

(Signed)

3/27 1913 (Address) Panna Idaho.

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death _____ yrs. _____ mos. _____ days. In the State _____ yrs. _____ mos. _____ days.

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

Roswell Ida 3/26 1913

20. UNDERTAKER

ADDRESS

Flatt & Bennett Panna

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Form V. S. No. 5 20M.1-16-12

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH. Registration District No. 3
County of Canyon Primary Registration District No. 2005
City of Caldwell, Rural (No. _____ St.)

File No. 4518
Registered No. 44

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Robert Spencer King

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX M 4. COLOR OR RACE W 5. SINGLE, MARRIED, WIDOWED OR DIVORCED.
(Write the word.)

6. DATE OF BIRTH

June 2 1910
(Month) (Day) (Year)

7. AGE

3 yrs. 3 mos. 6 ds.

IF LESS than 1 day
how many _____ hrs. or
_____ mins.?

8. OCCUPATION

- (a) Trade, profession or particular kind of work
(b) General nature of industry business, or establishment in which employed (or employer)

9. BIRTHPLACE

(State or Country) Baldwell

10. NAME OF FATHER

M. S. King

11. BIRTHPLACE OF FATHER

(State or Country) Mich.

12. MAIDEN NAME OF MOTHER

Julia Stella Billing

13. BIRTHPLACE OF MOTHER

(State or Country) Iowa

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) M. S. King

(Address) Caldwell

15.

Filed April 5 1913

J. S. Meyer
Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH

4 7 1913
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from Mar 6 1913 to Apr. 6 1913, that I last saw him alive on Apr. 6 1913, and that death occurred on the date stated above, at _____ M.

The CAUSE OF DEATH* was as follows:

Bronchial Pneumonia

(Duration) _____ yrs. _____ mos. _____ ds.

Contributory (Secondary) measles

(Duration) _____ yrs. _____ mos. _____ ds.

(Signed) C. M. Meyer M. D.

Apr 8 1913 (Address) Caldwell

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death _____ yrs. _____ mos. _____ days. In the State _____ yrs. _____ mos. _____ days.

Where was disease contracted if not at place of death?

Former or usual residence _____

19. PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

Canyon Hill

4-8 1913

20. UNDERTAKER

ADDRESS

W. L. Dyer

Caldwell

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Form V. S. No. 5. 10M. 6-2

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics
File No. 451
Registered No. 45

If death occurred in a hospital, institution or camp give its NAME instead of street and number.

1. PLACE OF DEATH
County of Canyon
City of Hamlet

Registration District No. 1003
Primary Registration District No. 100
(No. St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

Alfonse Generoux

PERSONAL AND STATISTICAL PARTICULARS

3. SEX Male 4. COLOR OR RACE White 5. SINGLE, MARRIED, WIDOWED OR DIVORCED Married
(Write the word.)

6. DATE OF BIRTH

Feb. 9 1861
(Month) (Day) (Year)

7. AGE

52 yrs. — 11 mos. 11 ds.
IF LESS than 1 day
how many hrs. or min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work
(b) General nature of industry business or establishment in which employed (or employer)

Hamlet

9. BIRTHPLACE

(State or Country)

Canada

10. NAME OF FATHER

E. Verbillen

11. BIRTHPLACE OF FATHER

(State or Country)

Canada

12. MAIDEN NAME OF MOTHER

Alice

13. BIRTHPLACE OF MOTHER

(State or Country)

Canada

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

(Address)

J. Generoux
Hamlet

15.

Filed 9-20- 1913

O. B. Bellevue
Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

2 24 1913
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from

Oct. 10, 1910, to Feb. 20, 1913

that I last saw him alive on Feb. 19, 1913,

and that death occurred on the date stated above, at 5:20 A.M.

The CAUSE OF DEATH* was as follows:

Mitral regurgitation

(Duration) 2 yrs. 4 mos. ds.

Contributory (Secondary)

heart dilatation

(Duration) yrs. mos. ds.

(Signed) Geo. D. Kelley M. D.

2/20/1913 (Address) Hamlet, Ida

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted?

If not at place of death?

Former or usual residence.

19. PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

Hamlet, Ida 2-21-1913

20. UNDERTAKER

ADDRESS

E. B. Shella Hamlet, Ida
Shella & Son

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PERSONS CLAIMING should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Form V. B. No. 5. 10M. 6-20-11.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics
File No. 4520

1. PLACE OF DEATH
County of Campan
City of Manitoba

Registration District 1003
Primary Registrar [Redacted] District No. 2006
(No. [Redacted] St.)

Registered No. 46
If death occurred in a hospital, institution or camp give the NAME instead of street and number.

If death occurs away from usual residence, give facts called for under special information. 2. FULL NAME Edward Phaneuf

PERSONAL AND STATISTICAL PARTICULARS

3. SEX male 4. COLOR OR RACE White 5. SINGLE, MARRIED, WIDOWED OR DIVORCED. Widowed
(Write the word.)

6. DATE OF BIRTH Aug 4 1913
(Month) (Day) (Year)

7. AGE 64 yrs 7 mos 95 ds
IF LESS than 1 day how many hrs. or min.

8. OCCUPATION
(a) Trade, profession or particular kind of work Farmers
(b) General nature of industry, business or establishment in which employed (or employer)

9. BIRTHPLACE (State or Country) Canada

10. NAME OF FATHER Ernest Phaneuf

11. BIRTHPLACE OF FATHER (State or Country) Canada

12. MAIDEN NAME OF MOTHER Louise Bissac

13. BIRTHPLACE OF MOTHER (State or Country) Canada

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Mrs. H. Keene
(Address) Bainville

15. Filed Mar 29 1913 O. B. Beller
Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH Mar 29 1913
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from Mar 28 1913 to Mar 29 1913
that I last saw him alive on Mar 28 1913
and that death occurred on the date stated above, at 1 P. M.
The CAUSE OF DEATH* was as follows:

Cerebral hemorrhage

(Duration) — yrs. — mos. 0 ds.
Contributory (Secondary) arteriosclerosis
(Duration) Don't know yrs. — mos. — ds.

(Signed) H. P. Ross M. D.
Mar 29 1913 (Address) Kampa, Id.

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death — yrs. — mos. — ds. In the State — yrs. — mos. — ds.
Where was disease contracted?
If not at place of death?
Former or usual residence —

19. PLACE OF BURIAL OR REMOVAL St. Shillaburg DATE OF BURIAL 2-31-1913

20. UNDERTAKER Joseph Potahs ADDRESS Idaho

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Form V. S. No. 5. 10M. 6-20-11.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics
File No. 4521

Registered No. 47

If death occurred in a hospital, institution or camp give its NAME instead of street and number.

1. PLACE OF DEATH.

Registration District No. 1003County of CanyonPrimary Registration District No. 2006City of Glendale

(No. _____, _____ St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

Mary Radcliffe

PERSONAL AND STATISTICAL PARTICULARS

3. SEX

Female

4. COLOR OR RACE

White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED.

(Write the word.)

6. DATE OF BIRTH

Feb. 24. 1825

(Month)

(Day)

(Year)

7. AGE

88

yrs.

mos.

ds.

IF LESS than 1 day

how many _____ hrs. or _____ min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work

(b) General nature of industry business or establishment in which employed (or employer)

Housewife

9. BIRTHPLACE

(State or Country)

Ohio

10. NAME OF FATHER

Daniel Radcliffe

11. BIRTHPLACE OF FATHER

(State or Country)

Virginia

12. MAIDEN NAME OF MOTHER

Rachel McManis

13. BIRTHPLACE OF MOTHER

(State or Country)

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

Elijah L. Newton

(Address)

307. 8th Ave S

15.

Filed

3/25/1913O. B. Beller

Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

(Month)

(Day)

1913
(Year)

17. I HEREBY CERTIFY, That I attended deceased from March 23 1913, to March 23 1913

that I last saw her alive on March 23 1913, and that death occurred on the date stated above, at 12:30 PM

The CAUSE OF DEATH was as follows:

Senility(Duration) 88 yrs. mos. ds.

Contributory (Secondary)

(Duration) _____ yrs. mos. ds.

(Signed)

S. S. Scalapene M. D.
March 24 1913 (Address) Nampa, Ida

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death _____ yrs. mos. ds. State _____ yrs. mos. ds.

Where was disease contracted,

If not at place of death?

Former or

usual residence

19. PLACE OF BURIAL OR REMOVAL DATE OF BURIAL

Kohler Burial Nampa, Id. 3/25/1913

20. UNDERTAKER

ADDRESS

S. B. Shellabarger Nampa, Id.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Form V-20-11.

STATE OF IDAHO
CERTIFICATE OF DEATHState of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

File No. 1522

Registered No. 48

If death occurred in a hospital, institution or camp give its NAME instead of street and number.

1. PLACE OF DEATH.
County of Canyon
City ofampaRegistration District 3,
Primary Registration No. 2006
(No. St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME William Regan

PERSONAL AND STATISTICAL PARTICULARS

3. SEX Male
4. COLOR OR RACE White
5. SINGLE, MARRIED, WIDOWED OR DIVORCED. Single.
(Write the word.)6. DATE OF BIRTH Jan 24, 1829
(Month) (Day) (Year)7. AGE 84 yrs. 1 mos. 28 ds.
IF LESS than 1 day how many hrs. or min.?

8. OCCUPATION

(a) Trade, profession, or particular kind of work Farmer.
(b) General nature of industry business, or establishment in which employed (or employer)9. BIRTHPLACE
(State or Country) Howard Co. Mo.

10. NAME OF FATHER William Regan

11. BIRTHPLACE OF FATHER Tenn.

12. MAIDEN NAME OF MOTHER Rhoda Adell.

13. BIRTHPLACE OF MOTHER Tenn.

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) W. J. Regan
(Address)ampa, Ida.15. Filed 3-22-1913 C. B. Butler M.D.
Local Registrar

MEDICAL CERTIFICATE OF DEATH

OF DEATH
Mar 21 st 1913
(Month) (Day) (Year)17. I HEREBY CERTIFY, That I attended deceased from Mar 10 1913, to Mar 20 1913
that I last saw him alive on Mar 20 1913,
and that death occurred on the date stated above, at 8 A. M.
The CAUSE OF DEATH* was as follows:

Broncho Pneumonia

(Duration) yrs. mos. 17 ds.
Contributory (Secondary) senility(Duration) yrs. mos. ds.
(Signed) H. H. Ross M. D.
Mar 19 1913 (Address)ampa, Ida.

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place In the
of death yrs. mos. ds. State yrs. mos. ds.
Where was Disease contracted,
If not at place of death?
Former or usual residence:19. PLACE OF BURIAL OR REMOVAL DATE OF BURIAL
Hickman Cem 3/23 191320. UNDERTAKER ADDRESS
F. H. Robinsonampa, Ida.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Form V. S. No. 5. 10M. 6-20-11.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH.

Registration District No. 1003County of CanyonPrimary Registration District No. 2006City of Nampa

(No. _____, _____ St.)

File No. 1521Registered No. 50

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Thurman E. Terry

If death occurred in a hospital, institution or camp give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX

Male

4. COLOR OR RACE 5. SINGLE, MARRIED, WIDOWED OR DIVORCED.

Whitesingle
(Write the word.)

6. DATE OF BIRTH

November, 2, 1912
(Month) (Day) (Year)

7. AGE

4 yrs. 11 mos. 11 ds.
IF LESS than 1 day how many hrs. or min.?

8. OCCUPATION

- (a) Trade, profession or particular kind of work
(b) General nature of industry business or establishment in which employed (or employer)

none

9. BIRTHPLACE

(State or Country)

Canyon, Co. Idaho

10. NAME OF FATHER

Louis E. Terry

11. BIRTHPLACE OF FATHER

(State or Country)

Jackson Co. Ohio

12. MAIDEN NAME OF MOTHER

Lora Skinner

13. BIRTHPLACE OF MOTHER

(State or Country)

Marion, Indiana

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) E. G. Hansenman(Address) Nampa, Idaho

15.

Filed 3-13-1913

O. B. Bell
Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

march 13, 1913
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from

march 11, 1913, to march 13, 1913

that I last saw him alive on march 13, 1913, and that death occurred on the date stated above, at 7 A.M.

The CAUSE OF DEATH* was as follows:

Bronchopneumonia(Duration) _____ yrs. _____ mos. 5 ds.

Contributory (Secondary)

(Duration) _____ yrs. _____ mos. _____ ds.

(Signed) E. G. Hansenman M.D.
3/13, 1913 (Address) Nampa, Ida.

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death _____ yrs. _____ mos. _____ ds. State _____ yrs. _____ mos. _____ ds.

Where was disease contracted,

If not at place of death?

Former or

usual residence.

19. PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

Nampa Idaho 3-14-1913

20. UNDERTAKER

ADDRESS

J. K. Robinson Nampa Ida

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. FATHER'S NAME should be stated EXACTLY. Exact statement of CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Form V. S. No. 5. 10M. 6-20-1

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH. Registration District No. 1003
County of Canyon Primary Registrar District No. 2006
City of Nampa (State) _____

File No. 4525
Registered No. 51

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

John H. Hutsen

If death occurred in a hospital, institution or camp give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX Male 4. COLOR OR RACE White 5. SINGLE, MARRIED, WIDOWED OR DIVORCED Widowed
(Write the word.)

6. DATE OF BIRTH July 11 1887
(Month) (Day) (Year)

7. AGE 86 yrs. 7 mos. 24 ds. IF LESS than 1 day how many hrs. or min.

8. OCCUPATION Farmer
(a) Trade, profession, or particular kind of work
(b) General nature of industry, business, or establishment in which employed (or employer)

9. BIRTHPLACE Virginia
(State or Country)

10. NAME OF FATHER Abraham Hutsen

11. BIRTHPLACE OF FATHER Don't know
(State or Country)

12. MAIDEN NAME OF MOTHER Don't know

13. BIRTHPLACE OF MOTHER Germany
(State or Country)

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) E. G. Matthews
(Address) Nampa Ida

15. Mar 6 - 1913 O. B. Bell
Filed Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH March 6th 1913
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from Apr. 20th 1913, to Mar. 6th 1913, that I last saw him alive on Mar. 6th 1913, and that death occurred on the date stated above, at 6 P. M.

The CAUSE OF DEATH* was as follows:

acute dilatation of heart

(Duration) — yrs. — mos. 1 ds.
Contributory (Secondary) Reynold's disease

(Duration) — yrs. 6 mos. 5 ds.
(Signed) Geo. R. Kelly M. D.
3/6/1913 (Address) Nampa, Ida.

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place _____ In the _____
of death _____ yrs. _____ mos. _____ ds. State _____ yrs. _____ mos. _____ ds.
Where was Disease contracted,
If not at place of death? _____
Former or
usual residence. _____

19. PLACE OF BURIAL OR REMOVAL Star Cemetery DATE OF BURIAL 3/8 1913

20. UNDERTAKER F. T. Robinson ADDRESS Nampa Ida

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIAN should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Form V. S. No. 5. 10M. 6-20-11.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH.

Registration District No. 21County of BlainePrimary Registration District No. 2024City of Arco

(No. _____, _____ St.)

File No. 4526Registered No. 12

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

George Albert Armstrong

If death occurred in a hospital, institution or camp give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX

M.

4. COLOR OR RACE 5. SINGLE, MARRIED, WIDOWED OR DIVORCED.

WSingle
(Write the word.)

6. DATE OF BIRTH

Mar211913

(Month)

(Day)

(Year)

7. AGE

_____ yrs. _____ mos. _____ ds.

IF LESS than 1 day
how many... 5 hrs. or
_____ min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work
(b) General nature of industry business or establishment in which employed (or employer)

None9. BIRTHPLACE
(State or Country)Arco, Ida.

10. NAME OF FATHER

Frank Armstrong11. BIRTHPLACE OF FATHER
(State or Country)Utah

12. MAIDEN NAME OF MOTHER

Dorothy Grace Beale13. BIRTHPLACE OF MOTHER
(State or Country)Ida.

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

Frank Armstrong

(Address)

Arco, Ida.

15.

Filed

Mar 30 1913

Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

Mar27

(Month)

(Day)

1913
(Year)

17. I HEREBY CERTIFY, That I attended deceased from

1913, to1913that I last saw h. _____ alive on _____ 1913,

and that death occurred on the date stated above, at _____ M.

The CAUSE OF DEATH* was as follows:

Did not see body. Cause - probably
premature birth. The Registrar

(Duration) _____ yrs. _____ mos. _____ ds.

Contributory
(Secondary)

(Duration) _____ yrs. _____ mos. _____ ds.

(Signed) D. W. Mathias M. D.Mar 22 1913 (Address) Arco

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death... yrs... mos... ds. In the State... yrs... mos... ds.

Where was disease contracted,
If not at place of death?
Former or usual residence.

19. PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

Arco, Ida.Mar 23 1913

20. UNDERTAKER

ADDRESS

Mrs E BoyleArco

Form V. S. No. 5. 10M. 6-20-11.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH.

Registration District No. 21County of BlainePrimary Registration District No. 2024City of Home

(No. _____, _____ St.)

File No. 4527Registered No. 13

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

Harry T. Helt

If death occurred in a hospital, institution or camp give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX

M.

4. COLOR OR RACE

W

5. SINGLE, MARRIED, WIDOWED OR DIVORCED.

Single
(Write the word.)

6. DATE OF BIRTH

Jan
(Month)21
(Day)1889
(Year)

7. AGE

24 yrs. 1 mos. 27 ds.IF LESS than 1 day
how many hrs. or
..... min.?

8. OCCUPATION

- (a) Trade, profession or particular kind of work
-
- (b) General nature of industry business or establishment in which employed (or employer)

Farmer

9. BIRTHPLACE

(State or Country)

North Dakota

10. NAME OF FATHER

Julius T. Helt.

11. BIRTHPLACE OF FATHER

(State or Country)

Germany

12. MAIDEN NAME OF MOTHER

Emma Zink

13. BIRTHPLACE OF MOTHER

(State or Country)

Germany

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Hilda E. Helt.(Address) Bonduras, N. Dak.

15.

Filed Mar 14 1913D. W. Matthews
Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

Mar
(Month)18
(Day)1913
(Year)17. I HEREBY CERTIFY, That I attended deceased ~~from~~
on Mar 18 1913, to 1913that I last saw him alive on Jan 21 1913,
and that death occurred on the date stated above, at 9:30 P. M.

The CAUSE OF DEATH* was as follows:

Shock from loss of blood and
injuries received from dynamite
explosion accidentally.

(Duration) yrs. mos. ds.

Contributory (Secondary) Acute Appendicitis.

(Duration) yrs. mos. ds.

(Signed) D. W. Matthews M. D.
Mar 19 19 13 (Address) Arco, Ida.

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death yrs. mos. ds. State yrs. mos. ds.

Where was disease contracted.

If not at place of death?

Former or usual residence.

19. PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

McMullen1913

20. UNDERTAKER

ADDRESS

E. J. LuckBlackfoot

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Form V. S. No. 5. 10M. 6-20-11.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH.

Registration District No. 21County of BlainePrimary Registration District No. 2023City of Canal

(No. _____, _____ St.)

File No. 152Registered No. 14

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

Marguerite J. Clark

If death occurred in a hospital, institution or camp give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX

4. COLOR OR RACE 5. SINGLE, MARRIED, WIDOWED OR DIVORCED.

Female whiteSingle
(Write the word.)

6. DATE OF BIRTH

3 1 1913
(Month) (Day) (Year)

7. AGE

yrs. mos. 18 ds.IF LESS than 1 day
how many hrs. or min.?

8. OCCUPATION

- (a) Trade, profession, or particular kind of work
(b) General nature of industry business, or establishment in which employed (or employer)

9. BIRTHPLACE

(State or Country)

Idaho

10. NAME OF FATHER

D. S. Clark

11. BIRTHPLACE OF FATHER

(State or Country)

Texas

12. MAIDEN NAME OF MOTHER

Marguerite Edsall

13. BIRTHPLACE OF MOTHER

(State or Country)

Kansas

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

Frank Edsall

(Address)

Hill city Idaho

15.

Filed

Mar 30 1913

Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

3 19 1913
(Month) (Day) (Year)17. I HEREBY CERTIFY, That I attended deceased from 3-18 1913, to 3-19 1913that I last saw him alive on 3-18 1913,and that death occurred on the date stated above, at 8 A. M.

The CAUSE OF DEATH* was as follows:

Branch pneumonia(Duration) yrs. mos. 6 ds.Contributory
(Secondary)(Duration) yrs. mos. ds.(Signed) W. H. Stiggs M. D.3-19 1913 (Address) Golden

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place _____ In the _____
of death yrs. mos. ds. State yrs. mos. ds.

Where was Disease contracted,

If not at place of death?

Former or
usual residence.

19. PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

Canal Ida3-20 1913

20. UNDERTAKER

ADDRESS

Chas BabingtonCanal Ida

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Form V. S. No. 5. 10M. 6-20-11.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH.
County of Blaine
City of Soldier

Registration District No. 21
Primary Registration District No. 2023
(No. _____, St.)

File No. 4524
Registered No. 15

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Briley Barker

If death occurred in a hospital, institution or camp give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX M 4. COLOR OR RACE White 5. SINGLE, MARRIED, WIDOWED OR DIVORCED. Undwed
(Write the word.)

6. DATE OF BIRTH Aug 10 1841
(Month) (Day) (Year)

7. AGE 71 yrs. 7 mos. 18 ds. IF LESS than 1 day how many hrs. or min.?

8. OCCUPATION

- (a) Trade, profession, or particular kind of work
(b) General nature of industry, business, or establishment in which employed (or employer)

9. BIRTHPLACE
(State or Country) Mo

10. NAME OF FATHER Jerry James

11. BIRTHPLACE OF FATHER
(State or Country) Mo

12. MAIDEN NAME OF MOTHER Eliya ?

13. BIRTHPLACE OF MOTHER
(State or Country) Mo

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) James P Mosier
(Address) Hill City

15. Filed Mar 30 1913
R. H. H. H. H. H.
Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH 3 18 1913
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from 3-24-1913, to 3-28-1913

that I last saw him alive on 3-26-1913

and that death occurred on the date stated above, at 2 P. M.

The CAUSE OF DEATH* was as follows:

Senile Pneumonia

(Duration) _____ yrs. _____ mos. 4 ds.

Contributory
(Secondary)

(Duration) _____ yrs. _____ mos. _____ ds.

(Signed) Dr. H. H. H. H. H. M. D.
3-28-1913 (Address) Soldier Ida

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL OR HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place _____ In the _____
of death _____ yrs. _____ mos. _____ ds. State _____ yrs. _____ mos. _____ ds.

Where was Disease contracted,
If not at place of death?
Former or
usual residence _____

19. PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

Soldier 3-30-1913

20. UNDERTAKER

ADDRESS

Big Morrell Soldier Ida

Form V. S. No. 5. 10M. 6-20-11.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH.

Registration District No. 21County of BlainePrimary Registration District No. 7072City of Ketchum

(No. _____, _____ St.)

File No. 15311Registered No. 16

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

Daniel Hawthornth

If death occurred in a hospital, institution or camp give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX

Male

4. COLOR OR RACE 5. SINGLE, MARRIED, WIDOWED OR DIVORCED.

WhiteSingle
(Write the word.)

6. DATE OF BIRTH

1
(Month) (Day) (Year)

7. AGE

73 yrs. 0 mos. 0 ds.IF LESS than 1 day
how many 0 hrs. or
0 min.?

8. OCCUPATION

- (a) Trade, profession or particular kind of work
-
- (b) General nature of industry business or establishment in which employed (or employer)

Miner -

9. BIRTHPLACE

(State or Country)

Portland

10. NAME OF FATHER

11. BIRTHPLACE OF FATHER

(State or Country)

12. MAIDEN NAME OF MOTHER

13. BIRTHPLACE OF MOTHER

(State or Country)

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Wm Reynolds(Address) Ketchum

15.

Filed Mar 25 1913Robert H. Smith
Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

Nov171913

(Month)

(Day)

(Year)

17. I HEREBY CERTIFY, That I attended deceased from

Nov 211912

to

March 161913that I last saw him alive on March 17 1913and that death occurred on the date stated above, at 2:45 P.M.

The CAUSE OF DEATH* was as follows:

Bright's disease(Duration) 1 yrs. 0 mos. 0 ds.Contributory
(Secondary)(Duration) 0 yrs. 0 mos. 0 ds.

(Signed)

March 17 1913

(Address)

Hailey Idaho

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place

In the

of death 0 yrs. 0 mos. 0 ds. State 0 yrs. 0 mos. 0 ds.

Where was disease contracted,

If not at place of death?

Former or

usual residence.

19. PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

Ketchum3-191913

20. UNDERTAKER

ADDRESS

R. D. HarrisHailey Ida

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Form V. S. No. 5. 10M. 6-20-11.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics
File No. 4531
Registered No. 17

1. PLACE OF DEATH.

Registration District No. 21County of BlainePrimary Registration District No. 2024City of Moore Ida.

(No. _____, _____ St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

Harrison Meacham

If death occurred in a hospital, institution or camp give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX

M.

4. COLOR OR RACE

W

5. SINGLE, MARRIED, WIDOWED OR DIVORCED.

Single
(Write the word.)

6. DATE OF BIRTH

Jan 10 1913
(Month) (Day) (Year)

7. AGE

2 yrs. 4 mos. 4 ds.
IF LESS than 1 day how many hrs. or min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work

None

(b) General nature of industry business or establishment in which employed (or employer)

9. BIRTHPLACE

(State or Country)

Ida.

10. NAME OF FATHER

Chas. H. Meacham

11. BIRTHPLACE OF FATHER

(State or Country)

Utah

12. MAIDEN NAME OF MOTHER

Annie Babbitt

13. BIRTHPLACE OF MOTHER

(State or Country)

Ida.

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

Chas. H. Meacham

(Address)

Moore Ida.

15.

Filed

Mar 20 1913

John H. H. H.
Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

Mar 14 1913
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from

191 to 191

that I last saw h. alive on 191and that death occurred on the date stated above, at M.

The CAUSE OF DEATH* was as follows:

I was not called nor notified until after baby died. From symptoms given by parent, I found death was evidently due to Pneumonia
(Duration) yrs. mos. 2 ds.

Contributory (Secondary)

(Duration) yrs. mos. ds.

(Signed) D. W. Mathau M. D.

Mar 14 1913 (Address) Arco, Ida.

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death. yrs. mos. ds. In the State. yrs. mos. ds.

Where was disease contracted,

If not at place of death?

Former or

usual residence.

19. PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

Lost RiverMar 15 1913

20. UNDERTAKER

ADDRESS

J. H. H. H. H.Moore, Ida.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH.

Registration District No. 12County of BoonvillePrimary Registration District No. 10 & 3City of Coeur d'Alene

(No. _____ St.)

File No. 4532Registered No. 244

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

Henry Glasspock

If death occurred in a hospital, institution or camp give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX

Male

4. COLOR OR RACE

White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED.

Married
(Write the word.)

6. DATE OF BIRTH

Feb.
(Month)10
(Day)1839
(Year)

7. AGE

73 yrs.11 mos.24 ds.IF LESS than 1 day
how many hrs. or
..... min?

8. OCCUPATION

- (a) Trade, profession or particular kind of work.
-
- (b) General nature of industry business or establishment in which employed (or employer)

Farmer

9. BIRTHPLACE

(State or Country)

Ill.

10. NAME OF FATHER

J. Glasspock

11. BIRTHPLACE OF FATHER

(State or Country)

England

12. MAIDEN NAME OF MOTHER

Katherine Cook

13. BIRTHPLACE OF MOTHER

(State or Country)

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

William H. Glasspock
(Address) Coeur d'Alene, Idaho

15.

Filed

3/101913J. S. Newman
Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH

February
(Month)6
(Day)1913
(Year)

17. I HEREBY CERTIFY, That I attended deceased from

Jan 4 1913, to Jan 31 1913that I last saw him alive on Jan 31 1913and that death occurred on the date stated above, at 2:15 P. M.

The CAUSE OF DEATH* was as follows:

Haemorrhage of foot and stump of leg.(Duration) 3 yrs. 3 mos. 3 ds.Contributory Arterio sclerosis
(Secondary)(Duration) 2 yrs. 3 mos. 3 ds.(Signed) W. H. Stovall M. D.Feb 7 1913 (Address) Coeur d'Alene

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place _____ In the _____
of death _____ yrs. _____ mos. _____ ds. State _____ yrs. _____ mos. _____ ds.Where was disease contracted,
If not at place of death? _____Former or
usual residence _____

19. PLACE OF BURIAL OR REMOVAL DATE OF BURIAL

Forest Cemetery Feb 9 1913

20. UNDERTAKER ADDRESS

Cassidy & Nelson Coeur d'AleneMARGIN RESERVE
WRITE PLAINLY, WITH UNFADING INK.
N. B.—Every item of information should be carefully stated. REGISTRARS should state CAUSE OF DEATH in plain terms. The statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Form V. S. No. 5. 12½ M. 7-24-11

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics
File No. 153245
Registered No. 245

1. PLACE OF DEATH. Registration District No. 12
County of Boateau Primary Registration District No. 2051
City of Pastidun (No. , St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

John R. Wilson

If death occurred in a hospital, institution or camp give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX M 4. COLOR OR RACE W 5. SINGLE, MARRIED, WIDOWED OR DIVORCED. Married
(Write the word.)
6. DATE OF BIRTH Oct. 21 1913
(Month) (Day) (Year)

7. AGE 74 yrs. 13 mos. 13 ds. IF LESS than 1 day how many hrs. or min?

8. OCCUPATION

(a) Trade, profession or particular kind of work. Carpenter
(b) General nature of industry business or establishment in which employed (or employer)

9. BIRTHPLACE

(State or Country) Ind

10. NAME OF FATHER

Richard Wilson

11. BIRTHPLACE OF FATHER

(State or Country) Ind

12. MAIDEN NAME OF MOTHER

Bowers

13. BIRTHPLACE OF MOTHER

(State or Country) Ind

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Mr. G. E. Wilson
(Address) Pastidun

15.

Filed 3/10

Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH

Feb. 8 1913
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from Jan. 1913, to Feb. 8 1913

that I last saw him alive on Jan. 1913

and that death occurred on the date stated above, at 10 P.M.

The CAUSE OF DEATH* was as follows:

Stroke from cerebral vascular
degeneration

(Duration) 2 yrs. 0 mos. 0 ds.

Contributory
(Secondary)

(Duration) 0 yrs. 0 mos. 0 ds.

(Signed) A. J. Freeman M. D.
2/10 1913 (Address) Pastidun

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place In the
of death yrs. mos. ds. State yrs. mos. ds.
Where was disease contracted,
If not at place of death?
Former or
usual residence.

19. PLACE OF BURIAL OR REMOVAL DATE OF BURIAL

Pastidun 2/10 1913
20. UNDERTAKER Bob & Son ADDRESS Pastidun

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Form V. S. No. 5 20M.1-16-12

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH.

Registration District No. 17

County of Kootenai

Primary Registration District No. 2049

City of Boise

(No. _____, _____ St.)

File No. 1534

Registered No. 243

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

Jno. W. Bonn

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX

Male

4. COLOR OR RACE

White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED.

Single
(Write the word.)

6. DATE OF BIRTH

_____ 1 _____
(Month) (Day) (Year)

7. AGE

_____ yrs. _____ mos. _____ ds.

IF LESS than 1 day
how many _____ hrs. or
_____ mins.?

8. OCCUPATION

(a) Trade, profession or particular kind of work
(b) General nature of industry, business, or establishment in which employed (or employer)

9. BIRTHPLACE

(State or Country)

10. NAME OF FATHER

11. BIRTHPLACE OF FATHER

(State or Country)

12. MAIDEN NAME OF MOTHER

13. BIRTHPLACE OF MOTHER

(State or Country)

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) N. J. Bonn

(Address) 2/20 71913

15.

Filed 3/10 1913 W. H. Bonn
Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH

Feb 19 1913
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from

_____ 191____, to _____ 191____,
that I last saw h_____ alive on _____ 191____,

and that death occurred on the date stated above, at _____ M.

The CAUSE OF DEATH* was as follows:

Skull fracture
Internal injuries

_____ (Duration) _____ yrs. _____ mos. _____ ds.

Contributory
(Secondary)

_____ (Duration) _____ yrs. _____ mos. _____ ds.

(Signed) Chas. R. Schulte
_____ 19____ (Address) St. Marie, Ida.

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death _____ yrs. _____ mos. _____ days. In the State _____ yrs. _____ mos. _____ days.

Where was disease contracted if not at place of death?

Former or usual residence _____

19. PLACE OF BURIAL OR REMOVAL DATE OF BURIAL

St. John _____ 191____

20. UNDERTAKER ADDRESS

H. L. Mulcahy St. Marie

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Form V. S. No. 5. 12½ M. 7-24-11

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH. Registration District No. 2118
County of Butte Primary Registration District No. 2118
City of Desmet (No. _____, _____ St.)

File No. 1535
Registered No. 287

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Mary Louisa

If death occurred in a hospital, institution or camp give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX Female 4. COLOR OR RACE Indian 5. SINGLE, MARRIED, WIDOWED OR DIVORCED. Widowed
(Write the word.)

6. DATE OF BIRTH

about 1823
(Month) (Day) (Year)

7. AGE

90 yrs. 0 mos. 0 ds.

IF LESS than 1 day
how many hrs. or
..... min?

8. OCCUPATION

(a) Trade, profession or particular kind of work.

Housekeeper

(b) General nature of industry business or establishment in which employed (or employer)

9. BIRTHPLACE

(State or Country)

Old Mission

10. NAME OF FATHER

Anderson

11. BIRTHPLACE OF FATHER

(State or Country)

"

12. MAIDEN NAME OF MOTHER

"

13. BIRTHPLACE OF MOTHER

(State or Country)

"

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

(Address)

15. 3/10/13
Filed 3/10/13 1913

A. J. Schreiner
Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

Feb. 27 1913
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from

Feb. 23 1913, to Feb. 27 1913

that I last saw him alive on Feb. 26 1913

and that death occurred on the date stated above, at 7 P. M.

The CAUSE OF DEATH* was as follows:

Senility

(Duration) yrs. mos. 7 ds.

Contributory (Secondary)

Senility

(Duration) yrs. mos. ds.

(Signed) J. R. Kollard M. D.

March 3 1913 (Address) Desmet, Idaho

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place In the
of death yrs. mos. ds. State yrs. mos. ds.

Where was disease contracted,

If not at place of death?

Former or

usual residence

19. PLACE OF BURIAL OR REMOVAL DATE OF BURIAL

Desmet

Feb. 28 1913

20. UNDERTAKER

ADDRESS

none

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
 Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Form V. S. No. 5. 12½M.7-24-11

CERTIFICATE OF DEATH

State of Idaho
 BOARD OF HEALTH
 Bureau of Vital Statistics
 File No. 1536
 Registered No. 251

1. PLACE OF DEATH. Registration District No. 12
 County of Kootenai Primary Registration District No. 2051
 City of (No. St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Fred Schneider

If death occurred in a hospital, institution or camp give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX Male 4. COLOR OR RACE white 5. SINGLE, MARRIED, WIDOWED OR DIVORCED. married (Write the word.)

6. DATE OF BIRTH About 6 1/2 yrs ago 1 (Month) (Day) (Year)

7. AGE about 6 1/2 yrs. mos. ds. IF LESS than 1 day how many hrs. or min?

8. OCCUPATION (a) Trade, profession or particular kind of work. Saloon keeper (b) General nature of industry business or establishment in which employed (or employer)

9. BIRTHPLACE (State or Country)

10. NAME OF FATHER

11. BIRTHPLACE OF FATHER (State or Country)

12. MAIDEN NAME OF MOTHER

13. BIRTHPLACE OF MOTHER (State or Country)

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) W. Schneider (Address) Harrison Idaho

15. Filed 3/10 1913 J. J. Green Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH Feb 25 1913 (Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from Feb 24 1913, to Feb 25 1913. that I last saw him alive on Feb 25 1913, and that death occurred on the date stated above, at 3:30 P.M.

The CAUSE OF DEATH* was as follows: Chronic Alcoholism

about 3 yrs. mos. ds. (Duration)

Contributory (Secondary)

(Signed) E. J. Priddy M. D. Mar 3 1913 (Address) Spirit Lake

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place Spirit Lake In the Priddy Hospital of death yrs. mos. ds. State one day

Where was disease contracted, If not at place of death? Former or usual residence Harrison Id.

19. PLACE OF BURIAL OR REMOVAL DATE OF BURIAL Spirit Lake Id Feb 26 1913

20. UNDERTAKER ADDRESS J. J. Green Harrison

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Form V. S. No. 5. 12½ M. 7-24-11

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics
File No. 1537
Registered No. 250

1. PLACE OF DEATH. Registration District No. 12
County of Kootenai Primary Registration District No. 2057
City of _____ (No. _____, St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Infant Buchanan

If death occurred in a hospital, institution or camp give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX Male 4. COLOR OR RACE wh 5. SINGLE, MARRIED, WIDOWED OR DIVORCED. single
(Write the word.)

6. DATE OF BIRTH July 16 1913
(Month) (Day) (Year)

7. AGE _____ yrs. _____ mos. 5 ds. IF LESS than 1 day
how many _____ hrs. or _____ min?

8. OCCUPATION
(a) Trade, profession or particular kind of work. Infant
(b) General nature of industry business or establishment in which employed (or employer)

9. BIRTHPLACE
(State or Country) Spirit Lake

10. NAME OF FATHER Lincoln J. Buchanan

11. BIRTHPLACE OF FATHER
(State or Country) N.C.

12. MAIDEN NAME OF MOTHER Sallie Grant

13. BIRTHPLACE OF MOTHER
(State or Country) N.C.

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Earl J. Prindle
(Address) _____

15. Filed 3/10 1919 A. D. Buchanan
Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH Feb 21 1913
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from Feb 16 1913, to Feb 21 1913, that I last saw him alive on Feb 21 1913, and that death occurred on the date stated above, at 5:30 AM.

The CAUSE OF DEATH* was as follows:
Tubercular pneumonia

_____ (Duration) _____ yrs. _____ mos. 3 ds.

Contributory (Secondary)

_____ (Duration) _____ yrs. _____ mos. 5 ds.
(Signed) Earl J. Prindle M. D.
2-21 1913 (Address) Spirit Lake

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place In the
of death _____ yrs. _____ mos. _____ ds. State _____ yrs. _____ mos. _____ ds.
Where was disease contracted,
If not at place of death? _____
Former or
usual residence _____

19. PLACE OF BURIAL OR REMOVAL DATE OF BURIAL

Spirit Lake _____ 1919

20. UNDERTAKER ADDRESS

G. R. Klopfer Batavia

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Form V. S. No. 5 20M.1-16-12

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH. Registration District No. 12
County of Idaho Primary Registration District No. 1553
City of Condon (No. _____, St.)

File No. 4538
Registered No. 249

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Walter Davis

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX Male 4. COLOR OR RACE White 5. SINGLE, MARRIED, WIDOWED OR DIVORCED Married
(Write the word.)

6. DATE OF BIRTH 1861
(Month) (Day) (Year)

7. AGE 52 yrs. mos. ds. IF LESS than 1 day how many hrs. or mins.?

8. OCCUPATION
(a) Trade, profession or particular kind of work Miner
(b) General nature of industry business, or establishment in which employed (or employer)

9. BIRTHPLACE (State or Country) Texas

10. NAME OF FATHER Wm Davis

11. BIRTHPLACE OF FATHER (State or Country) Kentucky

12. MAIDEN NAME OF MOTHER

13. BIRTHPLACE OF MOTHER (State or Country)

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) E. Davis
(Address) 517 Waller St

15. Filed 3/10 1913 J. H. Shepherd
Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH Feb. 18 1913
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from Feb. 12, 1913, to Feb. 18, 1913, that I last saw him alive on Feb. 18, 1913, and that death occurred on the date stated above, at 12:00 PM.

The CAUSE OF DEATH* was as follows:

Severe Pneumonia

(Duration) yrs. mos. 6 ds.

Contributory (Secondary)

(Duration) yrs. mos. ds.

(Signed) M. D.

Feb. 1913 (Address) John J. Wood, P.O. 19.

*State the DISEASE CAUSING DEATH or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death yrs. mos. days. In the State yrs. mos. days.

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL DATE OF BURIAL

Funeral Home Feb 20 1913

20. UNDERTAKER ADDRESS

Edgar c w a

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Form V. S. No. 5 20M.1-16-12

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH.

Registration District No. 12

County of Vallejo

Primary Registration District No. 1003

City of Idaho

(No. _____, St.)

File No. 4539

Registered No. 248

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Mrs. Ellen M. Seepes

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX Female 4. COLOR OR RACE White 5. SINGLE, MARRIED, WIDOWED OR DIVORCED. Married
(Write the word.)

6. DATE OF BIRTH 1869
(Month) (Day) (Year)

7. AGE 44 yrs. 0 mos. 0 ds.
IF LESS than 1 day
how many 0 hrs. or 0 mins.

8. OCCUPATION
(a) Trade, profession or particular kind of work Wife
(b) General nature of industry, business, or establishment in which employed (or employer)

9. BIRTHPLACE Idaho
(State or Country)

10. NAME OF FATHER

11. BIRTHPLACE OF FATHER
(State or Country)

12. MAIDEN NAME OF MOTHER

13. BIRTHPLACE OF MOTHER
(State or Country)

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Mr. Seepes
(Address) 905 Garden St

15. Filed 3/10 1913 S. J. Seepes
Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH Feb 18th 1913
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from Feb 13th 1913, to Feb 18th 1913, that I last saw her alive on Feb 18th 1913, and that death occurred on the date stated above, at 12 PM.

The CAUSE OF DEATH* was as follows:

Cerebral Embolism

(Duration) 2 yrs. 0 mos. 0 ds.
Contributory Valvular disease
(Secondary) of the heart

(Duration) 0 yrs. 0 mos. 0 ds.
(Signed) John Burby M. D.

19 (Address) Ceres, Idaho City

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death 0 yrs. 0 mos. 0 days. In the State 0 yrs. 0 mos. 0 days.

Where was disease contracted if not at place of death? at home

Former or usual residence Ceres, Idaho City, Ida

19. PLACE OF BURIAL OR REMOVAL DATE OF BURIAL

Shipped to Lewiston Idaho 1913

20. UNDERTAKER ADDRESS

S. J. Seepes c w a

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Form V. S. No. 5 20M.1-16-12

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH.

Registration District No.

County of *Spokane*

Primary Registration District No. *2049*

City of *Vermeil*

(No. _____, _____ St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

Orntshaw

File No. *1540*

Registered No. *249*

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX *Female*

4. COLOR OR RACE *W*

5. SINGLE, MARRIED, WIDOWED OR DIVORCED. *Single* (Write the word.)

6. DATE OF BIRTH

July *8* *1913*
(Month) (Day) (Year)

7. AGE

_____ yrs. _____ mos. _____ ds.

IF LESS than 1 day
how many _____ hrs. or
5 mins?

8. OCCUPATION

(a) Trade, profession or particular kind of work

(b) General nature of industry business, or establishment in which employed (or employer)

9. BIRTHPLACE

(State or Country)

10. NAME OF FATHER

11. BIRTHPLACE OF FATHER

(State or Country)

12. MAIDEN NAME OF MOTHER

13. BIRTHPLACE OF MOTHER

(State or Country)

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) *Orntshaw*

(Address) *Vermeil*

15.

Filed *3/10* *1913*

1913

Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH

July *8* *1913*
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from

1913 to *1913*

that I last saw h. _____ alive on _____ *1913*

and that death occurred on the date stated above, at *10:00* M.

The CAUSE OF DEATH* was as follows:

Hydrocephalus kind 5 min.

(Duration) _____ yrs. _____ mos. _____ ds.

Contributory
(Secondary)

(Duration) _____ yrs. _____ mos. _____ ds.

(Signed) *McHenry* M. D.

8 1913 (Address) *Spokane Ida*

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death _____ yrs. _____ mos. _____ days. In the State _____ yrs. _____ mos. _____ days.

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

Vermeil

2/9 *1913*

20. UNDERTAKER

ADDRESS

None

F

MARGIN RESERVED FOR BINDING
WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics
File No. 4541
Registered No. 36

1. PLACE OF DEATH. Registration District No. 12
County of Boone Primary Registration District No. 1003
City of Coeur d'Alene (No. _____, St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Benjamin Shackelton

If death occurred in a hospital, institution or camp give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX Male 4. COLOR OR RACE White 5. SINGLE, MARRIED, WIDOWED OR DIVORCED. Married
(Write the word.)

6. DATE OF BIRTH October 15th 1926
(Month) (Day) (Year)

7. AGE 86 yrs. 3 mos. 15 ds. IF LESS than 1 day how many hrs. or min?

8. OCCUPATION

(a) Trade, profession or particular kind of work. Farmer
(b) General nature of industry business or establishment in which employed (or employer)

9. BIRTHPLACE New York
(State or Country)

10. NAME OF FATHER Robert Shackelton

11. BIRTHPLACE OF FATHER State of New Jersey
(State or Country)

12. MAIDEN NAME OF MOTHER not available

13. BIRTHPLACE OF MOTHER " "
(State or Country)

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) W. Greisser
(Address) 1307 East 32nd St. Spokane Wt.

15. Filed 3/10 1910 W. Schuman
Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH Feb. 14 1913
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from Feb 10th 1913, to Feb 14th 1913
that I last saw him alive on Feb 14th 1913
and that death occurred on the date stated above, at 11 P. M.
The CAUSE OF DEATH* was as follows:

Broncho - Pneumonia

(Duration) yrs. mos. about 6 ds.
Contributory (Secondary) Old age

(Duration) yrs. mos. ds.
(Signed) A. Hunter M. D.
19..... (Address)

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place In the
of death yrs. mos. ds. State yrs. mos. ds.
Where was disease contracted,
If not at place of death?
Former or
usual residence.

19. PLACE OF BURIAL OR REMOVAL Forest Cem. DATE OF BURIAL Feb. 17 1913
20. UNDERTAKER Cassidy & Nelson ADDRESS Coeur d'Alene

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Form V. S. No. 5. 12½M.7-24-11

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH. Registration District No. 27
County of Lemhi Primary Registration District No. 2116
City of Salmon (No. _____ St.)

File No. 4544Registered No. 9

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

Henry E Frost

If death occurred in a hospital, institution or camp give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX Male 4. COLOR OR RACE White 5. SINGLE, MARRIED, WIDOWED OR DIVORCED. Married
(Write the word.)

6. DATE OF BIRTH January 27th 1859
(Month) (Day) (Year)

7. AGE 54 yrs. mos. ds. IF LESS than 1 day how many hrs. or min?

8. OCCUPATION

(a) Trade, profession or particular kind of work.

Editor

(b) General nature of industry business or establishment in which employed (or employer)

9. BIRTHPLACE

(State or Country)

Illinois

10. NAME OF FATHER

Henry Frost

11. BIRTHPLACE OF FATHER

(State or Country)

Ohio

12. MAIDEN NAME OF MOTHER

Felby M. Ware

13. BIRTHPLACE OF MOTHER

(State or Country)

Do not know

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

(Address)

Mrs Frost
Salmon, Ida.

15.

Filed

3/22 1913

Local Registrar

O. B. Stratton

Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH

march 21st 1913
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from Feb. 15th 1913, to march 21 1913.

that I last saw him alive on march 21 1913

and that death occurred on the date stated above, at 7 P. M.

The CAUSE OF DEATH* was as follows:

Apoplexy

..... (Duration) yrs. mos. ds.

Contributory
(Secondary)

..... (Duration) yrs. mos. ds.

(Signed) W. L. Whitely M. D.

march 22 1913 (Address) Salmon, Idaho

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions Transients or Recent Residents.)

At place

In the

of death yrs. mos. ds. State yrs. mos. ds.

Where was disease contracted,

If not at place of death?

Former or

usual residence.

19. PLACE OF BURIAL OR REMOVAL DATE OF BURIAL

Salmon, Idahomarch 23 1913

20. UNDERTAKER

ADDRESS

W. C. DoeblSalmon
Ida.

MARGIN RESERVED FOR BINDING
WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Form V. S. No. 5. 12½ M. 7-24-11

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics
File No. 4545
Registered No. 8

1. PLACE OF DEATH. Registration District No. 27
County of Blaine Primary Registration District No. 2116
City of Carnegie (No. _____, St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Wm. Smith

If death occurred in a hospital, institution or camp give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX m. 4. COLOR OR RACE white 5. SINGLE, MARRIED, WIDOWED OR DIVORCED. single
(Write the word.)

6. DATE OF BIRTH do not know
(Month) (Day) (Year)

7. AGE About 20 yrs. mos. ds. IF LESS than 1 day how many... hrs. or min?

8. OCCUPATION
(a) Trade, profession or particular kind of work. none
(b) General nature of industry business or establishment in which employed (or employer)

9. BIRTHPLACE Ireland
(State or Country)

10. NAME OF FATHER do not know

11. BIRTHPLACE OF FATHER do not know
(State or Country)

12. MAIDEN NAME OF MOTHER do not know

13. BIRTHPLACE OF MOTHER do not know
(State or Country)

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Chas. F. Hammer
(Address) Idaho

15. Mar. 7 1913 A. B. Stratton
Filed Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH March 1 1913
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from May 1908, to March 1913.
that I last saw him alive on 26 Feb 1913 and that death occurred on the date stated above, at 9 A. M.

The CAUSE OF DEATH* was as follows:
Senile Debility

(Duration) 10 yrs. mos. ds.

Contributory (Secondary)

(Signed) Chas. F. Hammer M. D.
Mar. 1 1913 (Address) Idaho

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place In the
of death... yrs... mos... ds. State... yrs... mos... ds.
Where was disease contracted,
If not at place of death?.....
Former or
usual residence.....

19. PLACE OF BURIAL OR REMOVAL DATE OF BURIAL
Solomon Idaho March 2 1913

20. UNDERTAKER ADDRESS
W. P. Doeble Solomon
Ida.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Form V. S. No. 5. 12½ M. 7-24-11

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics
File No. 4546
Registered No. 198

1. PLACE OF DEATH. Registration District No. 8
County of Bonner Primary Registration District No. 2036
City of Preston Idaho (No. _____, St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

James Drinkwater

If death occurred in a hospital, institution or camp give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX Male 4. COLOR OR RACE White 5. SINGLE, MARRIED, WIDOWED OR DIVORCED. Single
(Write the word.)

6. DATE OF BIRTH Unknown
(Month) (Day) (Year)

7. AGE Unknown IF LESS than 1 day
about 60 yrs. mos. ds. how many hrs. or min?

8. OCCUPATION

(a) Trade, profession or particular kind of work Farmer
(b) General nature of industry business or establishment in which employed (or employer)

9. BIRTHPLACE

(State or Country) Unknown

10. NAME OF FATHER

11. BIRTHPLACE OF FATHER

(State or Country)

12. MAIDEN NAME OF MOTHER

13. BIRTHPLACE OF MOTHER

(State or Country)

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) W. Correll
(Address) Preston River Ida

15. ap 191 3 M. McKeon
Filed Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH

Feb-16 191 3
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from

191 to 191

that I last saw him alive on 191

and that death occurred on the date stated above, at M.

The CAUSE OF DEATH* was as follows:

Accidental Burning, trying to extinguish fire in his Residence during Twenty Hours.

(Duration) yrs. mos. ds.

Contributory (Secondary)

(Duration) yrs. mos. ds.

(Signed) M. D.

19 (Address)

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place In the

of death yrs. mos. ds. State yrs. mos. ds.

Where was disease contracted,

If not at place of death?

Former or

usual residence

19. PLACE OF BURIAL OR REMOVAL DATE OF BURIAL

Preston River Feb 20 191 3

20. UNDERTAKER ADDRESS

Klopp Newport Wash

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
 N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Form V. S. No. 5 20M.1-16-12

CERTIFICATE OF DEATH

 State of Idaho
 BOARD OF HEALTH
 Bureau of Vital Statistics

1. PLACE OF DEATH.

Registration District No. 8

County of Bonner

Primary Registration District No. 2034

City of Bonner Ferry Idaho

St.)

File No. 4547

Registered No. 199

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

Julia Lundgren

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX

Female

4. COLOR OR RACE

White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED.

married
(Write the word.)

6. DATE OF BIRTH

July 9th 1895

(Month)

(Day)

(Year)

7. AGE

37 yrs. 7 mos. 24 ds.

 IF LESS than 1 day
 how many hrs. or mins.

8. OCCUPATION

(a) Trade, profession or particular kind of work

House Wife

(b) General nature of industry, business, or establishment in which employed (or employer)

9. BIRTHPLACE

(State or Country)

Minnesota

10. NAME OF FATHER

Andrew Peterson

11. BIRTHPLACE OF FATHER

(State or Country)

Minnesota

12. MAIDEN NAME OF MOTHER

Carrie Johnson

13. BIRTHPLACE OF MOTHER

(State or Country)

Sweden

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

Susan E Lundgren

(Address)

Copeland

15

Filed Mar. 6th 1913

Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH

March 5th 1913

(Month)

(Day)

(Year)

17. I HEREBY CERTIFY, That I attended deceased from

Jan. 7th 1913, to March 5th 1913,

that I last saw her alive on March 4th 1913,

and that death occurred on the date stated above, at 3 A.M.

The CAUSE OF DEATH* was as follows:

Pneumonia

(Duration) - yrs. - mos. 8 ds.

Contributory Misadventure (Secondary)

(Duration) yrs. - mos. - ds.

(Signed) E. J. Mason M. D.

19 (Address)

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL OR HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death yrs. - mos. - days. In the State yrs. - mos. - days.

Where was disease contracted if not at place of death?

Former or usual residence.

19. PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

Copeland Ida

1913

20. UNDERTAKER

ADDRESS

John J. Mason

Bonner Ferry

Form V. S. No. 5. 10M. 6-20-11.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH.

Registration District No. 8County of BonnerPrimary Registration District No. 2034City of Bonniers Ferry

(No. _____ St.)

File No. 1549Registered No. 200

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

Park Holland

If death occurred in a hospital, institution or camp give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX

Male

4. COLOR OR RACE 5. SINGLE, MARRIED, WIDOWED OR DIVORCED.

WhiteMarried
(Write the word.)

6. DATE OF BIRTH

May 211853

(Month)

(Day)

(Year)

7. AGE

57 yrs. 9 mos. 12 ds.IF LESS than 1 day
how many hrs. or
..... min.?

8. OCCUPATION

- (a) Trade, profession or particular kind of work
-
- (b) General nature of industry business or establishment in which employed (or employer)

Doctor

9. BIRTHPLACE

(State or Country)

10. NAME OF FATHER

Charles Holland

11. BIRTHPLACE OF FATHER

(State or Country)

Belchior Town Mass

12. MAIDEN NAME OF MOTHER

Saphronia Brown Cobb

13. BIRTHPLACE OF MOTHER

(State or Country)

July 21 1829

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

Maria Holland

(Address)

Bonniers Ferry Ida

15.

Filed March 6 1913

Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

March

(Month)

5th

(Day)

1913

(Year)

17. I HEREBY CERTIFY, That I attended deceased from

Jan 11913to March 51913that I last saw him alive on March 5 1913and that death occurred on the date stated above, at 5:10 P. M.

The CAUSE OF DEATH* was as follows:

Myocardial degeneration(Duration) 2 yrs. mos. ds.Contributory
(Secondary)Arteriosclerosis

(Duration) yrs. mos. ds.

(Signed)

L. J. Stauffer

M. D.

March 27 1913(Address) Bonniers Ferry, Idaho

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place

In the

of death yrs. mos. ds. State yrs. mos. ds.

Where was disease contracted,

If not at place of death?

Former or

usual residence.

19. PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

Bonniers Ferry Ida3/71913

20. UNDERTAKER

ADDRESS

John J. Hagan

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Form V. S. No. 5 20M.1-16-12

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH.

Registration District No. *8*County of *Bonner*Primary Registration District No. *2034*File No. *4549*City of *Bonner Ferry*(No. *1*)

St.)

Registered No. *201*

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME *Patrick Sullivan*

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX

Male

4. COLOR OR RACE

White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED.

Married
(Write the word.)

6. DATE OF BIRTH

Feb

(Month)

9

(Day)

1866

(Year)

7. AGE

47 yrs. *1* mos. *4* ds.IF LESS than 1 day
how many hrs. or
..... mins.)

8. OCCUPATION

(a) Trade, profession or particular kind of work

Logging foreman

(b) General nature of industry, business, or establishment in which employed (or employer)

9. BIRTHPLACE

(State or Country)

Canada

10. NAME OF FATHER

Marrie Sullivan

11. BIRTHPLACE OF FATHER

(State or Country)

Canada

12. MAIDEN NAME OF MOTHER

Annis Cunningham

13. BIRTHPLACE OF MOTHER

(State or Country)

Canada

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

Patrick Sullivan

(Address)

East Grand Fork, Minnesota

15.

Filed

Mar. 13th 1913

Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH

March

(Month)

13

(Day)

1913

(Year)

17. I HEREBY CERTIFY, That I attended deceased from

191... to

191...

that I last saw him alive on *Mar 13th 1913*and that death occurred on the date stated above, at *4 P.M.*

The CAUSE OF DEATH* was as follows:

Concussion of Brain

(Duration)

yrs.

mos. *3 1/2* hrs.

Contributory

(Secondary)

(Duration)

yrs.

mos.

ds.

(Signed)

Mar. 13 1913

(Address)

Bonner Ferry, Idaho

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place

of death

..... yrs. mos. days.

In the

State

..... yrs. mos. days.

Where was disease contracted if not at place of death?

Former or

usual residence

19. PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

East Grand Fork, Minn

191...

20. UNDERTAKER

ADDRESS

*John J. Moore**Bonner Ferry, Idaho*

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Form V. S. No. 5 20M.1-16-12

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics
File No. 45511

1. PLACE OF DEATH.

Registration District No. 8County of BonnerPrimary Registration District No. 2034City of Bonner Ferry, IdahoNo. 202

St.)

Registered No. 202

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Herbert Hanson Hussey

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX Male4. COLOR OR RACE White5. SINGLE, MARRIED, WIDOWED OR DIVORCED. married
(Write the word.)6. DATE OF BIRTH July 19 1885
(Month) (Day) (Year)7. AGE 27 yrs. 7 mos. 26 ds.

IF LESS than 1 day
how many hrs. or
..... mins.?

8. OCCUPATION

(a) Trade, profession or particular kind of work Mail Clerk(b) General nature of industry business, or establishment in which employed (or employer) Railway

9. BIRTHPLACE

(State or Country) Puca, Idaho10. NAME OF FATHER James Hanson Hussey

11. BIRTHPLACE OF FATHER

(State or Country) New Hamer12. MAIDEN NAME OF MOTHER Melissa Grace Cropley

13. BIRTHPLACE OF MOTHER

(State or Country) Nova Scotia

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) James Hanson Hussey(Address) 313 E. Gordon Ave15. Spokane, Wn.Filed Mar. 16 th 1913Local Registrar E. E. Smith

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH March 15 1913
(Month) (Day) (Year)17. I HEREBY CERTIFY, That I attended deceased from — 191—, to — 191—,
that I last saw h. — alive on — 191—,
and that death occurred on the date stated above, at 9:30 P.M.

The CAUSE OF DEATH* was as follows:

Fracture of base of skull + of neck.

(Duration) yrs. mos. ds.

Contributory
(Secondary)

(Duration) yrs. mos. ds.

(Signed) E. E. Smith, M. D.Mar. 16 1913 (Address) Bonner Ferry, Ida.

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death yrs. mos. days. In the State yrs. mos. days.

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL SpokaneDATE OF BURIAL 3/18 191320. UNDERTAKER John J. MooreADDRESS Bonner Ferry

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Form V, S. No. 5. 12½ M. 7-24-11

CERTIFICATE

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics
File No. 4551
Registered No. 203

1. PLACE OF DEATH. Registration District No. 8
County of Bonner Primary Registration District No. 21036
City of Near Clayton (No. _____ St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Charles Kimes

If death occurred in a hospital, institution or camp give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX Male 4. COLOR OR RACE White 5. SINGLE, MARRIED, WIDOWED OR DIVORCED.
(Write the word.)

6. DATE OF BIRTH Mar - 9 - 1913
(Month) (Day) (Year)

7. AGE _____ yrs. _____ mos. 13 ds. IF LESS than 1 day how many _____ hrs. or _____ min?

8. OCCUPATION

- (a) Trade, profession or particular kind of work
(b) General nature of industry business or establishment in which employed (or employer)

9. BIRTHPLACE

(State or Country) Ida

10. NAME OF FATHER C W Kimes

11. BIRTHPLACE OF FATHER

(State or Country) Mich

12. MAIDEN NAME OF MOTHER Laura Callahan

13. BIRTHPLACE OF MOTHER

(State or Country) Mich

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) E J Priddy

(Address) Spirit St 1/4

15.

Filed Apr. 6 1913

M. McKenna
Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH

Mar 22 1913
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from _____ 191____, to _____ 191____

that I last saw h _____ alive on _____ 191____

and that death occurred on the date stated above, at 11 A M.

The CAUSE OF DEATH* was as follows:

Probably Pneumonia
I have never seen the case

_____ (Duration) _____ yrs. _____ mos. 4 or 5 ds.

Contributory Calif
(Secondary)

_____ (Duration) _____ yrs. _____ mos. _____ ds.

(Signed) E J Priddy M. D.

_____ 19____ (Address) Spirit St 1/4

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; (2) whether ACCIDENTAL, SUICIDAL OR HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place _____ In the _____
of death _____ yrs. _____ mos. _____ ds. State _____ yrs. _____ mos. _____ ds.

Where was disease contracted,

If not at place of death? _____

Former or

usual residence _____

19. PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

On the home farm.

Mar 23 1913

20. UNDERTAKER

ADDRESS

none

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Form V. S. No. 5 20M.1-16-12

CERTIFICATE OF DEATH

 State of Idaho
 BOARD OF HEALTH
 Bureau of Vital Statistics

1. PLACE OF DEATH.

Registration District No. 8County of BannerPrimary Registration District No. 2034File No. 4552City of Copeland

(No. _____, _____ St.)

Registered No. 204

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Mukensun

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX

Male

4. COLOR OR RACE

White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED.

(Write the word.)

6. DATE OF BIRTH

 _____ 1 _____
 (Month) (Day) (Year)

7. AGE

about 50

yrs. mos. ds.

 IF LESS than 1 day
 how many hrs. or
 mins.?

8. OCCUPATION

- (a) Trade, profession or particular kind of work
 (b) General nature of industry, business, or establishment in which employed (or employer)

9. BIRTHPLACE

(State or Country)

10. NAME OF FATHER

11. BIRTHPLACE OF FATHER

(State or Country)

12. MAIDEN NAME OF MOTHER

13. BIRTHPLACE OF MOTHER

(State or Country)

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

(Address)

15.

Filed Mar. 27 - 1913
E. J. Moore
 Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH

Not Known
 (Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from

_____ 191____, to _____ 191____,

that I last saw him _____ alive on _____ 191____,

and that death occurred on the date stated above, at _____ M.

The CAUSE OF DEATH* was as follows:

Unknown

_____ (Duration) _____ yrs. _____ mos. _____ ds.

 Contributory _____
 (Secondary)

_____ (Duration) _____ yrs. _____ mos. _____ ds.

(Signed) _____ M. D.

_____ 19____ (Address)

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death _____ yrs. _____ mos. _____ days. In the State _____ yrs. _____ mos. _____ days.

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

Banner Ferry Cemetery 3/27 1913

20. UNDERTAKER

ADDRESS

John J. Moore Banner Ferry, Idaho

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Form V. S. No. 5. 12½ M. 7-24-11

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics
File No. 4553
Registered No. 112

1. PLACE OF DEATH. Registration District No. 10
County of Idaho Primary Registration District No. 2041
City of Camfield (No. , St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Samuel P Jones

If death occurred in a hospital, institution or camp give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX M 4. COLOR OR RACE W 5. SINGLE, MARRIED, WIDOWED OR DIVORCED. Widowed
(Write the word.)

6. DATE OF BIRTH July 1834
(Month) (Day) (Year)

7. AGE 18 yrs. 6 mos. ds. IF LESS than 1 day how many hrs. or min?

8. OCCUPATION (a) Trade, profession or particular kind of work. Rancher
(b) General nature of industry business or establishment in which employed (or employer)

9. BIRTHPLACE (State or Country) Illinois

10. NAME OF FATHER —

11. BIRTHPLACE OF FATHER (State or Country) —

12. MAIDEN NAME OF MOTHER —

13. BIRTHPLACE OF MOTHER (State or Country) —

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE (Informant) W. A. Faskett
(Address) White Bird, Ida.

15. Filed April 2 1913 Jess L. Pains
Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH Mar 28 1913
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from Feb 20 1913, to Mar 23 1913
that I last saw him alive on Mar 23 1913
and that death occurred on the date stated above, at 4 M.

The CAUSE OF DEATH* was as follows:

Streptococcal

(Duration) yrs. mos. 23 ds.
Contributory (Secondary) Erysipelas
(Duration) yrs. mos. ds.
(Signed) W. A. Faskett M. D.
19 (Address) White Bird

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place In the
of death. yrs. mos. ds. State. yrs. mos. ds.
Where was disease contracted,
If not at place of death?
Former or
usual residence.

19. PLACE OF BURIAL OR REMOVAL DATE OF BURIAL
Camfield Mar 30 1913
20. UNDERTAKER ADDRESS
No undertaker

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Form V. S. No. 5. 12½ M. 7-24-11

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics
File No. 4554
Registered No. 111

1. PLACE OF DEATH.

Registration District No. 10

County of Idaho

Primary Registration District No. 2041

City of Joseph

(No. , St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

Ione Ida Hockersmith

If death occurred in a hospital, institution or camp give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX

F

4. COLOR OR RACE

white

5. SINGLE, MARRIED, WIDOWED OR DIVORCED.

single
(Write the word.)

6. DATE OF BIRTH

Jan
(Month)5
(Day)1910
(Year)

7. AGE

2 yrs. 2 mos. 10 ds.

IF LESS than 1 day
how many hrs. or
..... min?

8. OCCUPATION

(a) Trade, profession or particular kind of work.
(b) General nature of industry business or establishment in which employed (or employer)

Child

9. BIRTHPLACE

(State or Country)

Idaho

10. NAME OF FATHER

Wesley Hockersmith

11. BIRTHPLACE OF FATHER

(State or Country)

Oregon

12. MAIDEN NAME OF MOTHER

Myra Palmer

13. BIRTHPLACE OF MOTHER

(State or Country)

do not know

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

W. A. Fiskett

(Address)

15.

Filed April 2 1913

Jesse P. Paines

Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH

Mar

16

1918

(Month)

(Day)

(Year)

17. I HEREBY CERTIFY, That I attended deceased from

Mar 11 1913, to Mar 15 1913

that I last saw her alive on Mar 12 1913

and that death occurred on the date stated above, at 12:30 AM.

The CAUSE OF DEATH* was as follows:

Dysentery

(Duration) yrs. mos. 8 ds.

Contributory (Secondary)

(Duration) yrs. mos. ds.

(Signed) W. A. Fiskett M. D.

Mar 16 1913 (Address) Whitebird Ida

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place In the

of death yrs. mos. ds. State yrs. mos. ds.

Where was disease contracted,

If not at place of death?

Former or usual residence.

19. PLACE OF BURIAL OR REMOVAL DATE OF BURIAL

Grangerville

Mar 17 1913

20. UNDERTAKER

ADDRESS

Graham

Grangerville

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Form V. S. No. 5. 12½M. 7-24-11

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics
File No. 4555
Registered No. 113

1. PLACE OF DEATH. Registration District No. 10
County of Idaho Primary Registration District No. 2041
City of Whitebird (No. _____, _____ St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Emma Gladie Evans

If death occurred in a hospital, institution or camp give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX f 4. COLOR OR RACE white 5. SINGLE, MARRIED, WIDOWED OR DIVORCED. single
(Write the word.)

6. DATE OF BIRTH Mar 18 1913
(Month) (Day) (Year)

7. AGE _____ yrs. _____ mos. 4 ds. IF LESS than 1 day how many _____ hrs. or _____ min?

8. OCCUPATION
(a) Trade, profession or particular kind of work. _____
(b) General nature of industry business or establishment in which employed (or employer) _____

9. BIRTHPLACE Whitebird Ida
(State or Country)

10. NAME OF FATHER John Evans

11. BIRTHPLACE OF FATHER Glenelder Kansas
(State or Country)

12. MAIDEN NAME OF MOTHER Virginia L. Luther

13. BIRTHPLACE OF MOTHER Lennex Mo.
(State or Country)

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) W. A. Fiskett
(Address) White Bird, Idaho

15. Filed April 2 1913 James L. Raines
Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH Mar 22 1913
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from Mar 18 1913, to Mar 22 1913, that I last saw her alive on Mar 20 1913, and that death occurred on the date stated above, at 7 A.M.
The CAUSE OF DEATH* was as follows:

Breech presentation
causing Bronchitis Pneumonia

(Duration) _____ yrs. _____ mos. 4 ds.
Contributory (Secondary) _____

(Duration) _____ yrs. _____ mos. _____ ds.
(Signed) W. A. Fiskett M. D.
April 1 1913 (Address) Whitebird

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place _____ In the _____
of death _____ yrs. _____ mos. _____ ds. State _____ yrs. _____ mos. _____ ds.
Where was disease contracted, _____
If not at place of death? _____
Former or _____
usual residence. _____

19. PLACE OF BURIAL ~~OR REMOVAL~~ White Bird. DATE OF BURIAL Mar 24 1913

20. UNDERTAKER No undertaker ADDRESS _____

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. N. B.—Every item of information should be carefully supplied. AGE should be state EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Form V. S. No. 5. 10M. 6-20-11.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

File No. 4556

Registered No. 114

If death occurred in a hospital, institution or camp give its NAME instead of street and number.

1. PLACE OF DEATH.

Registration District No. 10

County of Ida

Primary Registration District No. 2041

City of Whitebird

(No. 8, St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

George Shearer

PERSONAL AND STATISTICAL PARTICULARS

3. SEX

Male

4. COLOR OR RACE

White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED.

Single
(Write the word.)

6. DATE OF BIRTH

Feb 8 1913
(Month) (Day) (Year)

7. AGE

86

yrs. mos. ds.

IF LESS than 1 day
how many hrs. or
min.?

8. OCCUPATION

(a) Trade, profession, or particular kind of work
(b) General nature of industry business, or establishment in which employed (or employer)

Packer

9. BIRTHPLACE

(State or Country)

Germany

10. NAME OF FATHER

11. BIRTHPLACE OF FATHER

(State or Country)

—

12. MAIDEN NAME OF MOTHER

—

13. BIRTHPLACE OF MOTHER

(State or Country)

—

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

W. A. Fosskett

(Address)

White Bird, Ida

15.

Filed

Mar. 16 1913

Jesse L. Rains

Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

Feb 8 1913
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from

Nov 3 1912 to Feb 8 1913

that I last saw him alive on Feb 8 1913

and that death occurred on the date stated above, at 8 P.M.

The CAUSE OF DEATH* was as follows:

Quarantion

(Duration) yrs. mos. 20 ds.

Contributory
(Secondary)

(Duration) yrs. mos. ds.

(Signed) W. A. Fosskett M. D.

Mar. 14 1913 (Address) Whitebird Ida

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place

In the

of death yrs. mos. ds. State yrs. mos. ds.

Where was Disease contracted,

If not at place of death?

Former or

usual residence

19. PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

Whitebird

Feb. 10 1913

20. UNDERTAKER

ADDRESS

Hancock

Grangwell

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. N. B.—Every item of information should be carefully supplied. AGE should be state EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Form V. S. No. 5. 10M. 6-20-11.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

File No. 4557

Registered No. 115

1. PLACE OF DEATH.

County of Idaho

City of Whitebird

Registration District No. 10

Primary Registration District No. 2041

(No. , St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

Mary Newman

If death occurred in a hospital, institution or camp give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX

F

4. COLOR OR RACE

White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED.

Single
(Write the word.)

6. DATE OF BIRTH

Feb

(Month)

5

(Day)

1913

(Year)

7. AGE

yrs.

mos. 4

ds.

IF LESS than 1 day
how many hrs. or
..... min.?

8. OCCUPATION

(a) Trade, profession, or particular kind of work

(b) General nature of industry business, or establishment in which employed (or employer)

9. BIRTHPLACE

(State or Country)

Whitebird Ida

10. NAME OF FATHER

Horner Newman

11. BIRTHPLACE OF FATHER

(State or Country)

Wash

12. MAIDEN NAME OF MOTHER

Marion Swartz

13. BIRTHPLACE OF MOTHER

(State or Country)

Idaho

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

W A Foskett

(Address)

Whitebird Ida

15.

Filed

Mar. 16

1913

Jesse L. Rains

Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

Feb

(Month)

9

(Day)

1913

(Year)

17. I HEREBY CERTIFY, That I attended deceased from

Feb 4

1913

to Feb 9

1913

that I last saw her alive on Feb 8 1913,

and that death occurred on the date stated above, at — M.

The CAUSE OF DEATH* was as follows:

Premature

(Duration) yrs. mos. 5 ds.

Contributory (Secondary)

Cold air

(Duration) yrs. mos. ds.

(Signed)

W A Foskett M. D.

Mar 19 1913 (Address) Whitebird

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place

In the

of death yrs mos ds State yrs mos ds.

Where was Disease contracted,

If not at place of death?

Former or

usual residence.

19. PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

Whitebird

Feb 9 1913

20. UNDERTAKER

ADDRESS

Hancock

Granville Ida

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Form V. S. No. 5. 12½ M. 7-24-11

CERTIFICATE OF DEATH

1. PLACE OF DEATH. Registration District No. 15
County of Latah Primary Registration District No. 2063
City of Seeley (No. _____ St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

Mary Broemelting

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics
File No. 1559
Registered No. 28

If death occurred in a hospital, institution or camp give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX Female 4. COLOR OR RACE White 5. SINGLE, MARRIED, WIDOWED OR DIVORCED Married
(Write the word.)
6. DATE OF BIRTH March 1st 1855
April 1st 1913
(Month) (Day) (Year)

7. AGE 57 yrs. 11 mos. 8 ds. IF LESS than 1 day
how many _____ hrs. or _____ min?

8. OCCUPATION
(a) Trade, profession or particular kind of work. Farmers Wife
(b) General nature of industry business or establishment in which employed (or employer)

9. BIRTHPLACE
(State or Country) Germany

10. NAME OF FATHER John Johanne

11. BIRTHPLACE OF FATHER
(State or Country) Germany

12. MAIDEN NAME OF MOTHER Mary Johanne

13. BIRTHPLACE OF MOTHER
(State or Country) Germany

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Thomas Broemelting
(Address) Seeley, Ida.

15. 4-3 1913 W. H. Clew
Filed _____ Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH 4 1 19113
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from March 31 19113 to April 1 19113
that I last saw h. alive on April 1 19113
and that death occurred on the date stated above, at 4:00 P.

The CAUSE OF DEATH* was as follows:
Pulmonary Edema

8 (Duration) _____ yrs. _____ mos. _____ ds.
Contributory Cerebral Hemorrhage
(Secondary)
(Signed) E. J. T. M. D.
Apr 2 1913 (Address) Seeley, Ida.

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place _____ In the _____
of death _____ yrs. _____ mos. _____ ds. State _____ yrs. _____ mos. _____ ds.
Where was disease contracted,
If not at place of death? _____
Former or
usual residence _____

19. PLACE OF BURIAL OR REMOVAL Cath. Cem. DATE OF BURIAL 4-3 19113

20. UNDERTAKER J. E. Lambert ADDRESS Seeley, Ida.

WRITE PLAINLY, WITH UNFADEING INK—THIS IS A PERMANENT RECORD.
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Form V. S. No. 5. 12½ M. 7-24-11

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH.

Registration District No. 151

County of IdahoPrimary Registration District No. 2065City of Idaho

(No. _____ St.)

File No. 4569Registered No. 25

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

Barbara Ann Laupheere

If death occurred in a hospital, institution or camp give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX

Female

4. COLOR OR RACE

White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED.

Married
(write the word.)

6. DATE OF BIRTH

March 30 1848
(Month) (Day) (Year)

7. AGE

64 yrs. 11 mos. 4 ds.IF LESS than 1 day
how many _____ hrs. or
_____ min?

8. OCCUPATION

(a) Trade, profession or particular kind of work

Housewife

(b) General nature of industry business or establishment in which employed (or employer)

Retired Farmer

9. BIRTHPLACE

(State or Country)

Lock Port N. Y.

10. NAME OF FATHER

Jacob Walters

11. BIRTHPLACE OF FATHER

(State or Country)

N. Y.

12. MAIDEN NAME OF MOTHER

Mary Ann Cable

13. BIRTHPLACE OF MOTHER

(State or Country)

N. Y.

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

Joshua G. Laupheere
Idaho

(Address)

15.

Filed March 4 1913J. W. Olson
Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH

March 4 1913
(Month) (Day) (Year)17. I HEREBY CERTIFY, That I attended deceased from
1909, to March 4 1913that I last saw her alive on March 4 1913
and that death occurred on the date stated above, at 5 a.m.

The CAUSE OF DEATH* was as follows:

Parenchymatous Nephritis(Duration) 4 yrs. 1 mos. 1 ds.Contributory general aedema
(Secondary)

(Duration) _____ yrs. _____ mos. _____ ds.

(Signed) J. W. Olson M. D.March 4 1913 (Address) Idaho

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place _____ In the _____
of death _____ yrs. _____ mos. _____ ds. State _____ yrs. _____ mos. _____ ds.Where was disease contracted,
If not at place of death? _____
Former or
usual residence. _____

19. PLACE OF BURIAL OR REMOVAL DATE OF BURIAL

Brent Ridge, Idaho March 6 1913

20. UNDERTAKER

ADDRESS

August Johnson Idaho

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Form V. S. No. 5. 12½ M. 7-24-11

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics
File No. 4561
Registered No. 24

1. PLACE OF DEATH.
County of Latah
City of Proy

Registration District No. 2065 15
Primary Registration District No. 1st 2065
(No. _____ St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

Bertha Belle Ahrens

If death occurred in a hospital, institution or camp give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX Female 4. COLOR OR RACE White 5. SINGLE, MARRIED, WIDOWED OR DIVORCED. Single
(Write the word.)

6. DATE OF BIRTH July 28 1911
(Month) (Day) (Year)

7. AGE 1 yrs. 7 mos. 24 ds. IF LESS than 1 day how many hrs. or min?

8. OCCUPATION

(a) Trade, profession or particular kind of work None
(b) General nature of industry business or establishment in which employed (or employer) Father - Farmer

9. BIRTHPLACE Fillmore, Saskatchewan Canada
(State or Country)

10. NAME OF FATHER Albert Ahrens

11. BIRTHPLACE OF FATHER Iowa
(State or Country)

12. MAIDEN NAME OF MOTHER Luella Mabel Bittick

13. BIRTHPLACE OF MOTHER Iowa
(State or Country)

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Albert Ahrens,
(Address) Proy, Idaho

15. Filed March 22 1913 J. W. Olson
Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH March 22 1913
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from March 12 1913, to March 22 1913, that I last saw her alive on March 21 1913 and that death occurred on the date stated above, at 7 A. M.

The CAUSE OF DEATH* was as follows:

Broncho-Pneumonia

(Duration) yrs. mos. ds.

Contributory (Secondary)

(Duration) yrs. mos. ds.

(Signed) J. W. Olson M. D.

March 22 1913 (Address) Proy, Idaho

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place In the
of death yrs. mos. ds. State yrs. mos. ds.

Where was disease contracted,

If not at place of death?.....

Former or

usual residence.....

19. PLACE OF BURIAL OR REMOVAL DATE OF BURIAL

Proy, Idaho March 24 1913

20. UNDERTAKER ADDRESS

August Johnson Proy, Ida.

1. PLACE OF DEATH County of <u>Zatah</u> City of <u>Avon</u>		Registration District No. <u>2068</u> (No. _____, _____ St.)		Bureau of Vital Statistics No. <u>4562</u> Registered No. <u>27</u>	
If death occurs away from usual residence, give facts called for under special information.					
2. FULL NAME <u>Joseph A. Davis</u>					
PERSONAL AND STATISTICAL PARTICULARS					
3. SEX <u>M.</u>	4. COLOR OR RACE <u>W</u>	5. SINGLE, MARRIED, WIDOWED OR DIVORCED. <u>widowed</u> (Write the word.)			
6. DATE OF BIRTH <u>Don't know</u> (Month) _____ (Day) <u>1</u> (Year) _____					
7. AGE <u>about 68</u> yrs. _____ mos. _____ ds.		IF LESS than 1 day how many _____ hrs. or _____ min?			
8. OCCUPATION (a) Trade, profession or particular kind of work _____ (b) General nature of industry, business or establishment in which employed (or employer) _____					
9. BIRTHPLACE <u>Don't know</u> (State or Country)					
10. NAME OF FATHER <u>Don't know</u>					
11. BIRTHPLACE OF FATHER <u>Wales</u> (State or Country)					
12. MAIDEN NAME OF MOTHER <u>Don't know</u>					
13. BIRTHPLACE OF MOTHER <u>Don't know</u> (State or Country)					
14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE (Informant) <u>P. A. Wilbur</u> (Address) <u>Avon, Idaho</u>					
15. Filed <u>Mar 17, 1913</u> <u>P. C. Faust</u> Local Registrar					
MEDICAL CERTIFICATE OF DEATH					
16. DATE OF DEATH <u>Mar 16</u> 191 <u>3</u> (Month) _____ (Day) _____ (Year) _____					
17. I HEREBY CERTIFY, That I attended deceased from <u>never</u> 191 <u>1</u> , to <u>now</u> 191 <u>3</u> that I last saw h. _____ alive on _____ 191 <u>1</u> and that death occurred on the date stated above, at _____ M. The CAUSE OF DEATH* was as follows: <u>from information of neighbors it was heart failure</u> (Duration) <u>0</u> yrs. <u>0</u> mos. <u>0</u> ds. Contributory _____ (Secondary) _____ (Duration) <u>0</u> yrs. <u>0</u> mos. <u>0</u> ds. (Signed) <u>P. C. Faust</u> M. D. <u>4/1</u> 191 <u>3</u> (Address) <u>Leary</u>					
*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.					
18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.) At place _____ In the _____ of death _____ yrs. _____ mos. _____ ds. State _____ yrs. _____ mos. _____ ds. Where was disease contracted, _____ If not at place of death? _____ Former or _____ usual residence _____					
19. PLACE OF BURIAL OR REMOVAL <u>Avon Cemetery</u>				DATE OF BURIAL <u>Mar 18, 1913</u>	
20. UNDERTAKER <u>none</u>				ADDRESS _____	

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Form V. S. No. 5 20M.1-16-12

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH

Registration District No. 19

County of Blainock

Primary Registration District No. 1012

File No. 4563

City of Pocatello

(No. 1016 N. 8th St.)

Registered No. 23

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

Wm Duggins

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX

4. COLOR OR RACE

5. SINGLE, MARRIED, WIDOWED OR DIVORCED.

Male

White

Married (Write the word.)

6. DATE OF BIRTH

Jan

13

1830

(Month)

(Day)

(Year)

7. AGE

82 yrs. 1 mos. 20 ds.

IF LESS than 1 day how many hrs. or mins.

8. OCCUPATION

(a) Trade, profession or particular kind of work

(b) General nature of industry business, or establishment in which employed (or employer)

Retired

9. BIRTHPLACE

(State or Country)

Idaho

10. NAME OF FATHER

11. BIRTHPLACE OF FATHER

(State or Country)

12. MAIDEN NAME OF MOTHER

13. BIRTHPLACE OF MOTHER

(State or Country)

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

Wm R. Duggins

(Address)

1016 N. 8th Ave

15.

Filed

3/7

1913

J B Steele

Loc

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH

March

5th

1913

(Month)

(Day)

(Year)

17. I HEREBY CERTIFY, That I attended deceased from Mar 1 1913, to March 5, 1913, that I last saw him alive on Mar 4, 1913, and that death occurred on the date stated above, at 2.00 A.M.

The CAUSE OF DEATH* was as follows:

Disturbance of heart (senility)

(Duration) yrs. mos. ds.

Contributory (Secondary)

(Duration) yrs. mos. ds.

(Signed)

J B Steele M. D.

35-1913 (Address) Pocatello Idaho

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death. yrs. mos. days. In the State. yrs. mos. days.

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

St. Bonaventure

Mar 6 1913

20. UNDERTAKER

ADDRESS

Wacker

Pocatello

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Form V. S. No. 5 20M.1-16-12

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital StatisticsFile No. **4565**Registered No. **25**

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

1. PLACE OF DEATH

Registration District No. **19**County of **Bannock**Primary Registration District No. **11902**City of **Pocatello**(No. **318**, Dr. **Garfield** St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME **Constance C. Kern**

PERSONAL AND STATISTICAL PARTICULARS

3. SEX

Male

4. COLOR OR RACE

White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED.

Married
(Write the word.)

6. DATE OF BIRTH

October 18 1842
(Month) (Day) (Year)

7. AGE

70 yrs. **4** mos. **20** ds.IF LESS than 1 day
how many hrs. or
..... mins.?

8. OCCUPATION

(a) Trade, profession or particular kind of work

(b) General nature of industry business, or establishment in which employed (or employer)

Retired

9. BIRTHPLACE

(State or Country)

Ohio

10. NAME OF FATHER

Harvey Glenn

11. BIRTHPLACE OF FATHER

(State or Country)

Kentucky

12. MAIDEN NAME OF MOTHER

Nancy Russell

13. BIRTHPLACE OF MOTHER

(State or Country)

Virginia

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

Ed J. Barnes

(Address)

Pocatello

15.

Filed

3/31 1913
O B Straly
Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH

March 7 1913
(Month) (Day) (Year)17. I HEREBY CERTIFY, That I attended deceased from **Feb 21 1913** to **March 7 1913**that I last saw him alive on **March 7 1913**
and that death occurred on the date stated above, at **6:30 A.M.**

The CAUSE OF DEATH* was as follows:

Acute Endocarditis

(Duration) yrs. mos. ds.

Contributory
(Secondary)

(Duration) yrs. mos. ds.

(Signed)

Ed J. Barnes
March 7 1913 (Address) **Pocatello Idaho**

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death yrs. mos. days. In the State yrs. mos. days.

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

Pocatello Idaho **1913**

20. UNDERTAKER

ADDRESS

W. R. Mackay **Pocatello Idaho**

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH

Registration District No. 19

County of

Primary Registration District No. 1902

City of

(No. 1902 St.)

File No. 4569

Registered No. 26

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX

4. COLOR OR RACE

5. SINGLE, MARRIED, WIDOWED OR DIVORCED

6. DATE OF BIRTH

7. AGE

IF LESS than 1 day
how many hrs. or mins.?

8. OCCUPATION

(a) Trade, profession or particular kind of work

(b) General nature of industry business, or establishment in which employed (or employer)

9. BIRTHPLACE

(State or Country)

10. NAME OF FATHER

11. BIRTHPLACE OF FATHER

(State or Country)

12. MAIDEN NAME OF MOTHER

13. BIRTHPLACE OF MOTHER

(State or Country)

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

(Address)

15.

Filed

1913

Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

17. I HEREBY CERTIFY, That I attended deceased from

Jan 12 1913 to March 9 1913
that I last saw her alive on March 9 1913

and that death occurred on the date stated above, at 7 A.M.

The CAUSE OF DEATH* was as follows:

Acute peritonitis, post-operative. Perforation of pelvic abscess during operation.
(Duration) yrs. mos. 3 ds.

Contributory (Secondary)

Chronic (Duration) 2 yrs. mos. 1 ds.

(Signed)

3/10 1913 (Address)

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place

of death

Where was disease contracted if not at place of death?

Former or

usual residence

19. PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

20. UNDERTAKER

ADDRESS

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Form V. S. No. 5 20M.1-16-12

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH

Registration District No. 19

County of Bannock

Primary Registration District No. 1002

File No. 4564

City of Pocatello

(No. 636 South 3rd St.)

Registered No. 27

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Alcedine Gertrude Smith

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX

4. COLOR OR RACE

5. SINGLE, MARRIED, WIDOWED OR DIVORCED.

Female White

Single (Write the word.)

6. DATE OF BIRTH

Feb. 9 1913
(Month) (Day) (Year)

7. AGE

1 yrs. 1 mos. 9 ds.

IF LESS than 1 day
how many hrs. or
..... mins.

8. OCCUPATION

(a) Trade, profession or particular kind of work

None

(b) General nature of industry business, or establishment in which employed (or employer)

9. BIRTHPLACE

(State or Country)

Pocatello

10. NAME OF FATHER

John T. Smith

11. BIRTHPLACE OF FATHER

(State or Country)

Utah

12. MAIDEN NAME OF MOTHER

Anna Clark

13. BIRTHPLACE OF MOTHER

(State or Country)

England

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

John T. Smith

(Address) 636 S. 2nd av.

15.

Filed

3/5/13 191 U B Staley

Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH

March 10 1913
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from

March 6 1913, to March 10 1913,

that I last saw him alive on March 10 1913,

and that death occurred on the date stated above, at 10:30 A.M.

The CAUSE OF DEATH* was as follows:

Broncho-pneumonia

(Duration) yrs. mos. 5 ds.

Contributory
(Secondary)

(Duration) yrs. mos. ds.

(Signed) J. S. Woolley M. D.

Mar 10 1913 (Address) Cor. Cen. & Main

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death yrs. mos. days. In the State yrs. mos. days.

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

Removal to Logan

3/11 1913

20. UNDERTAKER

ADDRESS

Ray Russell

Pocatello

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Form V. S. No. 5 20M.1-16-12

CERTIFICATE OF DEATH

A + B
State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics
File No. **4568**
Registered No. **28**

1. PLACE OF DEATH

Registration District No. **19**County of **Bannock**Primary Registration District No. **1002**City of **Idaho**(No. **Pocatello**

St.)

Registered No. **28**

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

Ray and Merl Larsen

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX

Male

4. COLOR OR RACE

White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED.

(Write the word.)

6. DATE OF BIRTH

March 1st 1913
(Month) (Day) (Year)

7. AGE

Premature Birth

IF LESS than 1 day
how many **3** hrs. **45** mins.

8. OCCUPATION

(a) Trade, profession or particular kind of work

(b) General nature of industry business, or establishment in which employed (or employer)

9. BIRTHPLACE

(State or Country)

Bannock Co

10. NAME OF FATHER

Lorenzo Larsen

11. BIRTHPLACE OF FATHER

(State or Country)

Hymus Utah

12. MAIDEN NAME OF MOTHER

Lillian Hendricks

13. BIRTHPLACE OF MOTHER

(State or Country)

Weston Mison

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

A. J. Green(Address) **605 N. Hayes Pocatello**

15.

Filed **3/31**191 **3****J. B. Sturdy**

Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

March 11th 1913
(Month) (Day) (Year)

17. I HEREBY CERTIFY, that I attended deceased from **March 11th 1913** to **March 11th 1913**, that I last saw him alive on **March 11th 1913**

and that death occurred on the date stated above, at **5 P. M.**

The CAUSE OF DEATH was as follows:

Premature birth

(Duration) yrs. mos. ds.

Contributory
(Secondary)

(Duration) yrs. mos. ds.

(Signed)

A. J. Green M. D.

March 1913 (Address) **Pocatello Idaho**

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death yrs. mos. days. In the State yrs. mos. days.

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

Removal to Hyattsville

191 **3**

20. UNDERTAKER

ADDRESS

Roy Russell

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Form V. S. No. 5 20M.1-16-12

CERTIFICATE OF DEATH

A+B
State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics
File No. 4568
Registered No. 28

1. PLACE OF DEATH

Registration District No. 19

County of Bannock

Primary Registration District No. 1002

City of Idaho

(No. Pocatello

St.)

Registered No. 28

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

Ray and Merl Larson

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX

Male

4. COLOR OR RACE

White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED.

(Write the word.)

6. DATE OF BIRTH

March 1st 1913
(Month) (Day) (Year)

7. AGE

Premature Birth
yrs. mos. ds.

IF LESS than 1 day
how many hrs. & mins.
4.5 mins.

8. OCCUPATION

(a) Trade, profession or particular kind of work

(b) General nature of industry business, or establishment in which employed (or employer)

9. BIRTHPLACE

(State or Country)

Bannock Co

10. NAME OF FATHER

Lorenzo Larsen

11. BIRTHPLACE OF FATHER

(State or Country)

Hymus Utah

12. MAIDEN NAME OF MOTHER

Lillian Hendricks

13. BIRTHPLACE OF MOTHER

(State or Country)

Weaton Misen

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

A. J. Green

(Address) 605 N. Hayes Pocatello

15.

Filed

3/31

1913

J. B. Sturley

Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

March 11th 1913
(Month) (Day) (Year)

17. I HEREBY CERTIFY, that I attended deceased from March 11th 1913, to March 11th 1913, that I last saw him alive on March 11th 1913, and that death occurred on the date stated above, at 5 P. M.

The CAUSE OF DEATH was as follows:

Premature Birth

(Duration) yrs. mos. ds.

Contributory (Secondary)

(Duration) yrs. mos. ds.

(Signed) H. W. Green M. D.

March 1913 (Address) Pocatello Idaho

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death yrs. mos. days. In the State yrs. mos. days.

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

Removal to Hymus Utah
March 11th 1913

20. UNDERTAKER

ADDRESS

Roy Russell

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Form V. S. No. 5 20M.1-16-12

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics
File No. 4560

1. PLACE OF DEATH.

Registration District No. 19

County of Bannock

Primary Registration District No. 1002

City of Pocatello

(No. Paul Hospital St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Joe Blackburn

Registered No. 29

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX Male

4. COLOR OR RACE Colored

5. SINGLE, MARRIED, WIDOWED OR DIVORCED.

(Write the word.)

6. DATE OF BIRTH

(Month)

(Day)

(Year) 1884

7. AGE

29 yrs. ✓ mos. ✓ ds.

IF LESS than 1 day
how many hrs. or
..... mins.?

8. OCCUPATION

(a) Trade, profession or particular kind of work

(b) General nature of industry business, or establishment in which employed (or employer)

Laborer

9. BIRTHPLACE

(State or Country)

10. NAME OF FATHER

11. BIRTHPLACE OF FATHER

(State or Country)

12. MAIDEN NAME OF MOTHER

13. BIRTHPLACE OF MOTHER

(State or Country)

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) M. Walker

(Address) Pocatello

15.

Filed March 13 1913

Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH

(Month)

(Day)

(Year) 1913

17. I HEREBY CERTIFY, That I attended deceased from

Feb 7 1913, to March 12 1913,

that I last saw him alive on March 12 1913,

and that death occurred on the date stated above, at 6 P.M.

The CAUSE OF DEATH* was as follows:

Burn from falling in fire

(Duration) yrs. mos. ds.

Contributory (Secondary)

(Duration) yrs. mos. ds.

(Signed) A. M. Newton M. D.

19. (Address) 125 N 2nd Ave

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death

..... yrs. 1 mos. 2 days.

In the State

..... yrs. mos. days.

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

Mt View Cemetery March 14 1913

20. UNDERTAKER

ADDRESS

M. Walker Pocatello

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Form V. S. No. 5 20M.1-16-12

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics
File No. 14570
Registered No. 30

1. PLACE OF DEATH.

Registration District No. 19

County of Laurel

Primary Registration District No. 1092

City of Pocatello

(No. Dist. No. 1092 St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

George Leslie Giltrik

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX

4. COLOR OR RACE

5. SINGLE, MARRIED, WIDOWED OR DIVORCED.

Male

White

Single
(Write the word.)

6. DATE OF BIRTH

Sep 30 1895
(Month) (Day) (Year)

7. AGE

17 yrs. 3 mos. 17 ds.

IF LESS than 1 day
how many hrs. or
..... mins.?

8. OCCUPATION

(a) Trade, profession or particular kind of work

School boy

(b) General nature of industry business, or establishment in which employed (or employer)

9. BIRTHPLACE

(State or Country)

Mendon Mass

10. NAME OF FATHER

Geo Giltrik Jr

11. BIRTHPLACE OF FATHER

(State or Country)

Rarhan England

12. MAIDEN NAME OF MOTHER

Anna Jensen

13. BIRTHPLACE OF MOTHER

(State or Country)

Mendon Utah

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

R. E. McLaughlin

(Address)

Pocatello Idaho

15.

Filed

Mar 19 1913

R. E. McLaughlin
Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH

March 17 1913
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from

Mar. 13, 1913, to Mar. 17, 1913

that I last saw him alive on Mar 17, 1913

and that death occurred on the date stated above, at 10 A.M.

The CAUSE OF DEATH* was as follows:

Appendicitis
Post operative stricture

(Duration) yrs. mos. 4 ds.

Contributory
(Secondary)

(Duration) yrs. mos. ds.

(Signed)

3-18-1913 (Address) Pocatello Idaho

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death yrs. mos. 4 days. In the State 17 yrs. 5 mos. 17 days.

Where was disease contracted if not at place of death?

Former or usual residence

Pocatello Idaho

19. PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

St. Peter's Church Mar 19 1913

20. UNDERTAKER

ADDRESS

R. E. McLaughlin Pocatello Idaho

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
N. B.—Every item of information should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Form V. S. No. 5 20M.1-16-12

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH

Registration District No.

County of

Primary Registration District No.

City of

(No. 13, Dr. Warren St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

File No.

Registered No.

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX

4. COLOR OR RACE

5. SINGLE, MARRIED, WIDOWED OR DIVORCED

6. DATE OF BIRTH

7. AGE

IF LESS than 1 day
how many hrs. or
..... mins.?

8. OCCUPATION

(a) Trade, profession or particular kind of work

(b) General nature of industry business, or establishment in which employed (or employer)

9. BIRTHPLACE

(State or Country)

10. NAME OF FATHER

11. BIRTHPLACE OF FATHER

(State or Country)

12. MAIDEN NAME OF MOTHER

13. BIRTHPLACE OF MOTHER

(State or Country)

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

(Address)

15.

Filed

191

Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

17. I HEREBY CERTIFY, That I attended deceased from

191., to 191.

that I last saw him alive on 191.

and that death occurred on the date stated above, at 12 M.

The CAUSE OF DEATH was as follows:

(Duration) yrs. mos. 22 ds.

Contributory (Secondary) Mitral insufficiency

(Duration) yrs. mos. ds.

(Signed) W. F. Howard M. D.

Mch 19 1913 (Address) Pocatello Idaho

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death. yrs. mos. days. In the State. yrs. mos. days.

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

Zumbrota Minn Mch 20 1913

20. UNDERTAKER

ADDRESS

M. Maerker Pocatello Ida

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Form V. S. No. 5 20M.1-16-12

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH

Registration District No.

County of

Primary Registration District No.

City of

(No. 558, V. Arthur St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

File No.

Registered No.

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX

4. COLOR OR RACE

5. SINGLE, MARRIED, WIDOWED OR DIVORCED.

6. DATE OF BIRTH

7. AGE

IF LESS than 1 day
how many hrs. or
..... mins.

8. OCCUPATION

(a) Trade, profession or particular kind of work

(b) General nature of industry business, or establishment in which employed (or employer)

9. BIRTHPLACE

(State or Country)

10. NAME OF FATHER

11. BIRTHPLACE OF FATHER

(State or Country)

12. MAIDEN NAME OF MOTHER

13. BIRTHPLACE OF MOTHER

(State or Country)

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

(Address)

15.

Filed

1913

Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH

17. I HEREBY CERTIFY, That I attended deceased from

March 18th 1913, to March 23rd 1913that I last saw her alive on March 23rd 1913and that death occurred on the date stated above, at 7th P.M.

The CAUSE OF DEATH* was as follows:

(Duration) yrs. mos. 7 ds.

Contributory
(Secondary)

(Duration) yrs. mos. ds.

(Signed)

M. D.

March 19/13 (Address) N. G. Castle

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death yrs. mos. days. In the State yrs. mos. days.

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

N. G. Castle, March 25th 1913

20. UNDERTAKER

ADDRESS

J. H. Miller, Pocatello

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Form V. S. No. 5 20M.1-16-12

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics
File No. **4573**

Registered No. **33**

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

1. PLACE OF DEATH.

Registration District No.

County of **Blaine**

Primary Registration District No. **1092**

City of **Pocatello**

(No. **Levee Hospital** St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME **Frank Eugene Ford**

PERSONAL AND STATISTICAL PARTICULARS

3. SEX

4. COLOR OR RACE

5. SINGLE, MARRIED, WIDOWED OR DIVORCED.

Male

White

Single
(Write the word.)

6. DATE OF BIRTH

March 4
(Month) (Day)

1906
(Year)

7. AGE

7 yrs. **2** mos. **20** ds.

IF LESS than 1 day
how many hrs. or
..... mins.

8. OCCUPATION

(a) Trade, profession or particular kind of work

(b) General nature of industry business, or establishment in which employed (or employer)

None

9. BIRTHPLACE

(State or Country)

Pocatello Ida.

10. NAME OF FATHER

Chas. T. Ford

11. BIRTHPLACE OF FATHER

(State or Country)

Utah

12. MAIDEN NAME OF MOTHER

Elizabeth Otainger

13. BIRTHPLACE OF MOTHER

(State or Country)

Utah

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

Elizabeth K. Kellebrant

(Address)

Unknown Ida.

15.

Filed

March 28 19**13**

O B Sturley

Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH

March 28
(Month) (Day)

1913
(Year)

17. I HEREBY CERTIFY, That I attended deceased from **March 28** 19**13**, to **March 28** 19**13**, that I last saw him alive on **March 28** 19**13**, and that death occurred on the date stated above, at **6 A.M.**

The CAUSE OF DEATH follows:

Pentimiles.

(Duration) yrs. mos. ds.

Contributory (Secondary)

(Duration) yrs. mos. ds.

(Signed)

W. Smith W. Allen M. D.
March 28 19**13** (Address) **Pocatello Idaho**

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death yrs. mos. days. In the State **12 hours** yrs. mos. days.

Where was disease contracted if not at place of death

Former or usual residence

Hospital
In home

19. PLACE OF BURIAL OR REMOVAL DATE OF BURIAL

Unknown Ida **March 30** 19**13**

20. UNDERTAKER

ADDRESS

W. B. Walker **Pocatello**

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK--THIS IS A PERMANENT RECORD. N. B.--Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Form V. S. No. 5 20M.1-13-12

STATE OF IDAHO

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics
File No. **4574**

1. PLACE OF DEATH

Registration District No.

County of Bannock

Primary Registration District No.

City of Pocatello

(No. 558 & Arthur St.)

Registered No. 34

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

Richard Buckley

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX

Male

4. COLOR OR RACE

White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED.

Married
(Write the word.)

6. DATE OF BIRTH

Sept

29

1883

(Month)

(Day)

(Year)

7. AGE

77 yrs. 5 mos. 27 ds.

IF LESS than 1 day
how many hrs. or
..... mins.?

8. OCCUPATION

(a) Trade, profession or particular kind of work
(b) General nature of industry, business, or establishment in which employed (or employer)

Retired

9. BIRTHPLACE

(State or Country)

Cork, Ireland

10. NAME OF FATHER

11. BIRTHPLACE OF FATHER

(State or Country)

12. MAIDEN NAME OF MOTHER

13. BIRTHPLACE OF MOTHER

(State or Country)

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

Mrs Julia Murphy

(Address)

Pocatello

15.

Filed

March 27 1913

3

O B Staley

Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH

March

27

1913

(Month)

(Day)

(Year)

17. I HEREBY CERTIFY, That I attended deceased from March 24 1913, to March 27 1913, that I last saw him alive on March 27 1913, and that death occurred on the date stated above, at 2:30 P. M.

The CAUSE OF DEATH* was as follows:

Pneumonia

(Duration)

yrs.

mos.

ds.

Contributory (Secondary)

Carcinoma

(Duration)

yrs.

mos.

ds.

(Signed)

H. A. Castle

M. D.

Mar 18 1913

(Address)

Pocatello, Ida

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death

.....yrs.....mos.....days.

In the State

.....yrs.....mos.....days.

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

St Lewis Cemetery

Mar 31 1913

20. UNDERTAKER

ADDRESS

H. A. Cracker

Pocatello Ida

Form V. S. No. 5 20M.1-16-12

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics
File No. **# 4577**

1. PLACE OF DEATH

Registration District No. **19**

County of **Blaine**

Primary Registration District No. **1002**

City of **Pocatello**

(No. **854**, **V. Arthur** St.)

Registered No. **37**

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

Ray E. Sutton

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX

Male

4. COLOR OR RACE

White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED.

Married
(Write the word.)

6. DATE OF BIRTH

Feb

4

1913

(Month)

(Day)

(Year)

7. AGE

1 yrs. **13** mos. **13** ds.

IF LESS than 1 day
how many hrs. or mins.?

8. OCCUPATION

(a) Trade, profession or particular kind of work

None

(b) General nature of industry business, or establishment in which employed (or employer)

9. BIRTHPLACE

(State or Country)

Pocatello

10. NAME OF FATHER

R. N. Sutton

11. BIRTHPLACE OF FATHER

(State or Country)

Paris Ida.

12. MAIDEN NAME OF MOTHER

Melvina Weaver.

13. BIRTHPLACE OF MOTHER

(State or Country)

Bennington Ida.

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

R. N. Sutton

(Address)

Pocatello

15.

Filed

3/18

191**3**

officer

Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH

March

17

1913

(Month)

(Day)

(Year)

17. I HEREBY CERTIFY, That I attended deceased from

March 15

1913

to **March 17**

1913

that I last saw him alive on **March 17**

1913

and that death occurred on the date stated above, at **6 P. M.**

The CAUSE OF DEATH* was as follows:

Auto Intoxication

(Duration) yrs. mos. ds.

Contributory
(Secondary)

(Duration) yrs. mos. ds.

(Signed)

W. Smith Woodley, M. D.

March 17, 1913 (Address) **Pocatello Ida**

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death. yrs. mos. days. In the State. yrs. mos. days.

Where was disease contracted if not at place of death?

Former or usual residence.

19. PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

Paris Idaho

3/18 1913

20. UNDERTAKER

ADDRESS

R. N. Weaver Pocatello Ida

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Form V. S. No. 5. 12½ M. 7-24-11

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics
File No. 457
Registered No. 52

1. PLACE OF DEATH. Registration District No. 3
County of Lanyon Primary Registration District No. 2005
City of Caldwell (No.) St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME John W. Grimes

If death occurred in a hospital, institution or camp give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX 4. COLOR OR RACE 5. SINGLE, MARRIED, WIDOWED OR DIVORCED.

Male White Single (Write the word.)

6. DATE OF BIRTH

Aug 27 1851
(Month) (Day) (Year)

7. AGE

61 yrs. 8 mos. 13 ds.

IF LESS than 1 day how many hrs. or min?

8. OCCUPATION

(a) Trade, profession or particular kind of work...
(b) General nature of industry business or establishment in which employed (or employer)...

Hotel Keeper

9. BIRTHPLACE

(State or Country)

Kentucky

10. NAME OF FATHER

Carlo Grimes

11. BIRTHPLACE OF FATHER

(State or Country)

Kentucky

12. MAIDEN NAME OF MOTHER

Hannah Tolbert

13. BIRTHPLACE OF MOTHER

(State or Country)

Kentucky

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

B. F. Clay

(Address)

Caldwell, Idaho.

15.

Filed April 11 1913

John S. Meyer
Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH

4 10 1913
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from Jan 16 1913, to Apr. 10 1913

that I last saw him alive on Apr. 8 1913

and that death occurred on the date stated above, at 4:30 M.

The CAUSE OF DEATH* was as follows:

Cardiac Insufficiency

(Duration) yrs. 3 mos. ds.

Contributory (Secondary)

Chronic Hepatitis

(Duration) yrs. mos. ds.

(Signed)

April 11 1913 (Address) Caldwell, Idaho

State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place In the
of death yrs. mos. ds. State yrs. mos. ds.

Where was disease contracted,

If not at place of death?

Former or

usual residence.

19. PLACE OF BURIAL OR REMOVAL DATE OF BURIAL

Lanyon Hills

Apr 12 1913

20. UNDERTAKER

ADDRESS

Platt-Reckham

Caldwell

MARGIN RESERVED FOR BINDING
WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Form V. S. No. 5. 12½ M. 7-24-11

STATE OF IDAHO

1. PLACE OF DEATH. Registrar 3
County of Canyon Primary Registration District No. 2005
City of Miner (No. _____, _____ St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME James T. Davis

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics
File No. 4579
Registered No. 53

If death occurred in a hospital, institution or camp give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX M 4. COLOR OR RACE W 5. SINGLE, MARRIED, WIDOWED OR DIVORCED. married
(Write the word.)

6. DATE OF BIRTH Oct. 25 1857
(Month) (Day) (Year)

7. AGE 62 yrs. 5 mos. 18 ds. IF LESS than 1 day
how many hrs. or
..... min?

8. OCCUPATION
(a) Trade, profession or particular kind of work. Farmer
(b) General nature of industry business or establishment in which employed (or employer)

9. BIRTHPLACE
(State or Country) Mo

10. NAME OF FATHER Hamilton Davis

11. BIRTHPLACE OF FATHER
(State or Country) Don't know

12. MAIDEN NAME OF MOTHER

13. BIRTHPLACE OF MOTHER
(State or Country)

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Mr James T. Davis
(Address) Miner Idaho

15. Filed April 14 1913 John S. Meyer
Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH April 13 1913
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from 191 , to April 13 1913
that I last saw h. in alive on last morning 1913
and that death occurred on the date stated above, at 8 a. M.
The CAUSE OF DEATH* was as follows:

Heart failure
acute dilatation
(Duration) yrs. mos. ds.
Contributory Hypertrophic Sclerosis of
(Secondary) liver
(Duration) 10 yrs. mos. ds.
(Signed) Geo. O. A. Kellogg M. D.
4/13 1913 (Address) Miner Idaho

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents)
At place Copied by John S. Meyer M.D.
of death yrs. mos. ds. State Idaho
Where was disease contracted, Idaho
If not at place of death?
Former or usual residence.

19. PLACE OF BURIAL OR REMOVAL Canyon Hill DATE OF BURIAL 4/15 1913

20. UNDERTAKER W. C. Byer ADDRESS Miner Idaho

MARGIN RESERVED FOR BINDING
WRITE PLAINLY, WITH UNFADEING INK—THIS IS A PERMANENT RECORD. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Form V. S. No. 5. 10M. 6-20-11.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH.

Registration District No. 3

County of Canyon

Primary Registration District No. 2005

File No. 155

City of Caldwell Rural

(No. St.)

Registered No. 54

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

Elmer Maxwell

If death occurred in a hospital, institution or camp give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX

M.

4. COLOR OR RACE

W.

5. SINGLE, MARRIED, WIDOWED OR DIVORCED.

Single.
(Write the word)

6. DATE OF BIRTH

December 3 1893
(Month) (Day) (Year)

7. AGE

19

yrs. mos. ds.

IF LESS than 1 day
how many hrs. or min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work

Signalman

(b) General nature of industry business or establishment in which employed (or employer)

W.R.R.

9. BIRTHPLACE

(State or Country)

Arkansas

10. NAME OF FATHER

J. L. Maxwell

11. BIRTHPLACE OF FATHER

(State or Country)

North Carolina

12. MAIDEN NAME OF MOTHER

Anna Patton

13. BIRTHPLACE OF MOTHER

(State or Country)

North Carolina

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

W. F. Maxwell

(Address)

Caldwell, Idaho

15.

Filed April 28 1913

John S. Meyer
Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

April 17 1913
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from

April 11, 1913, to April 17, 1913

that I last saw him alive on April 17, 1913

and that death occurred on the date stated above, at 7:30 AM

The CAUSE OF DEATH* was as follows:

Lobar Pneumonia

(Duration) yrs. mos. 6 ds.

Contributory (Secondary)

(Duration) yrs. mos. ds.

(Signed) Joseph H. Shaw

18 (Address) Arrowrock

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death yrs. mos. ds. State yrs. mos. ds.

Where was disease contracted.

If not at place of death?

Former or

usual residence

19. PLACE OF BURIAL OR REMOVAL

Caldwell

DATE OF BURIAL

4-19-1913

20. UNDERTAKER

Platt Peckham Co.

ADDRESS

Caldwell

Idaho

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH.

Registration District No. 3County of Canyon
City of CaldwellPrimary Registration District No. 1005

(No. _____, St.)

File No. 1581Registered No. 55

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Colo Grinnitt

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX

4. COLOR OR RACE

5. SINGLE, MARRIED, WID-
OWED OR DIVORCED.Married
(Write the word.)

6. DATE OF BIRTH

April 12 1883
(Month) (Day) (Year)

7. AGE

30 yrs. 13 mos. 13 ds.IF LESS than 1 day
how many _____ hrs. or
_____ mins.?

8. OCCUPATION

(a) Trade, profession or
particular kind of work(b) General nature of industry
business, or establishment in
which employed (or employer)House wife

9. BIRTHPLACE

(State or Country)

Utah10. NAME OF
FATHERColin Henderson11. BIRTHPLACE
OF FATHER

(State or Country)

Indiana12. MAIDEN NAME
OF MOTHERMiss Collins13. BIRTHPLACE
OF MOTHER

(State or Country)

Indiana

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

S. N. Grinnitt

(Address)

Caldwell Idaho

15.

Filed April 27 1913J. S. Meyer
Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH

April 25 1913
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from

March 10 1913, to April 25 1913,that I last saw her alive on April 25 1913,and that death occurred on the date stated above, at 4 P.M.

The CAUSE OF DEATH* was as follows:

I had following operation
for gall stones(Duration) _____ yrs. 1 1/2 mos. _____ ds.

Contributory

(Secondary)

Gall stones

(Duration) _____ yrs. _____ mos. _____ ds.

(Signed)

S. J. Miller

M. D.

4-26-1913 (Address) Caldwell Idaho

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place

of death _____ yrs. _____ mos. _____ days.

In the

State _____ yrs. _____ mos. _____ days.

Where was disease contracted
if not at place of death?Former or
usual residence

19. PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

Is BoisApril 27 1913

20. UNDERTAKER

ADDRESS

W. C. DyerCaldwell

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Form V. S. No. 5 20M.1-16-12

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH.

Registration District No. 3County of CanyonPrimary Registration District No. 1005City of Caldwell

(No. _____, _____ St.)

File No. 4582Registered No. 56

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Carson Lay Willson

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX

male

4. COLOR OR RACE

white

5. SINGLE, MARRIED, WIDOWED OR DIVORCED.

(Write the word.)

6. DATE OF BIRTH

August 8 1828
(Month) (Day) (Year)

7. AGE

84 yrs. 8 mos. 21 ds.IF LESS than 1 day
how many _____ hrs. or
_____ mins.

8. OCCUPATION

(a) Trade, profession or particular kind of work

(b) General nature of industry business, or establishment in which employed (or employer)

Carriage trimmer

9. BIRTHPLACE

(State or Country)

New York

10. NAME OF FATHER

Moses Willson

11. BIRTHPLACE OF FATHER

(State or Country)

12. MAIDEN NAME OF MOTHER

Mary Willson

13. BIRTHPLACE OF MOTHER

(State or Country)

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

Carson Willson

(Address)

Caldwell Idaho

15.

Filed April 30 1913John Meyer
Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH

April 29 1913
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from

April 17 1913, to April 29 1913that I last saw him alive on April 23 1913and that death occurred on the date stated above, at 6 AM

The CAUSE OF DEATH* was as follows:

Refrits

(Duration) _____ yrs. _____ mos. _____ ds.

Contributory
(Secondary)(Duration) 374 yrs. _____ mos. _____ ds.(Signed) Carson M. D.430 1913 (Address) Caldwell Id

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death _____ yrs. _____ mos. _____ days. In the State _____ yrs. _____ mos. _____ days.

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL

Canyon Hill

DATE OF BURIAL

May 1 1913

20. UNDERTAKER

W. B. Dyer

ADDRESS

Caldwell Idaho

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Form V. S. No. 5. 10M. 6-20-11.

1. PLACE OF DEATH
County of Canyon Co.
City of Nampa

Registration District No. 10026
Primary Registration District No. 1006
(No. _____, _____ St.)

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics
File No. 1582
Registered No. 57

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

May Annie Gilley

If death occurred in a hospital, institution or camp give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX 4. COLOR OR RACE 5. SINGLE, MARRIED, WIDOWED OR DIVORCED.

Female White Married
(Write the word.)

6. DATE OF BIRTH

Sept 25 1870
(Month) (Day) (Year)

7. AGE

42 yrs. 6 mos. 12 ds. IF LESS than 1 day
how many _____ hrs. or
min.)

8. OCCUPATION

(a) Trade, profession or particular kind of work
(b) General nature of industry business or establishment in which employed (or employer)

Home keeper

9. BIRTHPLACE

(State or Country)

Frankfort Kansas

10. NAME OF FATHER

Jos Wallace

11. BIRTHPLACE OF FATHER

(State or Country)

Vermont

12. MAIDEN NAME OF MOTHER

Lois Cutter

13. BIRTHPLACE OF MOTHER

(State or Country)

Wisconsin

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) O.R. Meredith
(Address) Nampa Idaho.

15.

Filed April 8 1913 O.B. Bellet
Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

April 7 1913
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from

March 13 1913, to April 7 1913

that I last saw him alive on April 7 1913

and that death occurred on the date stated above, at 9:20 P.M.

The CAUSE OF DEATH* was as follows:

Hyperthymic Chirrhosis
Cardiac hypertrophy

(Duration) 4 yrs. _____ mos. _____ ds.

Contributory
(Secondary)

(Duration) _____ yrs. _____ mos. _____ ds.

(Signed) O.R. Meredith M. D.

April 8 1913 (Address) Nampa Idaho.

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death _____ yrs. _____ mos. 3 ds. State _____ yrs. 5 mos. _____ ds.

Where was disease contracted.

If not at place of death?

Former or

usual residence

Nampa.

19. PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

Hochler Town Apr 8 1913

20. UNDERTAKER

ADDRESS

AB Hellaborga Nampa

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Form V. S. No. 5. 10M. 6-20-11.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH.

Registration District No. 1003

County of

Primary Registration District No. 1006

City of

(No. , St.)

File No. 4581

Registered No. 58

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

Ernest Staley

If death occurred in a hospital, institution or camp give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX

Male

4. COLOR OR RACE

White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED.

Single
(Write the word)

6. DATE OF BIRTH

April

(Month)

(Day)

1907
(Year)

7. AGE

5 yrs. 11 mos. 18 ds.

IF LESS than 1 day
how many . . . hrs. or
min.?

8. OCCUPATION

- (a) Trade, profession or particular kind of work
(b) General nature of industry business or establishment in which employed (or employer)

9. BIRTHPLACE

(State or Country)

Idaho

10. NAME OF FATHER

Ernest M. Staley

11. BIRTHPLACE OF FATHER

(State or Country)

Kaus-

12. MAIDEN NAME OF MOTHER

Emma R. Paschal

13. BIRTHPLACE OF MOTHER

(State or Country)

Kaus-

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

Ernest M. Staley

(Address)

Nampa Ida

15.

Filed

4-13-1913

O. B. Beller M.D.

Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

Apr

(Month)

13

(Day)

1913

(Year)

17. I HEREBY CERTIFY, That I attended deceased from

Apr 10 1913, to Apr 13 1913

that I last saw him alive on Apr 13 1913

and that death occurred on the date stated above, at 7 P. M.

The CAUSE OF DEATH* was as follows:

Cerebral hemorrhage

(Duration) . . . yrs. . . mos. 4 ds.

Contributory
(Secondary)

Valvular heart trouble

(Duration) . . . yrs. 5 yrs. 11 mos. 13 ds.

(Signed)

H. P. Ross M. D.

Apr 14 1913 (Address) Nampa Ida

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death . . . yrs. . . mos. . . ds. In the State . . . yrs. . . mos. . . ds.

Where was disease contracted.

If not at place of death?

Former or usual residence.

19. PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

Kohler Lawn Nampa Ida

Apr 15 - 1913

20. UNDERTAKER

ADDRESS

L. B. Shellsberger

Nampa

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Form V. S. No. 5 20M.1-16-12

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
 Bureau of Vital Statistics
 File No. 4530
 Registered No. 59

1. PLACE OF DEATH.

Registration District No. 3County of CanyonPrimary Registration District No. 2007City of Parma(No. Parl St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

Daisy Deemo

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX

Female

4. COLOR OR RACE

White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED.

married

6. DATE OF BIRTH

10 30 1883
 (Month) (Day) (Year)

7. AGE

29 yrs. 6 mos. 2 ds.IF LESS than 1 day
how many hrs. or
..... mins.?

8. OCCUPATION

(a) Trade, profession or particular kind of work

house wife

(b) General nature of industry business, or establishment in which employed (or employer)

9. BIRTHPLACE

(State or Country)

Iowa

10. NAME OF FATHER

Gus Bowden

11. BIRTHPLACE OF FATHER

(State or Country)

Do not know

12. MAIDEN NAME OF MOTHER

Jenny Ratter
Do not know

13. BIRTHPLACE OF MOTHER

(State or Country)

Do not know

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

Jesse Deemo

(Address)

Parma

15.

Filed

5/11913R. Plumer

Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH

Apr 29 1913
 (Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from

1910, to Apr. 29 1913,that I last saw her alive on Apr. 29 1913,and that death occurred on the date stated above, at 5 P.M.

The CAUSE OF DEATH* was as follows:

Chronic Bronchitis with
Bronchiectasis(Duration) 10 or more yrs. mos. ds.

Contributory (Secondary)

Emphysema & Asthma(Duration) several yrs. mos. ds.

(Signed)

Chas. B. Allen M. D.4-30-1913 (Address) Parma, Ida.

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death yrs. mos. days. In the State yrs. mos. days.

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

Canyon Hill5/1 1913

20. UNDERTAKER

ADDRESS

Walt Hickman CoParma

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Form V, S. No. 5. 12½ M. 7-24-11

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH. Registration District No. 75
County of Shoshone Primary Registration District No. 10
City of Burke (No. _____ St.)

File No. 4586

Registered No. _____

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

George Evans

If death occurred in a hospital, institution or camp give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX M. 4. COLOR OR RACE W 5. SINGLE, MARRIED, WIDOWED OR DIVORCED. Married
(Write the word.)

6. DATE OF BIRTH

_____ 1 _____
(Month) (Day) (Year)

7. AGE

54 yrs. — mos. — ds.

IF LESS than 1 day
how many _____ hrs. or
_____ min?

8. OCCUPATION

(a) Trade, profession or particular kind of work
(b) General nature of industry business or establishment in which employed (or employer)

Miner

9. BIRTHPLACE

(State or Country)

Kentucky

10. NAME OF FATHER

— Evans

11. BIRTHPLACE OF FATHER

(State or Country)

Don't know

12. MAIDEN NAME OF MOTHER

Don't know

13. BIRTHPLACE OF MOTHER

(State or Country)

Don't know

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

Jerry Outman

(Address)

Burke Ida

15.

Filed Jan 25 1913Richard D. Dittman

Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH

Jan 24 1913
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from

Jan 23 1913, to Jan 24 1913

that I last saw him alive on Jan 24 1913

and that death occurred on the date stated above, at 3 P M.

The CAUSE OF DEATH* was as follows:

Tobacco Pneumonia

(Duration) _____ yrs. _____ mos. 10 ds.

Contributory (Secondary)

Alcoholism

(Duration) _____ yrs. _____ mos. _____ ds.

(Signed) Chas. A. Dittman M. D.

Jan 25 1913 (Address) Burke Ida

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place _____ In the _____
of death _____ yrs. _____ mos. _____ ds. State _____ yrs. _____ mos. _____ ds.

Where was disease contracted,

If not at place of death?

Former or

usual residence.

19. PLACE OF BURIAL OR REMOVAL DATE OF BURIAL

Wallace Ida 1/27 1913

20. UNDERTAKER

ADDRESS

H. WardBurke Ida

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Form V. S. No. 5 20M.1-16-12

CERTIFICATE OF DEATH

 State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH.

Registration District No. 25County of ShoshonePrimary Registration District No. 2104File No. 4587City of Pine Creek

(No. _____, St.)

Registered No. _____

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Mildred Edna Bauman

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX

4. COLOR OR RACE

5. SINGLE, MARRIED, WIDOWED OR DIVORCED.

F.W.Infant (Write the word.)

6. DATE OF BIRTH

1
(Month)6
(Day)1913
(Year)

7. AGE

2 yrs. 7 mos. 26 ds.
 IF LESS than 1 day
how many hrs. or mins.?

8. OCCUPATION

(a) Trade, profession or

particular kind of work ✓

(b) General nature of industry

business, or establishment in

which employed (or employer)

9. BIRTHPLACE

(State or Country)

Pine Creek

10. NAME OF FATHER

Phil Bauman

11. BIRTHPLACE OF FATHER

(State or Country)

Mont.

12. MAIDEN NAME OF MOTHER

Lora M. James

13. BIRTHPLACE OF MOTHER

(State or Country)

Wash.

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

(Address)

15.

Filed

Apr 101913R. Char. G. Dethman

Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH

3

(Month)

11

(Day)

1913

(Year)

17. I HEREBY CERTIFY, That I attended deceased from

191, to191,that I last saw h. alive on 191,and that death occurred on the date stated above, at M.

The CAUSE OF DEATH* was as follows:

Nephritis. Caused by exposure
I did not see the child.
 (Duration) yrs. mos. ds.

Contributory

(Secondary)

(Duration)

yrs.

mos.

ds.

(Signed)

J. R. Mason M. D.246 1913 (Address) Kellogg

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place

of death

yrs.

mos.

days.

In the

State

yrs.

mos.

days.

Where was disease contracted if not at place of death?

Former or

usual residence.

19. PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

KelloggMarch 13 1913

20. UNDERTAKER

ADDRESS

Thom HillKellogg

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Form V. S. No. 5. 10M. 6-20-11.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH.

Registration District No. 25

County of Shoshone

Primary Registration District No. 2105

City of Kellogg

(No. _____)

St. _____

Registered No. _____

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Sam Gervy

If death occurred in a hospital, institution or camp give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX M

4. COLOR OR RACE W.

5. SINGLE, MARRIED, WIDOWED OR DIVORCED.
married
(Write the word.)

6. DATE OF BIRTH

(Month) (Day) (Year)

7. AGE 60

yrs.

mos.

ds.

IF LESS than 1 day
how many hrs. or
..... min.?

8. OCCUPATION

- (a) Trade, profession or particular kind of work
(b) General nature of industry business or establishment in which employed (or employer)

Millman

9. BIRTHPLACE

(State or Country)

Genewa

10. NAME OF FATHER

X

11. BIRTHPLACE OF FATHER

(State or Country)

X

12. MAIDEN NAME OF MOTHER

X

13. BIRTHPLACE OF MOTHER

(State or Country)

X

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

Geoff Kenneth

(Address)

Kellogg

15.

Filed Apr 10

1913

D. H. C. DeWitt

Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

Mar

23

1913

(Month)

(Day)

(Year)

17. I HEREBY CERTIFY, That I attended deceased from

1913

to

1913

that I last saw h. X alive on 1913

and that death occurred on the date stated above, at M.

The CAUSE OF DEATH* was as follows:

Branches
Pneumonia

(Duration)

yrs.

mos.

ds.

Contributory (Secondary)

(Duration)

yrs.

mos.

ds.

(Signed)

Geoff Kenneth

M. D.

1913 (Address)

Kellogg

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and 2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents)

At place

In the

of death yrs. mos. ds.

State

yrs. mos. ds.

Where was disease contracted,

If not at place of death?

Former or

usual residence.

19. PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

Harrison Jan

Mar 25 1913

20. UNDERTAKER

B. S. Warstell

ADDRESS

Wallace

MARGIN RESERVED FOR BINDING
WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Form V. S. No. 5. 10M. 6-20-11.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH

Registration District No. 25

County of *Shoshone*

Primary Registration District No. 2105

City of *Keelogg*

(No. *2105* St.)

File No. 4589

Registered No.

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

Math Timmons

If death occurred in a hospital, institution or camp give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX

M

4. COLOR OR RACE

W

5. SINGLE, MARRIED, WIDOWED OR DIVORCED.

single
(Write the word.)

6. DATE OF BIRTH

X

X

1861

(Month)

(Day)

(Year)

7. AGE

52 yrs. — mos. — ds.

IF LESS than 1 day
how many hrs. or
..... min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work
(b) General nature of industry business or establishment in which employed (or employer)

Miner

9. BIRTHPLACE

(State or Country)

High Seas

10. NAME OF FATHER

X *X*

11. BIRTHPLACE OF FATHER

(State or Country)

X *X*

12. MAIDEN NAME OF MOTHER

X *X*

13. BIRTHPLACE OF MOTHER

(State or Country)

X *X*

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

Geo H Kennett

(Address)

Keelogg

15.

Filed *Apr 10* 1913

D. Chas G. Withman

Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

Jan

29

1913

(Month)

(Day)

(Year)

17. I HEREBY CERTIFY, That I attended deceased from

191

to

191

that I last saw him alive on 191

and that death occurred on the date stated above, at M.

The CAUSE OF DEATH* was as follows:

Consumption

(Duration) yrs. mos. ds.

Contributory
(Secondary)

(Duration) yrs. mos. ds.

(Signed) *Geo H Kennett* M. D.

19 (Address) *Keelogg*

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted.

If not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

Keelogg

Feb 3 1913

20. UNDERTAKER

Chas H. Thorndike

ADDRESS

Keelogg

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Form V. S. No. 5 10M. 6-20-11.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics
File No. 459
Registered No. _____

1. PLACE OF DEATH. Registration District No. 75
County of Shoshone Primary Registration District No. 2105
City of Keellogg (No. _____ St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

Effie Lafon

If death occurred in a hospital, institution or camp give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX F 4. COLOR OR RACE W. 5. SINGLE, MARRIED, WIDOWED OR DIVORCED. single
(Write the word.)

6. DATE OF BIRTH

X X 1905
(Month) (Day) (Year)

7. AGE

8 yrs. 0 mos. 0 ds. IF LESS than 1 day how many 0 hrs. or 0 min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work X X
(b) General nature of industry business or establishment in which employed (or employer) X X

9. BIRTHPLACE

(State or Country)

10. NAME OF FATHER

H. C. Lafon

11. BIRTHPLACE OF FATHER

(State or Country)

12. MAIDEN NAME OF MOTHER

13. BIRTHPLACE OF MOTHER

(State or Country)

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Geo. H. Kennett

(Address) Keellogg

15.

Filed Apr 10 1913

Dr. Chas. G. Dethman

Local Registrar

MEDICAL CERTIFICATE OF DEATH

18. DATE OF DEATH

Feb 5 1913
(Month) (Day) (Year)

I HEREBY CERTIFY, That I attended deceased from _____ 191____, to _____ 191____

that I last saw h_____ alive on _____ 191____,

and that death occurred on the date stated above, at _____ M.

The CAUSE OF DEATH* was as follows:

acute rheumatic endocarditis

(Duration) _____ yrs. _____ mos. _____ ds.

Contributory (Secondary)

(Duration) _____ yrs. _____ mos. _____ ds.

(Signed) Geo. H. Kennett M. D.

19. (Address) Keellogg

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death _____ yrs. _____ mos. _____ ds. In the State _____ yrs. _____ mos. _____ ds.

Where was disease contracted.

If not at place of death? _____

Former or

usual residence _____

19. PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

Keellogg

Feb 6 1913

20. UNDERTAKER

ADDRESS

Ed. H. Hain

Keellogg

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Form V. S. No. 5 20M.1-16-12

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH.

Registration District No. *25*

County of *Shoshone*

Primary Registration District No. *7105*

City of *Kellogg*

(No. _____, St.)

Registered No. _____

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME *Arthur E. Hutton*

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX

m

4. COLOR OR RACE

White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED.

Baby
(Write the word.)

6. DATE OF BIRTH

Oct

16

1912

(Month)

(Day)

(Year)

7. AGE

4 yrs. *1* mos. *0* ds.

IF LESS than 1 day
how many _____ hrs. or
_____ mins.?

8. OCCUPATION

(a) Trade, profession or particular kind of work

Baby

(b) General nature of industry, business, or establishment in which employed (or employer)

9. BIRTHPLACE

(State or Country)

Kellogg, Shoshone, Idaho

10. NAME OF FATHER

Clayton Hutton

11. BIRTHPLACE OF FATHER

(State or Country)

Mich.

12. MAIDEN NAME OF MOTHER

B. J. Griffin

13. BIRTHPLACE OF MOTHER

(State or Country)

Mich.

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

(Address)

15.

Filed *Apr 10* 1913

D. C. A. DeHaven
Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH

Feb

14

1913

(Month)

(Day)

(Year)

17. I HEREBY CERTIFY, That I attended deceased from

Feb 13

1913

to

Feb 14

1913

that I last saw him alive on

Feb 13

1913

and that death occurred on the date stated above, at *5 P. M.*

The CAUSE OF DEATH was as follows:

Croup

(Duration) _____ yrs. _____ mos. _____ ds.

Contributory

(Secondary)

(Duration) _____ yrs. _____ mos. _____ ds.

(Signed)

G. R. Mason

M. D.

19 (Address) *Kellogg, Idaho*

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death _____ yrs. _____ mos. _____ days. In the State _____ yrs. _____ mos. _____ days.

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

Kellogg

Feb 16

1913

20. UNDERTAKER

ADDRESS

Thomhill

Kellogg

MARGIN RESERVED FOR BINDING
WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Form V. S. No. 5 20M.1-16-12

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH.

Registration District No. 25

County of Shoshone

Primary Registration District No. 2105

City of Kellogg

(No. _____, St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Harriett Belle Thomas.

File No. 4599

Registered No. _____

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX

F.

4. COLOR OR RACE

W

5. SINGLE, MARRIED, WIDOWED OR DIVORCED.

Infant (Write the word.)

6. DATE OF BIRTH

2 (Month) 15 (Day) 1913 (Year)

7. AGE

_____ yrs. 30 mos. _____ ds.

IF LESS than 1 day
how many _____ hrs. or
_____ mins.?

8. OCCUPATION

(a) Trade, profession or particular kind of work ✓

(b) General nature of industry, business, or establishment in which employed (or employer) _____

9. BIRTHPLACE

(State or Country) Kellogg, Shoshone Co.

10. NAME OF FATHER

L. A. Thomas

11. BIRTHPLACE OF FATHER

(State or Country) Idaho.

12. MAIDEN NAME OF MOTHER

Adeline Barkley

13. BIRTHPLACE OF MOTHER

(State or Country) Wash.

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) _____

(Address) _____

15.

Filed Apr 10 1913

D. H. C. Williams
Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH

3 (Month) 13 (Day) 1913 (Year)

17. I HEREBY CERTIFY, That I attended deceased from

7/15 1913, to 3/13 1913,

that I last saw her alive on 3/13 1913,

and that death occurred on the date stated above, at 11 A.M.

The CAUSE OF DEATH* was as follows:

Jaundice

(Duration) _____ yrs. _____ mos. _____ ds.

Contributory
(Secondary) _____

(Duration) _____ yrs. _____ mos. _____ ds.

(Signed) J. R. Munson M. D.

3/16 1913 (Address) Kellogg.

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death _____ yrs. _____ mos. _____ days. In the State _____ yrs. _____ mos. _____ days.

Where was disease contracted if not at place of death? _____

Former or usual residence _____

19. PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

Kellogg March 15 1913

20. UNDERTAKER

ADDRESS

Thornhill Kellogg

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. PHYSICIANS should be carefully supplied. AGE should be stated EXACTLY. Exact statement of CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Form V. S. No. 5. 10M. 6-20-11.

CERTIFICATE OF DEATH

 State of Idaho
 BOARD OF HEALTH
 Bureau of Vital Statistics

1. PLACE OF DEATH.

Registration District No. 25County of ShoshonePrimary Registration District No. 2105File No. 4593City of Kellogg

(No. _____)

St.)

Registered No. _____

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

Joseph Hardiman

If death occurred in a hospital, institution or camp give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX

M

4. COLOR OR RACE

W.

5. SINGLE, MARRIED, WIDOWED OR DIVORCED.

(Write the word.)

6. DATE OF BIRTH

XX

1

(Month)

(Day)

(Year)

7. AGE

26

yrs.

mos.

ds.

 IF LESS than 1 day
 how many hrs. or
 min.?

8. OCCUPATION

 (a) Trade, profession or particular kind of work
 (b) General nature of industry business or establishment in which employed (or employer)
Laborer - mine

9. BIRTHPLACE

(State or Country)

Chicago, Ill.

10. NAME OF FATHER

11. BIRTHPLACE OF FATHER

(State or Country)

XX

12. MAIDEN NAME OF MOTHER

XX

13. BIRTHPLACE OF MOTHER

(State or Country)

XX

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

(Address)

15.

Filed

Apr 101913D. Char. A. Williams

Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

Jan

(Month)

27

(Day)

1913

(Year)

17. I HEREBY CERTIFY, That I attended deceased from Jan 27 1913, to 191 that I last saw him alive or dead 191 , and that death occurred on the date stated above, at Jan 27 M.

The CAUSE OF DEATH* was as follows:

Crushing injury to chest

(Duration) yrs. mos. ds.

Contributory (Secondary)

(Duration) yrs. mos. ds.

(Signed) Geo H Kemet M. D.Jan 27 1913 (Address) Kellogg

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and 2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted.

If not at place of death?

Former or

usual residence.

19. PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

KelloggJan 31 1913

20. UNDERTAKER

ADDRESS

Edmund

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Form V. S. No. 5. 10M. 6-20-11.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH.

Registration District No. 25County of ShoshonePrimary Registration District No. 2105City of Kellogg(No. Joseph Gregor St.)File No. 4597

Registered No. _____

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

If death occurred in a hospital, institution or camp give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX

4. COLOR OR RACE 5. SINGLE, MARRIED, WID-
OWED OR DIVORCED.(Write the word.) single

6. DATE OF BIRTH

(Month)

(Day)

1

(Year)

7. AGE

28

yrs.

mos.

ds.

IF LESS than 1 day
how many hrs. or
..... min.?

8. OCCUPATION

- (a) Trade, profession or particular kind of work
(b) General nature of industry business or establishment in which employed (or employer)

9. BIRTHPLACE

(State or Country)

10. NAME OF FATHER

11. BIRTHPLACE OF FATHER

(State or Country)

12. MAIDEN NAME OF MOTHER

13. BIRTHPLACE OF MOTHER

(State or Country)

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

(Address)

15.

Filed Apr 10 1913A. Char. G. Williams
Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

Jan
(Month)26
(Day)1913
(Year)

17. I HEREBY CERTIFY, That I attended deceased from

191 , to191

that I last saw him alive on

191

and that death occurred on the date stated above, at

M.

The CAUSE OF DEATH* was as follows:

TuberculosisSeveral months
(Duration) yrs. mos. ds.Contributory
(Secondary)(Signed) Geo. H. Kenneth M. D.
Jan 27 1913 (Address) Kellogg, Idaho

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and 2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place In the
of death yrs. mos. ds. State yrs. mos. ds.

Where was disease contracted,

If not at place of death?

Former or

usual residence

19. PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

Kellogg, IdaJan 26 1913

20. UNDERTAKER

ADDRESS

E. B. HammondKellogg

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. CLANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. ment of OCCUPATION is very important. See instructions on back of certificate.

3YMS-YORK CO., PRINTERS & BINDERS, BOISE 18872

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Form V. S. No. 5. 10M. 6-20-11.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH Registration District No. 25
County of Shoshone Primary Registration District No. 2105
City of Keeloy (No. St.)

File No. 459Registered No.

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

William Leonard Sheehy

If death occurred in a hospital, institution or camp give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX M 4. COLOR OR RACE W 5. SINGLE, MARRIED, WIDOWED OR DIVORCED. Single
(Write the word.)

6. DATE OF BIRTH Feb 20 1897
(Month) (Day) (Year)

7. AGE 16 yrs. mos. ds. IF LESS than 1 day how many hrs. or min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work
(b) General nature of industry business or establishment in which employed (or employer)

Student.

9. BIRTHPLACE
(State or Country)

Mullan Idaho

10. NAME OF FATHER

Jas. B. Sheehy

11. BIRTHPLACE OF FATHER
(State or Country)

America

12. MAIDEN NAME OF MOTHER

Anna E. Murray

13. BIRTHPLACE OF MOTHER
(State or Country)

Montreal Canada

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

(Address)

15.

Filed Apr 10 1913

D. C. W. D. Williams
Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH Feb 4 1913
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from 191 to 191

that I last saw him alive on 191

and that death occurred on the date stated above, at M.

The CAUSE OF DEATH* was as follows:

Accident - crushed by railway train

(Duration) yrs. mos. ds.

Contributory (Secondary)

(Duration) yrs. mos. ds.

(Signed) Chas. R. Murray M. D.

Feb 6 1913 (Address)

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and 2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, If not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL Spokane, Wash DATE OF BURIAL Feb 8 1913

20. UNDERTAKER B. J. Warstell ADDRESS Wallace

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Form V. S. No. 5. 10M. 6-20-11.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH.
County of Shoshone
City of Kellogg

Registration District No. 25
Primary Registration District No. 2105
(No. Wilbur Redding St.)

File No. 159
Registered No. _____

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

Wilbur Redding

If death occurred in a hospital, institution or camp give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX M 4. COLOR OR RACE Wh 5. SINGLE, MARRIED, WIDOWED OR DIVORCED.
married
(Write the word.)

6. DATE OF BIRTH

(Month) (Day) (Year)

7. AGE 37 yrs. 1 mos. 1 ds.
IF LESS than 1 day
how many hrs. or
..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work
(b) General nature of industry business or establishment in which employed (or employer)
Miner

9. BIRTHPLACE
(State or Country)

10. NAME OF FATHER

11. BIRTHPLACE OF FATHER
(State or Country)

12. MAIDEN NAME OF MOTHER

13. BIRTHPLACE OF MOTHER
(State or Country)

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) _____
(Address) _____

15. Filed Apr 10 1913 D. H. G. Williams
Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH
Feb 20 1913
(Month) (Day) (Year)

17. I HEREBY CERTIFY That I attended deceased from _____ 191____, to _____ 191____
that I last saw him _____ 191____,
and that death occurred on the date stated above, at _____ M.
The CAUSE OF DEATH* was as follows:

Accidental - Crushed by
train car.

(Duration) _____ yrs. _____ mos. _____ ds.

Contributory (Secondary)

(Duration) _____ yrs. _____ mos. _____ ds.
Signed Chas. R. Mowery M.D.
Feb 22 1913 (Address) Walla Walla, Wa.

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and 2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death _____ yrs. _____ mos. _____ ds. In the State _____ yrs. _____ mos. _____ ds.
Where was disease contracted, If not at place of death? _____
Former or usual residence _____

19. PLACE OF BURIAL OR REMOVAL Kellogg, Ida. DATE OF BURIAL Feb 23 1913

20. UNDERTAKER E. B. Thornhill ADDRESS Kellogg, Ida.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Form V. S. No. 5. 10M. 6-20-11.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH.

Registration District No. 75

County of

Primary Registration District No. 2105

City of

(No. _____ St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

Mrs. Mary A. Nelson

File No. 459

Registered No. _____

If death occurred in a hospital, institution or camp give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX

F

4. COLOR OR RACE

W

5. SINGLE, MARRIED, WIDOWED OR DIVORCED.

widowed
(Write the word.)

6. DATE OF BIRTH

Do not know

(Month)

(Day)

(Year)

7. AGE

about 80 yrs.

mos.

IF LESS than 1 day
how many hrs. or min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work

(b) General nature of industry business or establishment in which employed (or employer)

9. BIRTHPLACE

(State or Country)

Irene

10. NAME OF FATHER

11. BIRTHPLACE OF FATHER

(State or Country)

12. MAIDEN NAME OF MOTHER

13. BIRTHPLACE OF MOTHER

(State or Country)

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

(Address)

15.

Filed Apr 10 1913

D. Char. A. Nelson
Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

Mar
(Month)15
(Day)1913
(Year)

17. I HEREBY CERTIFY, That I attended deceased from

191

to

191

that I last saw him alive on 191

and that death occurred on the date stated above, at M.

The CAUSE OF DEATH* was as follows:

Old Age Found dead

(Duration) yrs. mos. ds.

Contributory (Secondary)

(Duration) yrs. mos. ds.

(Signed)

Mar 20

1913 (Address)

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and 2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents)

At place

In the

of death yrs. mos. ds. State yrs. mos. ds.

Where was disease contracted.

If not at place of death?

Former or

usual residence.

19. PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

Kellogg, Ida.

Mar 18 1913

20. UNDERTAKER

ADDRESS

E. B. Shanker

Kellogg, Ida.

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Form V. S. No. 5 10M. 6-20-11.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics
File No. 459

1. PLACE OF DEATH. Registration District No. 25
County of Shoshone Primary Registration District No. 2105
City of Kellogg (No. , St.)
If death occurs away from usual residence, give facts called for under special information.

Registered No.
If death occurred in a hospital, institution or camp give its NAME instead of street and number.

2. FULL NAME Jessie Kester

PERSONAL AND STATISTICAL PARTICULARS

3. SEX F. 4. COLOR OR RACE W. 5. SINGLE, MARRIED, WIDOWED OR DIVORCED. married
(Write the word.)

6. DATE OF BIRTH X 1 X
(Month) (Day) (Year)

7. AGE 24 yrs. X mos. X ds. IF LESS than 1 day how many hrs. or min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work Housewife
(b) General nature of industry business or establishment in which employed (or employer)

9. BIRTHPLACE Finland
(State or Country)

10. NAME OF FATHER X

11. BIRTHPLACE OF FATHER X
(State or Country)

12. MAIDEN NAME OF MOTHER X

13. BIRTHPLACE OF MOTHER X
(State or Country)

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

(Address)

15. Filed Apr 10 1913 Dr. Chas. A. Dittman
Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH Mc 18 1913
(Month) (Day) (Year)

17. I HEREBY CERTIFY, that I attended deceased from 191 to 191

that I last saw him alive on 191

and that death occurred on the date stated above, at M.

The CAUSE OF DEATH* was as follows:

Tuberculosis of Lungs

(Duration) yrs. mos. ds.

Contributory (Secondary)

(Duration) yrs. mos. ds.
(Signed) Chas. R. Mowery M. D.
Mar 20 1913 (Address) Wallace St

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and 2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place In the
of death yrs. mos. ds. State yrs. mos. ds.

Where was disease contracted,

If not at place of death?

Former or

usual residence.

19. PLACE OF BURIAL OR REMOVAL Kellogg, Ida DATE OF BURIAL Mc 1913

20. UNDERTAKER E. B. Sharnhill ADDRESS Kellogg

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Form V. S. No. 5. 10M. 6-20-11.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH.

Registration District No. 25

County of

Primary Registration District No. 2105

City of

(No. 1)

St.)

Registered No. 1000

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

If death occurred in a hospital, institution or camp give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX

4. COLOR OR RACE 5. SINGLE, MARRIED, WIDOWED OR DIVORCED.

M

W

married

(Write the word.)

6. DATE OF BIRTH

(Month)

(Day)

1 (Year)

7. AGE

48

yrs.

mos.

ds.

IF LESS than 1 day
how many hrs. or
min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work

(b) General nature of industry business or establishment in which employed (or employer)

Drainman

9. BIRTHPLACE

(State or Country)

America

10. NAME OF FATHER

X

11. BIRTHPLACE OF FATHER

(State or Country)

America

12. MAIDEN NAME OF MOTHER

X

13. BIRTHPLACE OF MOTHER

(State or Country)

X

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

(Address)

15.

Filed Apr 10 1913

D. C. G. Williams
Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

Mar

17

1913

(Month)

(Day)

(Year)

17. I HEREBY CERTIFY, that I attended deceased from

191

to

191

that I last saw him alive on 191

and that death occurred on the date stated above, at M.

The CAUSE OF DEATH* was as follows:

Tuberculosis of Lungs

(Duration)

yrs.

mos.

ds.

Contributory
(Secondary)

(Duration)

yrs.

mos.

ds.

(Signed)

Mar 19 1913

(Address)

Chas. R. Noworym, M. D.
Wallace, Ida

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and 2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place

In the

of death

yrs.

mos.

ds.

State

yrs.

mos.

ds.

Where was disease contracted.

If not at place of death?

Former or

usual residence

19. PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

Kellogg, Ida

Mar 20 1913

20. UNDERTAKER

ADDRESS

E. S. Shanhill

Kellogg, Ida

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

No. 2. FORM. 6-20-11.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH. Registration District No. 75
County of Shoshone Primary Registrar District No. 2105
City of Keelogg (No. Keelogg Hospital St.)
If death occurs away from usual residence, give facts called for under special information.

File No. 4601
Registered No. _____
If death occurred in a hospital, institution or camp give its NAME instead of street and number.

2. FULL NAME Jno. Henry Einhouse

PERSONAL AND STATISTICAL PARTICULARS

3. SEX Male 4. COLOR OR RACE White 5. SINGLE, MARRIED, WIDOWED OR DIVORCED. Widowed
(Write the word.)

6. DATE OF BIRTH See 8 1863
(Month) (Day) (Year)

7. AGE 49 yrs. 0 mos. 0 ds. IF LESS than 1 day how many hrs. or min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work Labourer
(b) General nature of industry business or establishment in which employed (or employer)

9. BIRTHPLACE (State or Country) Batesville, Ind.

10. NAME OF FATHER Jno. H. Einhouse

11. BIRTHPLACE OF FATHER (State or Country) America

12. MAIDEN NAME OF MOTHER X X

13. BIRTHPLACE OF MOTHER (State or Country) America

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Nancy Einhouse
(Address) Keelogg, Idaho

15. Filed Apr 17 1913 Dr. Chas. A. Wetmore
Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH April 8 1913
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from Dec 23d, 1912, to April 8 1913
that I last saw him alive on April 8 1913,
and that death occurred on the date stated above, at 1:10 P.M.

The CAUSE OF DEATH* was as follows:
Myocarditis
Edema of lungs
General anasarca
(Duration) 1 yrs. 0 mos. 0 ds.

Contributory (Secondary) _____
(Duration) _____ yrs. _____ mos. _____ ds.
(Signed) Geo. K. Kuntz M. D.
April 9 1913 (Address) Keelogg

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place Keelogg In the Wardman Hospital
of death _____ yrs. _____ mos. _____ ds. State _____ yrs. _____ mos. _____ ds.
Where was disease contracted, If not at place of death? In Keelogg, Idaho
Former or Keelogg, Idaho
usual residence

19. PLACE OF BURIAL OR REMOVAL DATE OF BURIAL
Coeur d'Alene, Idaho Mar 11 1913
20. UNDERTAKER ADDRESS
Bruce G. Mastee Walla

Form V. S. No. 5 20M.1-16-12

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH.

Registration District No. 25

County of Shoshone

Primary Registration District No. 2106

City of Wardner

(No. St.)

File No. 400

Registered No.

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME William H. Able

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX

M.

4. COLOR OR RACE

W

5. SINGLE, MARRIED, WIDOWED OR DIVORCED.

Married
(Write the word.)

6. DATE OF BIRTH

1 9 1845
(Month) (Day) (Year)

7. AGE

65 yrs. 1 mos. 11 ds.IF LESS than 1 day
how many hrs. or
..... mins.)

8. OCCUPATION

(a) Trade, profession or particular kind of work Had none.(b) General nature of industry, business, or establishment in which employed (or employer) use to farm.

9. BIRTHPLACE

(State or Country) Kentucky

10. NAME OF FATHER

John B. Able.

11. BIRTHPLACE OF FATHER

(State or Country) Kentucky

12. MAIDEN NAME OF MOTHER

Serra Kiper

13. BIRTHPLACE OF MOTHER

(State or Country) Kentucky

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

(Address)

15.

Filed Apr 10 1913 D. Char. G. B. B. B.

Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH

2 20 1913
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from

12/6 1912, to 2/20 1913,
that I last saw him alive on 2/19 1913,
and that death occurred on the date stated above, at M.

The CAUSE OF DEATH* was as follows:

Liver trouble,

(Duration) yrs. mos. ds.

Contributory
(Secondary)

(Duration) yrs. mos. ds.

(Signed) J. R. Neeson M. D.19 (Address) Kellogg

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death yrs. mos. days. In the State yrs. mos. days.

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL | DATE OF BURIAL

Kellogg Feb 23 1913

20. UNDERTAKER

Worstell & Co

ADDRESS

Kellogg

MARGIN RESERVED FOR BINDING
WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Form V. S. No. 5. 10M. 6-20-11.

CERTIFICATE OF DEATH

M. Chapman
State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics
File No. *4503*

1. PLACE OF DEATH.
County of *Shoshone*
City of *Malheur*

Registration District No. *25*
Primary Registration District No. *2106*

(No. *Julia M. Waller* St.)

Registered No. _____

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

Julia M. Waller

If death occurred in a hospital, institution or camp give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX *F* 4. COLOR OR RACE *W.* 5. SINGLE, MARRIED, WIDOWED OR DIVORCED.

(Write the word.)

6. DATE OF BIRTH

Nov. 16 1910
(Month) (Day) (Year)

7. AGE

2 1/2 yrs. — mos. — ds. IF LESS than 1 day how many hrs. or min.?

8. OCCUPATION

- (a) Trade, profession or particular kind of work
(b) General nature of industry business or establishment in which employed (or employer)

9. BIRTHPLACE

(State or Country)

Laskwana, Canada

10. NAME OF FATHER

Lewis Waller

11. BIRTHPLACE OF FATHER

(State or Country)

Murphy, Ill.

12. MAIDEN NAME OF MOTHER

Hannah E. Hutton

13. BIRTHPLACE OF MOTHER

(State or Country)

Calmar, Ill.

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

Geoff Kennell

(Address)

Keelogg

15.

Filed *Apr 10* 191*3*

D. C. G. Dittman
Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

Feb 17 1913
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from _____ 191____, to _____ 191____

that I last saw h_____ alive on _____ 191____,

and that death occurred on the date stated above, at _____ M.

The CAUSE OF DEATH* was as follows:

Lobar Pneumonia

(Duration) _____ yrs. _____ mos. _____ ds.

Contributory (Secondary)

(Duration) _____ yrs. _____ mos. _____ ds.

(Signed) *Geoff Kennell* M. D.

19. (Address) *Keelogg*

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death. _____ yrs. _____ mos. _____ ds. In the State. _____ yrs. _____ mos. _____ ds.

Where was disease contracted.

If not at place of death? _____

Former or

usual residence _____

19. PLACE OF BURIAL OR REMOVAL

Keelogg

DATE OF BURIAL

Feb 8 1913

20. UNDERTAKER

E. B. Kennell

ADDRESS

Keelogg

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Form V. S. No. 5. 12½ M. 7-24-11

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH.

Registration District No. 28

County of *Shoshone*

Primary Registration District No. 2108

City of *Mullan*

(No. _____, _____ St.)

File No. 4601

Registered No. _____

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME *Floren (No name)*

If death occurred in a hospital, institution or camp give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX ☒ 4. COLOR OR RACE 5. SINGLE, MARRIED, WIDOWED OR DIVORCED.

Male

White

Single
(Write the word.)

6. DATE OF BIRTH

Feb
(Month)

15
(Day)

1913
(Year)

7. AGE

— yrs. *—* mos. *34* ds.

IF LESS than 1 day
how many hrs. or
..... min?

8. OCCUPATION

(a) Trade, profession or particular kind of work.
(b) General nature of industry business or establishment in which employed (or employer)

None

9. BIRTHPLACE

(State or Country)

Mullan Idaho

10. NAME OF FATHER

Carl Floren

11. BIRTHPLACE OF FATHER

(State or Country)

Sweden

12. MAIDEN NAME OF MOTHER

Helena Miller

13. BIRTHPLACE OF MOTHER

(State or Country)

Sweden

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

Carl Floren
(Address)

15.

Mullan Idaho

Filed

Apr 10

1913

Bohmer G. Dethman

Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH

March 20 191*3*
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from *March 20* 191*3*, to *March 20* 191*3*

that I last saw him alive on *March 20* 191*3* and that death occurred on the date stated above, at *7 a*. M.

The CAUSE OF DEATH* was as follows:

Acute Bronchitis

(Duration) *—* yrs. *—* mos. *3* ds.

Contributory (Secondary)

(Duration) *—* yrs. *—* mos. *—* ds.

(Signed) *James R. Scan* M. D.

3/20 191*3* (Address) *Mullan Idaho*

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place In the
of death yrs. mos. ds. State yrs. mos. ds.
Where was disease contracted.
If not at place of death?
Former or usual residence.

19. PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

Mullan

March 21 1913

20. UNDERTAKER

ADDRESS

Further

Mullan

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
N. B.—Every item of information should be carefully supplied. AGE should be state EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Form V. S. No. 5. 10M. 6-20-11.

CERTIFICATE

of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH.

Registration District No. _____

County of Shoshone

Primary Registration District No. 2108

File No. 1802

City of Mullan

(No. _____, _____ St.)

Registered No. _____

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME William Harwood

If death occurred in a hospital, institution or camp give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX

Male

4. COLOR OR RACE

White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED.

Widower
(Write the word.)

6. DATE OF BIRTH

Aug 28 1860
(Month) (Day) (Year)

7. AGE

52 6 19
yrs. mos. ds. IF LESS than 1 day how many hrs. or min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work

miller right

(b) General nature of industry business or establishment in which employed (or employer)

9. BIRTHPLACE

(State or Country)

England

10. NAME OF FATHER

unknown

11. BIRTHPLACE OF FATHER

(State or Country)

—

12. MAIDEN NAME OF MOTHER

unknown

13. BIRTHPLACE OF MOTHER

(State or Country)

—

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

Tom Harwood

(Address)

Mullan Ida

15.

Filed

Apr 10

1913

Dr. Chas. G. Dethman

Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

March 17 1913
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from

March 13 1913, to March 17 1913

that I last saw him alive on March 16 1913

and that death occurred on the date stated above, at 4:00 A.M.

The CAUSE OF DEATH* was as follows:

Bronchial Pneumonia

(Duration) _____ yrs. _____ mos. 4 ds.

Contributory (Secondary)

(Duration) _____ yrs. _____ mos. _____ ds.

(Signed) James R. Dean M. D.

March 19 1913 (Address) Mullan Idaho

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death _____ yrs. _____ mos. _____ ds. State _____ yrs. _____ mos. _____ ds.

Where was disease contracted,

If not at place of death?

Former or

usual residence.

19. PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

Mullan

1913

20. UNDERTAKER

ADDRESS

Hardy Undertaking Hallace St.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Form V. S. No. 5. 12½ M. 7-24-11

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH. Registration District No. 25
County of Shoshone Primary Registration District No. 2107
City of Mullan (No. _____, _____ St.)

File No. 4609

Registered No. _____

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

If death occurred in a hospital, institution or camp give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX boy 4. COLOR OR RACE W 5. SINGLE, MARRIED, WIDOWED OR DIVORCED. Single
(Write the word.)

6. DATE OF BIRTH Sept 12 1911
(Month) (Day) (Year)

7. AGE 1 yrs. 5 mos. 15 ds. IF LESS than 1 day how many hrs. or min?

8. OCCUPATION

(a) Trade, profession or particular kind of work. Infant
(b) General nature of industry business or establishment in which employed (or employer)

9. BIRTHPLACE

(State or Country) Mullan

10. NAME OF FATHER

Nels Christerson

11. BIRTHPLACE OF FATHER

(State or Country) Norway

12. MAIDEN NAME OF MOTHER

Jenne Ransstrom

13. BIRTHPLACE OF MOTHER

(State or Country) Sweden

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Dr Ralf

(Address) Mullan

15.

Filed Mar 1 1913

Local Registrar FW Ralf

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH

Feb 27 1913
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from Feb 1 1913, to Feb 27 1913

that I last saw him alive on Feb 27 1913

and that death occurred on the date stated above, at P. M.

The CAUSE OF DEATH* was as follows:

Pneumonia

..... (Duration) yrs. mos. 4 ds.

Contributory (Secondary) Influenza

..... (Duration) yrs. mos. 23 ds.

(Signed) FW Ralf M. D.

Mar 1 1913 (Address) Mullan

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place In the
of death yrs. mos. ds. State yrs. mos. ds.

Where was disease contracted,

If not at place of death?

Former or

usual residence

19. PLACE OF BURIAL OR REMOVAL DATE OF BURIAL

Mullan Ida Mar 2 1913

20. UNDERTAKER

ADDRESS

Ward + Thompson Wallace

Apr 10 - 1913

Dr. H. L. Peterson

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Form V. S. No. 5 20M.1-16-12

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH.

Registration District No. 25

County of Shoshone

Primary Registration District No. 2110

City of Adair

(No. _____, _____ St.)

File No. 4604

Registered No. _____

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME William J. Ward

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX

male

4. COLOR OR RACE

white

5. SINGLE, MARRIED, WIDOWED OR DIVORCED.

divorced
(Write the word.)

6. DATE OF BIRTH

_____ 1 _____
(Month) (Day) (Year)

7. AGE

42 yrs. _____ mos. _____ ds.

IF LESS than 1 day
how many _____ hrs. or
_____ mins.?

8. OCCUPATION

(a) Trade, profession or particular kind of work miner

(b) General nature of industry business, or establishment in which employed (or employer)

9. BIRTHPLACE

(State or Country) Canada

10. NAME OF FATHER

Benjamin Ward

11. BIRTHPLACE OF FATHER

(State or Country) Canada

12. MAIDEN NAME OF MOTHER

M Gullan

13. BIRTHPLACE OF MOTHER

(State or Country) Canada

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

(Address) Rodney, Michigan

15.

Filed Apr 10 1913

In Char. A. Decker
Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH

_____ 3 _____ 18 _____ 1913
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from

_____ 1913, to _____ 1913,

that I last saw h _____ alive on _____ 1913,

and that death occurred on the date stated above, at _____ M.

The CAUSE OF DEATH* was as follows:

Gun shot wound supposed to be murdered

_____ (Duration) _____ yrs. _____ mos. _____ ds.

Contributory
(Secondary)

_____ (Duration) _____ yrs. _____ mos. _____ ds.

(Signed) Chas. R. Mowery

3/18.1913. (Address) Wallace, Idaho

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death _____ yrs. _____ mos. _____ days. In the State _____ yrs. _____ mos. _____ days.

Where was disease contracted if not at place of death?

Former or usual residence _____

19. PLACE OF BURIAL OR REMOVAL

Wallace, Idaho.

DATE OF BURIAL

3/18 1913

20. UNDERTAKER

Bruce G. Waisted

ADDRESS

Wallace

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Form V. S. No. 5. 12½ M. 7-24-11

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH. Registration District No. 16
County of Nez Perce Primary Registration District No. 1009
City of Lewiston (No. Cor 7st & 9 Ave St.)

File No. 4609
Registered No. 40

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

Unknown

If death occurred in a hospital, institution or camp give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX M 4. COLOR OR RACE W 5. SINGLE, MARRIED, WIDOWED OR DIVORCED. Single
(Write the word.)

6. DATE OF BIRTH Unknown
(Month) (Day) (Year)

7. AGE _____ IF LESS than 1 day
_____ yrs. _____ mos. _____ ds. how many _____ hrs. or _____ min?

8. OCCUPATION

- (a) Trade, profession or particular kind of work.....
(b) General nature of industry business or establishment in which employed (or employer)

9. BIRTHPLACE

(State or Country)

Unknown

10. NAME OF FATHER

11. BIRTHPLACE OF FATHER

(State or Country)

12. MAIDEN NAME OF MOTHER

13. BIRTHPLACE OF MOTHER

(State or Country)

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) C. J. Vassar
(Address) Coroner

15.

Filed May 6 1918

L. J. Perkins
Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH

not known 1913
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from _____ 191____, to _____ 191____

that I last saw h _____ alive on _____ 191____

and that death occurred on the date stated above, at _____ M.

The CAUSE OF DEATH* was as follows:

Was called by Policeman Tabor to observe placid death. Cause of death was not found but he personally still believed
(Duration) _____ yrs. _____ mos. _____ ds.

Contributory (Secondary)

(Duration) _____ yrs. _____ mos. _____ ds.

(Signed) C. J. Vassar, Coroner M. D.
19____ (Address)

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place _____ In the _____
of death _____ yrs. _____ mos. _____ ds. State _____ yrs. _____ mos. _____ ds.
Where was disease contracted, _____
If not at place of death? _____
Former or _____
usual residence. _____

19. PLACE OF BURIAL OR REMOVAL DATE OF BURIAL

Lewiston _____ 191____

20. UNDERTAKER

ADDRESS

C. J. Vassar Lewiston

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Form V. S. No. 5. 12½M. 7-24-11

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics
File No. 4611
Registered No. 42

1. PLACE OF DEATH.

County of Key PierceCity of LewistonRegistration District No. 12Primary Registration District No. 1009

(No. _____, _____ St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

James R. Nelson

If death occurred in a hospital, institution or camp give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX

Male

4. COLOR OR RACE

White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED.

Married
(Write the word.)

6. DATE OF BIRTH

April
(Month)6
(Day)1913
(Year)

7. AGE

72 yrs. 5 mos. 6 ds.

IF LESS than 1 day
how many _____ hrs. or
_____ min?

8. OCCUPATION

(a) Trade, profession or particular kind of work
(b) General nature of industry business or establishment in which employed (or employer)

Farmer

9. BIRTHPLACE

(State or Country)

Adams Co Ill

10. NAME OF FATHER

James Nelson

11. BIRTHPLACE OF FATHER

(State or Country)

Don't Know

12. MAIDEN NAME OF MOTHER

Don't Know

13. BIRTHPLACE OF MOTHER

(State or Country)

Don't Know

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

C. B. Nelson

(Address)

Lewiston Idaho

15.

Filed May 6 1913L. J. Perkins

Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH

April
(Month)6
(Day)1913
(Year)

17. I HEREBY CERTIFY, That I attended deceased from

Apr. 1st 1913, to Apr. 6 1913that I last saw him alive on Apr. 5 1913and that death occurred on the date stated above, at 6 A.M.

The CAUSE OF DEATH* was as follows:

Intermittent nephritis..... (Duration) yrs. mos. 10 ds.Contributory
(Secondary)

..... (Duration) yrs. mos. ds.

(Signed) C. Sausier M. D.4/8 1913 (Address) Lewiston

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place In the
of death yrs. mos. ds. State yrs. mos. ds.

Where was disease contracted,
If not at place of death?
Former or
usual residence.....

19. PLACE OF BURIAL OR REMOVAL DATE OF BURIAL

61 Ann Mary1913

20. UNDERTAKER

C. J. Vassar

ADDRESS

Lewiston

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Form V. S. No. 5. 12½ M. 7-24-11

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH.
County of *Nespecke*
City of *Leaverton*

Registration District No. *16*
Primary Registration District No. *1009*
(No. *518*, *3rd* *are.* St.)

File No. *1512*
Registered No. *43*

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

Vinnie J Brooks

If death occurred in a hospital, institution or camp give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX *Female* 4. COLOR OR RACE *White* 5. SINGLE, MARRIED, WIDOWED OR DIVORCED. *Divorced*
(Write the word.)

6. DATE OF BIRTH *January 2 1884*
(Month) (Day) (Year)

7. AGE *29* yrs. *3* mos. *7* ds. IF LESS than 1 day
how many.....hrs. or
.....min?

8. OCCUPATION
(a) Trade, profession or particular kind of work. *attending Business Col.*
(b) General nature of industry business or establishment in which employed (or employer) *Legl*

9. BIRTHPLACE
(State or Country) *Nebraska*

10. NAME OF FATHER *August. Pierstorff*

11. BIRTHPLACE OF FATHER
(State or Country) *Germany*

12. MAIDEN NAME OF MOTHER *Elysa S Mitchell*

13. BIRTHPLACE OF MOTHER
(State or Country) *New Jersey*

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) *Mrs Elysa Pierstorff*
(Address) *Leaverton Idaho*

15. Filed *May 6* 191*3* *S. J. Beckner*
Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH *April 9 1913*
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from *4/8* 1913, to *4/9* 1913
that I last saw h. *is* alive on *4/9* 1913
and that death occurred on the date stated above, at *3:15* A.M.
The CAUSE OF DEATH* was as follows:

Gastrocolitis

(Duration) yrs. mos. ds.
Contributory *Indigestible Food.*
(Secondary)

(Duration) yrs. mos. ds.
(Signed) *L. F. Vassar* M. D.
4/9 1913. (Address) *Leaverton Idaho*

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; (2) whether ACCIDENTAL, SUICIDAL OR HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place In the
of death yrs. mos. ds. State yrs. mos. ds.
Where was disease contracted,
If not at place of death?
Former or
usual residence.....

19. PLACE OF BURIAL OR REMOVAL DATE OF BURIAL

Leaverton *Apr 10 1913*
20. UNDERTAKER ADDRESS

C J Vassar

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Form V. S. No. 5. 12½ M. 7-24-11

CERTIFICATE OF DEATH

State of Idaho

BOARD OF HEALTH
Bureau of Vital StatisticsFile No. 4613Registered No. 43

If death occurred in a hospital, institution or camp give its NAME instead of street and number.

1. PLACE OF DEATH.
County of Nez Perce
City of LewistonRegistration District No. 16
Primary Registration District No. 1009
(No. 1603, 7 Ave. St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Harry C. Livengood

PERSONAL AND STATISTICAL PARTICULARS

3. SEX M 4. COLOR OR RACE W 5. SINGLE, MARRIED, WIDOWED OR DIVORCED. W
(Write the word.)6. DATE OF BIRTH Oct. 6 1893
(Month) (Day) (Year)7. AGE 3 yrs. 0 mos. 0 ds. IF LESS than 1 day
how many.....hrs. or
.....min?

8. OCCUPATION

(a) Trade, profession or particular kind of work. Engineer
(b) General nature of industry business or establishment in which employed (or employer)

9. BIRTHPLACE

(State or Country)

10. NAME OF FATHER G. F. Livengood11. BIRTHPLACE OF FATHER Kans.
(State or Country)12. MAIDEN NAME OF MOTHER Dora. Hays13. BIRTHPLACE OF MOTHER Kans.
(State or Country)

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) A. M. Livengood
(Address)

15.

Filed May 6 1913 R. J. Perkins
Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH April 9th 1913
(Month) (Day) (Year)17. I HEREBY CERTIFY, That I attended deceased from April 9th 1913, to April 9th 1913
that I last saw him alive on April 9th 1913
and that death occurred on the date stated above, at 12:30 P.M.

The CAUSE OF DEATH* was as follows:

Accidental fall causing Concussion of BrainPractically Instant
(Duration) yrs. mos. ds.

Contributory (Secondary)

(Signed) Edgar R. White M. D.
April 9th 1913 (Address) Lewiston, Ida.

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place In the
of death.....yrs.....mos.....ds. State.....yrs.....mos.....ds.
Where was disease contracted,
If not at place of death?.....
Former or
usual residence.....

19. PLACE OF BURIAL OR REMOVAL DATE OF BURIAL

Clarkston Wash Apr. 10 1913

20. UNDERTAKER ADDRESS

C. J. Vassar Lewiston

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Form V. S. No. 5. 12½ M. 7-24-11

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics
File No. 481
Registered No. 44

1. PLACE OF DEATH. Registration District No. 16
County of Myer Primary Registration District No. 1009
City of Barber (No. _____ St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

P. P. Paplinzher

If death occurred in a hospital, institution or camp give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX M 4. COLOR OR RACE W 5. SINGLE, MARRIED, WIDOWED OR DIVORCED. Married
(Write the word.)

6. DATE OF BIRTH not known 1
(Month) (Day) (Year)

7. AGE 38 yrs. _____ mos. _____ ds. IF LESS than 1 day
how many _____ hrs. or _____ min?

8. OCCUPATION

(a) Trade, profession or particular kind of work. conductor
(b) General nature of industry business or establishment in which employed (or employer)

9. BIRTHPLACE

(State or Country) not known

10. NAME OF FATHER

11. BIRTHPLACE OF FATHER

(State or Country)

12. MAIDEN NAME OF MOTHER

13. BIRTHPLACE OF MOTHER

(State or Country)

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) J. B. Harris

(Address) Lawton Idaho

15.

Filed May 6 1913

1913

P. P. Paplinzher
Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH

11 (Month) 10 (Day) 1917 (Year)

17. I HEREBY CERTIFY, That I attended deceased from _____ 1917 to _____ 1917

that I last saw h. _____ alive on _____ 1917
and that death occurred on the date stated above, at 10:30 M.

The CAUSE OF DEATH* was as follows:

Overturning of car going in Clearwater river

_____ (Duration) _____ yrs. _____ mos. _____ ds.

Contributory
(Secondary)

_____ (Duration) _____ yrs. _____ mos. _____ ds.

(Signed) J. B. Harris M. D.

_____ 19 (Address) Lawton Idaho

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place _____ In the _____
of death _____ yrs. _____ mos. _____ ds. State _____ yrs. _____ mos. _____ ds.

Where was disease contracted,

If not at place of death?

Former or

usual residence.

19. PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

Lawton Ida

_____ 1917

20. UNDERTAKER

ADDRESS

C. J. Vassar

Lawton

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Form V. S. No. 5. 12½ M. 7-24-11

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH. Registration District No. 12
County of My Perce Primary Registration District No. 1009
City of Lewiston (No. 607, Snake River St.)

File No. 1015Registered No. 45

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

Lattie May Brooks

If death occurred in a hospital, institution or camp give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX F 4. COLOR OR RACE W 5. SINGLE, MARRIED, WIDOWED OR DIVORCED. Single
(Write the word.)

6. DATE OF BIRTH May 1 1
(Month) (Day) (Year)

7. AGE 10 yrs. 11 mos. 10 ds. IF LESS than 1 day how many.....hrs. or.....min?

8. OCCUPATION

(a) Trade, profession or particular kind of work
(b) General nature of industry business or establishment in which employed (or employer)

schoolgirl

9. BIRTHPLACE

(State or Country)

Peola Wn

10. NAME OF FATHER

L J Brooks

11. BIRTHPLACE OF FATHER

(State or Country)

12. MAIDEN NAME OF MOTHER

Rebecca Anderson

13. BIRTHPLACE OF MOTHER

(State or Country)

Lalif

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

(Address)

William Emerson
607 Lewiston Id.
Snake River

15.

Filed

May 6 1913L J Brooks
Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH

Apr 12 1913
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from March 31 1913, to Apr 12 1913

that I last saw her alive on Apr 12 1913

and that death occurred on the date stated above, at 10 P.M.

The CAUSE OF DEATH* was as follows:

acute subduralitis

(Duration) yrs. mos. 4 ds.

Contributory (Secondary)

Typhoid

(Duration) yrs. mos. 20 ds.

(Signed) C. Samson M. D.

4/14 1913 (Address) Lewiston

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place In the
of death yrs. mos. ds. State yrs. mos. ds.

Where was disease contracted,

If not at place of death?

Former or

usual residence

19. PLACE OF BURIAL OR REMOVAL DATE OF BURIAL

Lewiston Id. Apr 14 1913

20. UNDERTAKER

ADDRESS

C. J. Vassar Lewiston

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Form V. S. No. 5. 12 1/2 M. 7-24-11

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics
File No. **4617**
Registered No. **47**

1. PLACE OF DEATH. Registration District No. **16**
County of **Key River** Primary Registration District No. **1009**
City of **Lewiston** (No. **818**, **4th** St.) St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME **Bill Loin Wilkinson**

If death occurred in a hospital, institution or camp give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX **F** 4. COLOR OR RACE **W** 5. SINGLE, MARRIED, WIDOWED OR DIVORCED. **Single**
(Write the word.)

6. DATE OF BIRTH **April 15 1913**
(Month) (Day) (Year)

7. AGE **3** IF LESS than 1 day
..... yrs. mos. ds. how many hrs. or min?

8. OCCUPATION

(a) Trade, profession or particular kind of work. **None**
(b) General nature of industry business or establishment in which employed (or employer)

9. BIRTHPLACE **Lewiston**
(State or Country)

10. NAME OF FATHER **Claude Wilkinson**

11. BIRTHPLACE OF FATHER **Key River Co Idaho**
(State or Country)

12. MAIDEN NAME OF MOTHER **Myrtle Minions**

13. BIRTHPLACE OF MOTHER **Ogden Utah**
(State or Country)

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) **Claude Wilkinson**
(Address) **Lewiston**

15. Filed **May 6 1913** **L.P. Perkins**
Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH **April 17 1913**
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from **April 15 1913**, to **April 17 1913**
that I last saw him alive on **April 17 1913**
and that death occurred on the date stated above, at **7 PM.**

The CAUSE OF DEATH* was as follows:

Respiratory Inanition

(Duration) yrs. mos. ds.

Contributory **Maternal**
(Secondary)

(Duration) yrs. mos. ds.

(Signed) **J. D. Hurlbut** M. D.
April 15 1913 (Address) **Lewiston Idaho**

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place In the
of death yrs. mos. ds. State yrs. mos. ds.

Where was disease contracted,

If not at place of death?

Former or

usual residence.

19. PLACE OF BURIAL OR REMOVAL DATE OF BURIAL

Lewiston **Apr 18 1913**

20. UNDERTAKER ADDRESS

C. J. Vassar **Lewiston**

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Form V. S. No. 5. 12½ M. 7-24-11

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH. Registration District No. 16
County of Nez Perce Primary Registration District No. 1009
City of Leuciston (No. East Leuciston St.)

File No. 461
Registered No. 48

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

Melby Kenyon

If death occurred in a hospital, institution or camp give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX Male 4. COLOR OR RACE W 5. SINGLE, MARRIED, WIDOWED OR DIVORCED. Married
(Write the word.)

6. DATE OF BIRTH July 5 1913
(Month) (Day) (Year)

7. AGE 70 yrs. 2 mos. 11 ds. IF LESS than 1 day how many hrs. or min?

8. OCCUPATION
(a) Trade, profession or particular kind of work. Farmer
(b) General nature of industry business or establishment in which employed (or employer)

9. BIRTHPLACE Pa.
(State or Country)

10. NAME OF FATHER Thomas Kenyon

11. BIRTHPLACE OF FATHER Vermont
(State or Country)

12. MAIDEN NAME OF MOTHER Cherry

13. BIRTHPLACE OF MOTHER Connecticut
(State or Country)

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) A. E. Kenyon
(Address) _____

15. Filed May 6 1913 L. J. Perkins
Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH Apr. 24 1913
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from Nov. 1912, to Apr. 23 1913
that I last saw him alive on Apr. 24 1913
and that death occurred on the date stated above, at 29 A. M.
The CAUSE OF DEATH* was as follows:

Sclerosis of brain multiple

(Duration) 6 yrs. - mos. - ds.
Contributory Acute military typhoid
(Secondary) enclosed

(Duration) 1 yrs. - mos. - ds.
(Signed) L. J. Perkins M. D.
Apr. 25 1913 (Address) L. J. Perkins

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place In the
of death 6 yrs. - mos. - ds. State Idaho yrs. - mos. - ds.
Where was disease contracted,
If not at place of death?
Former or usual residence _____

19. PLACE OF BURIAL OR REMOVAL Leuciston Idaho DATE OF BURIAL Apr 26 1913

20. UNDERTAKER O. J. Vassar ADDRESS Leuciston

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
 N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Form V. S. No. 5. 12½ M. 7-24-11

* CERTIFICATE OF DEATH

1. PLACE OF DEATH. Registration District No. 16
 County of My Rence Primary Registration District No. 1009
 City of Lewiston (No. _____, _____ St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

Mary Ann Drever

State of Idaho
 BOARD OF HEALTH
 Bureau of Vital Statistics

File No. 1619Registered No. 49

If death occurred in a hospital, institution or camp give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX Female 4. COLOR OR RACE White 5. SINGLE, MARRIED, WIDOWED OR DIVORCED. Widowed
 (Write the word.)

6. DATE OF BIRTH Don't Know
 (Month) (Day) (Year)

7. AGE About 71 or 72 yrs. IF LESS than 1 day
old yrs. mos. ds. how many hrs. or min?

8. OCCUPATION
 (a) Trade, profession or particular kind of work. Lived on Homestead
 (b) General nature of industry business or establishment in which employed (or employer)

9. BIRTHPLACE
 (State or Country) Minnesota

10. NAME OF FATHER Don't Know

11. BIRTHPLACE OF FATHER
 (State or Country) Ireland

12. MAIDEN NAME OF MOTHER Don't Know

13. BIRTHPLACE OF MOTHER
 (State or Country) Ireland

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) J. E. Drever
 (Address) Asotin Wash.

15. May 6 1913 L. J. Perkins
 Filed _____ Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH April 28 1913
 (Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from Apr 26 1913, to Apr 28 1913
 that I last saw h. er alive on Apr 27 1913
 and that death occurred on the date stated above, at S. A. M.

The CAUSE OF DEATH* was as follows:

Gangrene Bright leg & old age.

Don't Know.
 (Duration) yrs. mos. ds.

Contributory (Secondary)

(Signed) David H. Ransom M. D.
Apr 28 1913 (Address) Clarkston Wash.

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death. St Joseph Hospital In the Lewiston Idaho
 yrs. mos. ds. State yrs. mos. ds.
 Where was disease contracted. Asotin Co., Wash.
 If not at place of death? Asotin Co., Wash.
 Former or usual residence. Asotin, Wash.

19. PLACE OF BURIAL OR REMOVAL DATE OF BURIAL

Clarkston, Wash Apr 30 1913

20. UNDERTAKER ADDRESS

Henry Merchant Asotin, Wash.

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Form V. S. No. 5 20M.1-16-12

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH.

Registration District No. 16

County of Nez Perce

Primary Registration District No. 1009

City of Lewiston

(No. 1302, 13 ave St.)

File No. 4021

Registered No. 61

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

T. E. Barker

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX

M

4. COLOR OR RACE

W

5. SINGLE, MARRIED, WIDOWED OR DIVORCED.

(Write the word.)

6. DATE OF BIRTH

May 1 1897
(Month) (Day) (Year)

7. AGE

45 yrs. 11 mos. 25 ds.

IF LESS than 1 day
how many hrs. or mins.

8. OCCUPATION

(a) Trade, profession or particular kind of work

Bank Keeper

(b) General nature of industry business, or establishment in which employed (or employer)

9. BIRTHPLACE

(State or Country)

Connecticut

10. NAME OF FATHER

John Barker

11. BIRTHPLACE OF FATHER

(State or Country)

Ireland

12. MAIDEN NAME OF MOTHER

John Barker

13. BIRTHPLACE OF MOTHER

(State or Country)

Ireland

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

John Barker

(Address)

1302, 13 ave

15.

Filed

May 6

1913

T. E. Barker

Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH

Apr
March 29
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from

June 1912, to March 29 1913
that I last saw him alive on March 28 1913

and that death occurred on the date stated above, at 2:30 P. M.

The CAUSE OF DEATH* was as follows:

Chronic Interstitial Nephritis

(Duration) yrs. mos. ds.

Contributory (Secondary)

(Duration) yrs. mos. ds.

(Signed)

J. P. Hourse M. D.

19 (Address) Lewiston, Idaho

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death yrs. mos. days. In the State yrs. mos. days.

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

Lewiston, Idaho

1913

20. UNDERTAKER

ADDRESS

C. J. Vassar

Lewiston

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Form V. S. No. 5. 12½ M. 7-24-11

CERTIFICATE OF DEATH

1. PLACE OF DEATH. Registration District No. 9
County of Bernmont Primary Registration District No. 2039
City of Hillborn (No. _____, St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Cora M. Wilmore

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics
File No. 462+
Registered No. 40

If death occurred in a hospital, institution or camp give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX 7 4. COLOR OR RACE W 5. SINGLE, MARRIED, WIDOWED OR DIVORCED. Married
(Write the word.)

6. DATE OF BIRTH Sept 15 1913
(Month) (Day) (Year)

7. AGE 5 mos 27 ds IF LESS than 1 day
how many _____ hrs. or _____ min?

8. OCCUPATION
(a) Trade, profession or particular kind of work. Household
(b) General nature of industry business or establishment in which employed (or employer)

9. BIRTHPLACE (State or Country) Idaho

10. NAME OF FATHER H. J. Wilmore

11. BIRTHPLACE OF FATHER (State or Country) Idaho

12. MAIDEN NAME OF MOTHER Mary Z. Parks

13. BIRTHPLACE OF MOTHER (State or Country) Idaho

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) H. J. Wilmore
(Address) Hillborn

15. Apr 10 1913 Ray H. Fisher
Filed _____ Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH Mar 12 1913
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from Mar 1 1913, to Mar 10 1913
that I last saw him alive on Mar 10 1913
and that death occurred on the date stated above, at 8 A. M.
The CAUSE OF DEATH* was as follows:

Pneumo-pneumonia
(Duration) _____ yrs. _____ mos. _____ ds.
Contributory (Secondary) _____
(Duration) _____ yrs. _____ mos. _____ ds.
(Signed) J. R. Shupe M. D.
Mar 10 1913 (Address) Bugor City

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place In the
of death _____ yrs. _____ mos. _____ ds. State _____ yrs. _____ mos. _____ ds.
Where was disease contracted,
If not at place of death? _____
Former or
usual residence _____

19. PLACE OF BURIAL OR REMOVAL Exburg DATE OF BURIAL Mar 14 1913
20. UNDERTAKER John Phillips ADDRESS Exburg

Form V. S. No. 5. 12½ M. 7-24-11

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH. Registration District No. 9
 County of Armstrong Primary Registration District No. 2039
 City of Reiburg (No. _____, _____ St.)

File No. 4625
 Registered No. 39

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

Ada Hergig

If death occurred in a hospital, institution or camp give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX F 4. COLOR OR RACE W 5. SINGLE, MARRIED, WIDOWED OR DIVORCED married
 (Write the word.)

6. DATE OF BIRTH Jan 18 1896
 (Month) (Day) (Year)

7. AGE 67 yrs. 7 mos. 7 ds. IF LESS than 1 day how many _____ hrs. or _____ min?

8. OCCUPATION

- (a) Trade, profession or particular kind of work
 (b) General nature of industry business or establishment in which employed (or employer)

Housewife

9. BIRTHPLACE

(State or Country)

Germany

10. NAME OF FATHER

Don't know

11. BIRTHPLACE OF FATHER

(State or Country)

Germany

12. MAIDEN NAME OF MOTHER

Don't know

13. BIRTHPLACE OF MOTHER

(State or Country)

Germany

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

Mrs. X (Hergig)

(Address)

(Hermok) Reiburg

15.

Filed

Apr 10 1913Ray H. Fisher
Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH

Feb 17 1913
 (Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from Feb 11 1913, to Feb 17 1913 that I last saw him alive on Feb 11 1913

and that death occurred on the date stated above, at 8:30 AM.
 The CAUSE OF DEATH* was as follows:

Myocarditis
Hemiplegia

(Duration) _____ yrs. _____ mos. _____ ds.

Contributory (Secondary)

(Duration) _____ yrs. _____ mos. _____ ds.

(Signed)

R. A. Osmon M. D.
Feb 15 1913 (Address) Reiburg

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place

In the

of death _____ yrs. _____ mos. _____ ds. State _____ yrs. _____ mos. _____ ds.

Where was disease contracted,

If not at place of death?

Former or

usual residence _____

19. PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

BurtonFeb 20 1913

20. UNDERTAKER

ADDRESS

J. R. YoungReiburg

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Form V. S. No. 5. 12½ M. 7-24-11

CERTIFICATE OF DEATH

1. PLACE OF DEATH. Registration District No. 9
County of Formont Primary Registration District No. 5039
City of Sugar (No. _____ St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

Am. Nelson

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics
File No. 1626
Registered No. 38

If death occurred in a hospital, institution or camp give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX M. 4. COLOR OR RACE W. 5. SINGLE, MARRIED, WIDOWED OR DIVORCED. Chief
(Write the word.)

6. DATE OF BIRTH Dec 30 1 91
(Month) (Day) (Year)

7. AGE 2 yrs. 19 mos. 19 ds. IF LESS than 1 day
how many _____ hrs. or _____ min?

8. OCCUPATION

- (a) Trade, profession or particular kind of work
(b) General nature of industry business or establishment in which employed (or employer)

Chief

9. BIRTHPLACE

(State or Country)

Idaho

10. NAME OF FATHER

J. W. Nelson

11. BIRTHPLACE OF FATHER

(State or Country)

Idaho

12. MAIDEN NAME OF MOTHER

Yvessa L. Nieder

13. BIRTHPLACE OF MOTHER

(State or Country)

Idaho

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

(Address)

J. W. Nelson
Sugar City

15.

Filed Apr 10 1913

Ray Fisher
Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH

Feb 18 1913
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from Feb 15 1913, to Feb 18 1913, that I last saw him alive on Feb 17 1913, and that death occurred on the date stated above, at 3 P.M.
The CAUSE OF DEATH* was as follows:

Broncho pneumonia
(Duration) _____ yrs. _____ mos. _____ ds.

Contributory
(Secondary)

(Duration) _____ yrs. _____ mos. _____ ds.
(Signed) J. R. Shupe M. D.
Feb 17 1913 (Address) Sugar City

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place _____ In the _____
of death _____ yrs. _____ mos. _____ ds. State _____ yrs. _____ mos. _____ ds.
Where was disease contracted,
If not at place of death?
Former or
usual residence _____

19. PLACE OF BURIAL OR REMOVAL DATE OF BURIAL

Sugar City Idaho Feb 20 1913

20. UNDERTAKER ADDRESS

John Phillips Rebburg

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Form V. S. No. 5. 12½ M. 7-24-11

CERTIFICATE OF DEATH

State of Idaho

BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH. Registration District No. 9
County of Boise Primary Registration District No. 2039
City of Boise (No. _____, _____ St.)

File No. 462Registered No. 37

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

Kaunino Nakashimo

If death occurred in a hospital, institution or camp give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX Female 4. COLOR OR RACE Jap. 5. SINGLE, MARRIED, WIDOWED OR DIVORCED married
(Write the word.)

6. DATE OF BIRTH Dec 21st 1890
(Month) (Day) (Year)

7. AGE 23 yrs. 7 mos. 25 ds. IF LESS than 1 day how many _____ hrs. or _____ min?

8. OCCUPATION

(a) Trade, profession or particular kind of work
(b) General nature of industry business or establishment in which employed (or employer)

Housewife

9. BIRTHPLACE
(State or Country)

Japan

10. NAME OF FATHER

S. Hosokawa

11. BIRTHPLACE OF FATHER
(State or Country)

Japan

12. MAIDEN NAME OF MOTHER

Unknown

13. BIRTHPLACE OF MOTHER
(State or Country)

Japan

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

(Address)

J. C. SmithBoise

15.

Filed

Apr 10 1913Ray F. Fisher
Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH

Mar 18 1913
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from Mar 15 1913 to Mar 18 1913 that I last saw her alive on Mar 17 1913 and that death occurred on the date stated above, at 12 M. The CAUSE OF DEATH* was as follows:

Myocarditis
indefinite

(Duration) _____ yrs. _____ mos. _____ ds.

Contributory (Secondary)

Pregnancy & abortion

(Duration) _____ yrs. _____ mos. _____ ds.

(Signed)

R. A. Chrisman M. D.

Mar 19 1913 (Address) Boise, Ida.

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place _____ In the _____
of death _____ yrs. _____ mos. _____ ds. State _____ yrs. _____ mos. _____ ds.

Where was disease contracted,
If not at place of death?
Former or
usual residence _____

19. PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

ArcherMar 19 1913

20. UNDERTAKER

ADDRESS

J. R. YoungRexburg

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Form V. S. No. 5. 12½ M. 7-24-11

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics
File No. **4628**
Registered No. **36**

1. PLACE OF DEATH. Registration District No. **9**
County of **Jerome** Primary Registration District No. **2039**
City of **Idaho** (No. _____, _____ St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

Eliza B. Briggs

If death occurred in a hospital, institution or camp give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX **F** 4. COLOR OR RACE **W** 5. SINGLE, MARRIED, WIDOWED OR DIVORCED. **girl**
(Write the word.)
6. DATE OF BIRTH **Feb 10** 1900
(Month) (Day) (Year)

7. AGE **13** yrs. **1** mos. **10** ds. IF LESS than 1 day how many _____ hrs. or _____ min?

8. OCCUPATION

(a) Trade, profession or particular kind of work
(b) General nature of industry business or establishment in which employed (or employer)

Chief

9. BIRTHPLACE

(State or Country)

Idaho

10. NAME OF FATHER

John Briggs

11. BIRTHPLACE OF FATHER

(State or Country)

Idaho

12. MAIDEN NAME OF MOTHER

Sarah E. Gullett

13. BIRTHPLACE OF MOTHER

(State or Country)

Idaho

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

(Address)

James S. Sadowsky
Idaho

15.

Filed

Apr 10 1913

Ray H. Fiske
Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH

March 20 1913
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from **March 8** 1913, to **March 20** 1913 that I last saw him alive on **March 20** 1913 and that death occurred on the date stated above, at **10 A.** M.
The CAUSE OF DEATH* was as follows:

Appendicitis

(Duration) _____ yrs. _____ mos. _____ ds.
Contributory (Secondary)

(Duration) _____ yrs. _____ mos. _____ ds.
(Signed) **J. R. Shupe** M. D.
March 21 1913 (Address) **Pugor City**

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place _____ In the _____
of death _____ yrs. _____ mos. _____ ds. State _____ yrs. _____ mos. _____ ds.
Where was disease contracted,
If not at place of death?
Former or
usual residence _____

19. PLACE OF BURIAL OR REMOVAL DATE OF BURIAL

Idaho **March 21** 1913

20. UNDERTAKER

ADDRESS

John Phillips **Rexburg, Idaho**

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Form V. S. No. 5. 12½ M. 7-24-11

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics1. PLACE OF DEATH.
County of Tremont
City of CubaRegistration District No. 9
Primary Registration District No. 2037
(No. _____, _____ St.)File No. 4639
Registered No. 42

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME William Isaac Douglas

If death occurred in a hospital, institution or camp give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX male 4. COLOR OR RACE W 5. SINGLE, MARRIED, WIDOWED OR DIVORCED. Child
(Write the word.)6. DATE OF BIRTH May 24 1912
(Month) (Day) (Year)7. AGE ten yrs. 0 mos. 0 ds. IF LESS than 1 day how many _____ hrs. or _____ min?

8. OCCUPATION

(a) Trade, profession or particular kind of work Child
(b) General nature of industry business or establishment in which employed (or employer)

9. BIRTHPLACE

(State or Country) Idaho10. NAME OF FATHER Chris Douglas11. BIRTHPLACE OF FATHER Utah
(State or Country)12. MAIDEN NAME OF MOTHER Lena Sweet13. BIRTHPLACE OF MOTHER Idaho
(State or Country)

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) R. S. Mickle
(Address) Cuba, Idaho15. Filed Apr. 10 1913 Raymond
Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH May 30 1913
(Month) (Day) (Year)17. I HEREBY CERTIFY, That I attended deceased from May 4 1913, to May 30 1913 that I last saw him alive on May 26 1913 and that death occurred on the date stated above, at 6 A.M. The CAUSE OF DEATH* was as follows:Pneumo Pneumonia(Duration) _____ yrs. _____ mos. 21 ds.

Contributory (Secondary)

(Duration) _____ yrs. _____ mos. _____ ds.

(Signed) Orin D. Keith M. D.May 30 1913 (Address) Briggs

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place _____ In the _____ of death _____ yrs. _____ mos. _____ ds. State _____ yrs. _____ mos. _____ ds.

Where was disease contracted,

If not at place of death?

Former or

usual residence _____

19. PLACE OF BURIAL OR REMOVAL DATE OF BURIAL

Cuba, Idaho Apr. 1 1913

20. UNDERTAKER ADDRESS

Chas. Churington Briggs

Form V. S. No. 5. 12½ M. 7-24-11

CERTIFICATE OF DEATH

State of Idaho
 BOARD OF HEALTH
 Bureau of Vital Statistics
 File No. 463
 Registered No. 4

1. PLACE OF DEATH. Registration District No. 9
 County of Blaine Primary Registration District No. 2039-7
 City of Hammond (No. _____, _____ St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

Not named

If death occurred in a hospital, institution or camp give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX F 4. COLOR OR RACE W. 5. SINGLE, MARRIED, WIDOWED OR DIVORCED. Mar.
 (Write the word.)

6. DATE OF BIRTH

_____ 1 _____
 (Month) (Day) (Year)

7. AGE

_____ yrs. _____ mos. _____ ds.

IF LESS than 1 day
 how many _____ hrs. or
 _____ min?

8. OCCUPATION

- (a) Trade, profession or particular kind of work
 (b) General nature of industry business or establishment in which employed (or employer)

9. BIRTHPLACE

(State or Country)

Idaho

10. NAME OF FATHER

Robt. Speed

11. BIRTHPLACE OF FATHER

(State or Country)

Wis.

12. MAIDEN NAME OF MOTHER

Addie Overfield

13. BIRTHPLACE OF MOTHER

(State or Country)

Wash.

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

Robt. Speed

(Address)

Hammond, Ind.

15.

Filed Apr. 10 1913

Ray H. Hinkle
 Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH

Mar 18 1913
 (Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from

21 1913, to 1913

that I last saw h. S. alive on Mar 18 1913

and that death occurred on the date stated above, at 9 P. M.

The CAUSE OF DEATH* was as follows:

Mania
Atelactasis

_____ (Duration) _____ yrs. _____ mos. _____ ds.

Contributory
 (Secondary)

Prunella

_____ (Duration) _____ yrs. _____ mos. _____ ds.

(Signed)

W. H. Hinkle M. D.

Mar 18 1913 (Address) Hammond, Ind.

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES state (1) MEANS OF INJURY; (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place _____ In the _____

of death _____ yrs. _____ mos. _____ ds. State _____ yrs. _____ mos. _____ ds.

Where was disease contracted,

If not at place of death?

Former or

usual residence _____

19. PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

DriggsMar 18 1913

20. UNDERTAKER

ADDRESS

O. CherringtonDriggs

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Form V. S. No. 5. 12½ M. 7-24-11

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics
File No. 483
Registered No. 35

1. PLACE OF DEATH. Registration District No. 9
County of Jerome Primary Registration District No. 2037
City of Driggs, Idaho (No. _____, St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

Albert R. Clements

If death occurred in a hospital, institution or camp give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX M 4. COLOR OR RACE W 5. SINGLE, MARRIED, WIDOWED OR DIVORCED. Chief

(Write the word.)

6. DATE OF BIRTH Feb 26 1913
(Month) (Day) (Year)

7. AGE X yrs. 1 mos. 3 ds. IF LESS than 1 day how many.....hrs. or min?

8. OCCUPATION

(a) Trade, profession or particular kind of work.
(b) General nature of industry business or establishment in which employed (or employer)

Baby

9. BIRTHPLACE

(State or Country)

Idaho

10. NAME OF FATHER

M. S. Clements

11. BIRTHPLACE OF FATHER

(State or Country)

Utah

12. MAIDEN NAME OF MOTHER

Sophia Rath

13. BIRTHPLACE OF MOTHER

(State or Country)

Utah

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

M. S. Clements

(Address)

Driggs, Ida

15.

Filed

Apr 10 1913 Ray H. Foster

Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH

Mar 28 1913
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from Mar 29 1913, to Mar 29 1913 that I last saw him alive on Mar 29 1913 and that death occurred on the date stated above, at 530 M. The CAUSE OF DEATH* was as follows:

Broncho pneumonia

(Duration) yrs. mos. 2 ds.

Contributory (Secondary)

(Duration) yrs. mos. ds.

(Signed)

J. W. Reed, M. D.

Mar 28 1913 (Address) Driggs, Ida

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place In the
of death yrs. mos. ds. State yrs. mos. ds.

Where was disease contracted,

If not at place of death?

Former or

usual residence

19. PLACE OF BURIAL OR REMOVAL DATE OF BURIAL

Bates - Idaho Mar 31 1913

20. UNDERTAKER

ADDRESS

C. O. Sherrington Driggs, Ida

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Form V. S. No. 5. 12½ M. 7-24-11

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH. Registration District No. 9 2081
County of Idaho Primary Registration District No. 2038
City of Chester (No. St.)

File No. 16345
Registered No. 45

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

John M. Johnson

If death occurred in a hospital, institution or camp give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX m. 4. COLOR OR RACE w. 5. SINGLE, MARRIED, WIDOWED OR DIVORCED. married
(Write the word.)

6. DATE OF BIRTH Sept. 17 1835
(Month) (Day) (Year)

7. AGE 78 yrs. 6 mos. 8 ds. IF LESS than 1 day how many hrs. or min?

8. OCCUPATION

(a) Trade, profession or particular kind of work.
(b) General nature of industry business or establishment in which employed (or employer)

Farmer

9. BIRTHPLACE

(State or Country)

Norway

10. NAME OF FATHER

Los Johnson

11. BIRTHPLACE OF FATHER

(State or Country)

Norway

12. MAIDEN NAME OF MOTHER

Julie Gunderson

13. BIRTHPLACE OF MOTHER

(State or Country)

Norway

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

E. L. Horgis

(Address)

Ashton

15.

Filed

Apr 10 1913

Ray H. H. H.

Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH

Oct 20 1913
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from Oct 20 1913, to Oct 20 1913 that I last saw him alive on Oct 20 1913

and that death occurred on the date stated above, at 10 A. M.

The CAUSE OF DEATH* was as follows:

Pneumonia
Arterio-sclerosis
Ch. nephritis
Myocarditis
(Duration) 3 yrs. mos. ds.

Contributory (Secondary)

(Duration) 3 yrs. mos. ds.

(Signed) E. L. Horgis M. D.
Oct 20 1913 (Address) Ashton Ida

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; (2) whether ACCIDENTAL, SUICIDAL OR HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place In the
of death yrs. mos. ds. State yrs. mos. ds.
Where was disease contracted,
If not at place of death?
Former or
usual residence

19. PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

Wilford

Oct 20 1913

20. UNDERTAKER

ADDRESS

Frederic

Chester

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Form V. S. No. 5. 12½ M. 7-24-11

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH Registration District No. 9
County of St. Anthony Primary Registration District No. 2038
City of Fremont (No. _____, _____ St.)

File No. 15347
Registered No. 47

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

Mog Labena Murri

If death occurred in a hospital, institution or camp give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX F 4. COLOR OR RACE W 5. SINGLE, MARRIED, WIDOWED OR DIVORCED Widowed
(Write the word.)

6. DATE OF BIRTH Nov 17 1891
(Month) (Day) (Year)

7. AGE 81 yrs. 3 mos. 20 ds. IF LESS than 1 day how many hrs. or min?

8. OCCUPATION

- (a) Trade, profession or particular kind of work.....
(b) General nature of industry business or establishment in which employed (or employer).....

Housewife

9. BIRTHPLACE
(State or Country)

Switzerland

10. NAME OF FATHER

C. Balsiger

11. BIRTHPLACE OF FATHER
(State or Country)

Switzerland

12. MAIDEN NAME OF MOTHER

Mog. Smith

13. BIRTHPLACE OF MOTHER
(State or Country)

Switzerland

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Rudolph Murri
(Address) St. Anthony

15. Filed Apr 10 1913 Ray H. Fisher
Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH Mar 5 1913
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from Jan 30 1913, to Mar 5 1913 that I last saw h. Er alive on Mar 5 1913 and that death occurred on the date stated above, at 3:30 P.M.

The CAUSE OF DEATH* was as follows:

Senility
Stroke
(Duration) yrs. mos. ds.

Contributory
(Secondary)

(Duration) yrs. mos. ds.
(Signed) W. B. West M. D.
Mar 6 1913 (Address) St. Anthony

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place In the
of death yrs. mos. ds. State yrs. mos. ds.
Where was disease contracted,
If not at place of death?
Former or
usual residence.....

19. PLACE OF BURIAL OR REMOVAL DATE OF BURIAL

Wilford Mar 7 1913

20. UNDERTAKER

Friends ADDRESS St. Anthony

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Form V. S. No. 5. 12½ M. 7-24-11

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics
File No. 4635
Registered No. 48

1. PLACE OF DEATH. Registration District No. 9
County of Fremont Primary Registration District No. 2038
City of St. Anthony (No. _____, _____ St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

Ira A. Saeph

If death occurred in a hospital, institution or camp give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX M 4. COLOR OR RACE W. 5. SINGLE, MARRIED, WIDOWED OR DIVORCED. Married.
(Write the word.)

6. DATE OF BIRTH Nov. 7th 1913
(Month) (Day) (Year)

7. AGE 3 yrs. 10 mos. 20 ds. IF LESS than 1 day how many _____ hrs. or _____ min?

8. OCCUPATION
(a) Trade, profession or particular kind of work. Farmer.
(b) General nature of industry business or establishment in which employed (or employer)

9. BIRTHPLACE
(State or Country) Gentry Co. Mo.

10. NAME OF FATHER Alfred Saeph.

11. BIRTHPLACE OF FATHER
(State or Country) Don't know.

12. MAIDEN NAME OF MOTHER Don't know

13. BIRTHPLACE OF MOTHER
(State or Country) Don't know Mrs. Lurella Saeph

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) St. Anthony, Idaho
(Address)

15. Filed Apr. 10 1918 Ray H. Fisher.
Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH Nov. 7 1913
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from Feb. 28 1913, to Nov. 7th 1913 that I last saw him alive on Nov. 7 1913 and that death occurred on the date stated above, at 5 P. M.

The CAUSE OF DEATH* was as follows:

Pyemia

(Duration) 2 yrs. 2 mos. 7 ds.

Contributory (Secondary)

(Duration) _____ yrs. _____ mos. _____ ds.

(Signed) W. D. Yager M. D.

Nov 7th 1913 (Address) St. Anthony

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place In the
of death _____ yrs. _____ mos. _____ ds. State _____ yrs. _____ mos. _____ ds.

Where was disease contracted,
If not at place of death? _____

Former or
usual residence _____

19. PLACE OF BURIAL OR REMOVAL DATE OF BURIAL

St. Anthony Nov 1 1913

20. UNDERTAKER ADDRESS

W. D. Yager St. Anthony

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Form V. S. No. 5. 12½ M. 7-24-11

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics
File No. 463
Registered No. 46

1. PLACE OF DEATH. Registration District No. 9
County of Bernoux Primary Registration District No. 2038
City of St. Anthony (No. _____, _____ St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

Carrie Allen

If death occurred in a hospital, institution or camp give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX W. 4. COLOR OR RACE W. 5. SINGLE, MARRIED, WIDOWED OR DIVORCED. Single
(Write the word.)

6. DATE OF BIRTH mech 8 1913
(Month) (Day) (Year)

7. AGE 1 yrs. 3 mos. 6 ds. IF LESS than 1 day how many _____ hrs. or _____ min?

8. OCCUPATION

(a) Trade, profession or particular kind of work
(b) General nature of industry business or establishment in which employed (or employer)

Babe

9. BIRTHPLACE

(State or Country)

Utah

10. NAME OF FATHER

Julius Allen

11. BIRTHPLACE OF FATHER

(State or Country)

Utah

12. MAIDEN NAME OF MOTHER

Ada Glover

13. BIRTHPLACE OF MOTHER

(State or Country)

Utah

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

(Address)

J. Allen
St. Anthony

15.

Filed

Apr 10 1913 Ray H. Fisher
Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH

mech 8 1913
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from mech 6 1913, to mech 8 1913 that I last saw he alive on mech 7 1913 and that death occurred on the date stated above, at 2a M. The CAUSE OF DEATH* was as follows:

Broncho pneumonia

(Duration) _____ yrs. _____ mos. 6 ds.
Contributory (Secondary)

(Duration) _____ yrs. _____ mos. _____ ds.
(Signed) W. B. West M. D.
mech 9 1913 (Address) St. Anthony

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place _____ In the _____
of death _____ yrs. _____ mos. _____ ds. State _____ yrs. _____ mos. _____ ds.
Where was disease contracted,
If not at place of death?
Former or
usual residence.

19. PLACE OF BURIAL OR REMOVAL

Parker

DATE OF BURIAL

mech 10 1913

20. UNDERTAKER

Frieds

ADDRESS

Parker

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH. Registration District No. 9
 County of Inmont Primary Registration District No. 2040
 City of Regley (No. _____, _____ St.)

File No. 1637
 Registered No. 34

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

Henry L. Morton

If death occurred in a hospital, institution or camp give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX M 4. COLOR OR RACE W 5. SINGLE, MARRIED, WIDOWED OR DIVORCED.
married
 (Write the word.)

6. DATE OF BIRTH Sept. 1875
 (Month) (Day) (Year)

7. AGE 37 yrs. 6 mos. 1 ds. IF LESS than 1 day how many _____ hrs. or _____ min?

8. OCCUPATION

(a) Trade, profession or particular kind of work.
 (b) General nature of industry business or establishment in which employed (or employer)

Photographer

9. BIRTHPLACE

(State or Country)

Utah

10. NAME OF FATHER

John Morton

11. BIRTHPLACE OF FATHER

(State or Country)

Scotland

12. MAIDEN NAME OF MOTHER

Eliiz. Wright

13. BIRTHPLACE OF MOTHER

(State or Country)

Scotland

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

(Address)

J. W. Morton
Ariston-Ida

15.

Filed Apr 10 1913 Ray H. Fisher
 Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH

Apr 5 1913
 (Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from Mar 25 1913, to Apr 5 1913

that I last saw h. i. alive on Apr 5 1913

and that death occurred on the date stated above, at 12:45 P.

The CAUSE OF DEATH* was as follows:

P. Labor
Pneumonia

(Duration) 11 days, mos. _____ ds. _____

Contributory
 (Secondary)

(Duration) _____ yrs. _____ mos. _____ ds. _____

(Signed) H. A. Anderson M. D.
Apr 6 1913 (Address) Regley, Ida

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place _____ In the _____
 of death. _____ yrs. _____ mos. _____ ds. State. _____ yrs. _____ mos. _____ ds.

Where was disease contracted,

If not at place of death?

Former or

usual residence.

19. PLACE OF BURIAL OR REMOVAL DATE OF BURIAL

Regley Apr 8 1913

20. UNDERTAKER ADDRESS

M. J. Fick & Sons Regley, Ida

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Form V. S. No. 5 20M.1-16-12

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH.

Registration District No. 9County of FremontPrimary Registration District No. 2040City of Rigby

(No. _____, _____ St.)

File No. 4638Registered No. 28

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

Frank Calvin La Mayner

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX

M

4. COLOR OR RACE

W.

5. SINGLE, MARRIED, WIDOWED OR DIVORCED.

Bachelor
(Write the word.)

6. DATE OF BIRTH

Sept. 27 1912
(Month) (Day) (Year)

7. AGE

5 yrs. 20 mos. 20 ds.IF LESS than 1 day
how many _____ hrs. or
_____ mins.?

8. OCCUPATION

(a) Trade, profession or particular kind of work

(b) General nature of industry business, or establishment in which employed (or employer)

9. BIRTHPLACE

(State or Country)

Idaho

10. NAME OF FATHER

John La Mayner

11. BIRTHPLACE OF FATHER

(State or Country)

New Jersey

12. MAIDEN NAME OF MOTHER

Eva Irene Fife

13. BIRTHPLACE OF MOTHER

(State or Country)

Idaho

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

Calvin Fife

(Address)

Lewisville - Id.

15.

Filed

Mar 17 1913
Apr 10Ray Stisher

Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH

Mar 15 1913
(Month) (Day) (Year)17. I HEREBY CERTIFY, That I attended deceased from Mar 10 1913, to Mar 15 1913that I last saw him alive on Mar 13 1913and that death occurred on the date stated above, at 5 P. M.

The CAUSE OF DEATH* was as follows:

Pneumonia

(Duration) _____ yrs. _____ mos. _____ ds.

Contributory
(Secondary)

(Duration) _____ yrs. _____ mos. _____ ds.

(Signed)

Ray Stisher

M. D.

Mar 17 1913 (Address) Rigby

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death _____ yrs. _____ mos. _____ days. In the State _____ yrs. _____ mos. _____ days.

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

LewisvilleMar 18 1913

20. UNDERTAKER

ADDRESS

M. J. P. & SonsRigby

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Form V. S. No. 5 20M.1-16-12

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH

Registration District No. 9County of ShoshonePrimary Registration District No. 2040City of Big Sky

(No. _____, St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Oliver Thomas DavisFile No. 4631Registered No. 31

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX

4. COLOR OR RACE

5. SINGLE, MARRIED, WID-
OWED OR DIVORCEDFemaleWhiteMarried
(Write the word.)

6. DATE OF BIRTH

Aug-15 1987
(Month) (Day) (Year)

7. AGE

25 yrs. 7 mos. 9 ds.IF LESS than 1 day
how many _____ hrs. or
_____ mins.

8. OCCUPATION

(a) Trade, profession or
particular kind of work(b) General nature of industry
business, or establishment in
which employed (or employer)Housewife

9. BIRTHPLACE

(State or Country)

Idaho10. NAME OF
FATHERJohn Wesley Minear11. BIRTHPLACE
OF FATHER

(State or Country)

W. Va.12. MAIDEN NAME
OF MOTHERLaura Han13. BIRTHPLACE
OF MOTHER

(State or Country)

Iowa

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

Eva C. Minear

(Address)

Soldier Idaho

15.

Filed

Apr 101913Ray H. Hinkle

Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH

Mar 24 1913
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from

Mar-24 1913, to Mar-24 1913that I last saw him alive on Mar 24 1913and that death occurred on the date stated above, at P.M.

The CAUSE OF DEATH* was as follows:

Post partum hemorrhage; adherent placenta

(Duration) _____ yrs. _____ mos. _____ ds.

Contributory

(Secondary)

Boiled presentation
protracted labor

(Duration) _____ yrs. _____ mos. _____ ds.

(Signed)

Asst. Police and Ray H. Hinkle M. D.Mar 24 1913 (Address) Big Sky Idaho

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death _____ yrs. _____ mos. _____ days. In the State _____ yrs. _____ mos. _____ days.

Where was disease contracted if not at place of death?

Former or usual residence _____

19. PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

Fairfield IdahoMar 27 1913

20. UNDERTAKER

ADDRESS

W. H. HuntIdaho Falls

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Form V. S. No. 5. 12½ M. 7-24-11

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH. Registration District No. 9
County of Jerome Primary Registration District No. 2040
City of Reilly (No. _____ St.)

File No. 4641
Registered No. 53

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

Heron May Greenwell

If death occurred in a hospital, institution or camp give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX m 4. COLOR OR RACE w 5. SINGLE, MARRIED, WIDOWED OR DIVORCED. Married
(Write the word.)

6. DATE OF BIRTH 23 9 Feb 1913
(Month) (Day) (Year)

7. AGE 18 yrs. 18 mos. 18 ds. IF LESS than 1 day how many _____ hrs. or _____ min?

8. OCCUPATION

(a) Trade, profession or particular kind of work
(b) General nature of industry business or establishment in which employed (or employer)

9. BIRTHPLACE

(State or Country)

Idaho

10. NAME OF FATHER

Richard Greenwell

11. BIRTHPLACE OF FATHER

(State or Country)

Utah

12. MAIDEN NAME OF MOTHER

Eli. Chapple

13. BIRTHPLACE OF MOTHER

(State or Country)

Utah

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

Richard Greenwell

(Address)

15.

Filed

Apr. 10. 1913 Ray H. Fisher
Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH

mch. 13 1913.
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from mch. 9 1913, to mch. 13 1913 that I last saw him alive on mch. 13 1913 and that death occurred on the date stated above, at 3:30 M. The CAUSE OF DEATH* was as follows:

Broncho-pneumonia

(Duration) _____ yrs. _____ mos. _____ ds.

Contributory
(Secondary)

(Duration) _____ yrs. _____ mos. _____ ds.

(Signed) A. M. Palmer M. D.
mch. 14 1913 (Address) Reilly, Ida.

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place _____ In the _____
of death _____ yrs. _____ mos. _____ ds. State _____ yrs. _____ mos. _____ ds.
Where was disease contracted,
If not at place of death?
Former or
usual residence _____

19. PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

Reilly mch. 14 1913

20. UNDERTAKER

ADDRESS

M. T. Beck & Sons Reilly, Ida.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Form V. S. No. 5. 12½ M. 7-24-11

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics1. PLACE OF DEATH.
County of *Pringle*
City of *Pringle*Registration District No. _____
Primary Registration District No. *2040*
(No. _____, _____ St.)File No. *464*
Registered No. *32*

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

Doris Bernadette Prophet

If death occurred in a hospital, institution or camp give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX *M* 4. COLOR OR RACE *W* 5. SINGLE, MARRIED, WIDOWED OR DIVORCED. *Born*

(Write the word.)

6. DATE OF BIRTH *Oct. 2 1911*
(Month) (Day) (Year)7. AGE *1* yrs. *6* mos. *-* ds. IF LESS than 1 day how many.....hrs. or.....min?

8. OCCUPATION

(a) Trade, profession or particular kind of work.....
(b) General nature of industry business or establishment in which employed (or employer).....*Baby.*9. BIRTHPLACE
(State or Country)*Idaho.*

10. NAME OF FATHER

*Richard Prophet*11. BIRTHPLACE OF FATHER
(State or Country)*Utah.*

12. MAIDEN NAME OF MOTHER

*Edith Porten*13. BIRTHPLACE OF MOTHER
(State or Country)*England.*

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

Richard Prophet

(Address)

Pringle, Ida.

15.

Filed

*Apr 10 1913**Ray St. Fisher M.D.*
Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH

Nov. 24 1913
(Month) (Day) (Year)17. I HEREBY CERTIFY, That I attended deceased from *Nov 7 1913*, to *Nov 24 1913*that I last saw him alive on *Nov 22 1913*and that death occurred on the date stated above, at *11:00 A.M.*

The CAUSE OF DEATH* was as follows:

Broncho-pneumonia

(Duration) yrs. mos. ds.

Contributory
(Secondary)

(Duration) yrs. mos. ds.

(Signed) *Am. Palmer* M. D.*Nov 25 1913* (Address) *Pringle, Ida.*

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place In the

of death yrs. mos. ds. State yrs. mos. ds.

Where was disease contracted,

If not at place of death?

Former or

usual residence.....

19. PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

*Pringle**Nov 26 1913*

20. UNDERTAKER

ADDRESS

*M. J. Beckers Sons.**Pringle, Ida.*

Form V. S. No. 5. 12½ M. 7-24-11

CERTIFICATE OF DEATH

State of Idaho

BOARD OF HEALTH
Bureau of Vital Statistics1. PLACE OF DEATH. *Yamont*
County of *Yamont*
City of *Annis*Registration District No. _____
Primary Registration District No. *2000*
(No. _____, _____ St.)File No. *1642*
Registered No. *30*

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

Solymare Sylvanus Merrill

If death occurred in a hospital, institution or camp give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX *M* 4. COLOR OR RACE *W* 5. SINGLE, MARRIED, WIDOWED OR DIVORCED.
married
(Write the word.)6. DATE OF BIRTH *Dec 12* 18*90*
(Month) (Day) (Year)7. AGE *77* yrs. *3* mos. *14* ds. IF LESS than 1 day how many _____ hrs. or _____ min?

8. OCCUPATION

(a) Trade, profession or particular kind of work
(b) General nature of industry business or establishment in which employed (or employer)*Former*

9. BIRTHPLACE

(State or Country)

Idaho

10. NAME OF FATHER

Austin Merrill

11. BIRTHPLACE OF FATHER

(State or Country)

Do not know

12. MAIDEN NAME OF MOTHER

Laura Wilder

13. BIRTHPLACE OF MOTHER

(State or Country)

Do not know

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

(Address)

*Elias Merrill**Romney Rd.*

15.

Filed

Apr. 10 191*3**Ray H. Fisher, M.D.*

Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH

Mar. 24 191*3*
(Month) (Day) (Year)17. I HEREBY CERTIFY, That I attended deceased from *May 15* 191*2*, to *Mar 24* 191*3*, that I last saw him alive on *Mar 23* 191*3*, and that death occurred on the date stated above, at *12 P.M.*
The CAUSE OF DEATH* was as follows:*Chronic myocarditis*
and "nephritis"

(Duration) _____ yrs. _____ mos. _____ ds.

Contributory (Secondary)

Drapsy
urritia

(Duration) _____ yrs. _____ mos. _____ ds.

(Signed)

*Ray H. Fisher, M.D.**Mar 24* 191*3* (Address) *Regis Idaho*

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place

In the

of death _____ yrs. _____ mos. _____ ds. State _____ yrs. _____ mos. _____ ds.

Where was disease contracted,

If not at place of death?

Former or

usual residence

19. PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

*Little Butte Cemetery**Mar 25* 191*3*

20. UNDERTAKER

ADDRESS

*M. T. Peck & Sons**Regis Idaho*

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. PHYSICIANS should be stated EXACTLY. Exact statement of CAUSE OF DEATH in plain terms, so that it may be properly classified. See instructions on back of certificate.

Form V. S. No. 5. 12½ M. 7-24-11

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics
File No. **4643**
Registered No. **29**

1. PLACE OF DEATH. Registration District No. **9**
County of _____ Primary Registration District No. **2040**
City of _____ (No. _____, _____ St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME **Dorothy Austin Cole**

If death occurred in a hospital, institution or camp give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX **M.** 4. COLOR OR RACE **W** 5. SINGLE, MARRIED, WIDOWED OR DIVORCED. **Married**
(Write the word.)

6. DATE OF BIRTH **24 of May 1913**
(Month) (Day) (Year)

7. AGE **10** yrs. **10** mos. **—** ds. IF LESS than 1 day how many hrs. or min?

8. OCCUPATION

(a) Trade, profession or particular kind of work.
(b) General nature of industry business or establishment in which employed (or employer)

9. BIRTHPLACE
(State or Country) **Idaho.**

10. NAME OF FATHER **Reuben Cole**

11. BIRTHPLACE OF FATHER
(State or Country) **Utah.**

12. MAIDEN NAME OF MOTHER **Pearl Browning**

13. BIRTHPLACE OF MOTHER
(State or Country) **Idaho.**

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) **Reuben Cole**
(Address) **Annis - Idaho.**

15. **Apr. 10** 191**3** **Ray H. Fisher**
Filed _____ Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH **March 16** 191**3**
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from **May 24** 191**3**, to **March 16** 191**3**, that I last saw him alive on **March 1** 191**3** and that death occurred on the date stated above, at **10:30 P.** M. The CAUSE OF DEATH* was as follows:

Acute indigestion
(Duration) yrs. mos. ds.

Contributory (Secondary) **Mononucleosis**
(Duration) yrs. mos. ds.
(Signed) **Ray H. Fisher** M. D.
3-20 1913 (Address) **Highway - Idaho.**

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place yrs. mos. ds. In the
of death yrs. mos. ds. State yrs. mos. ds.
Where was disease contracted,
If not at place of death?
Former or usual residence.

19. PLACE OF BURIAL OR REMOVAL DATE OF BURIAL

Little Butte Cemetery **March 19** 191**3**

20. UNDERTAKER ADDRESS

Friends. **Annis.**

MARGIN RESERVED FOR BINDING
WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Form V. S. No. 5. 12½ M. 7-24-11

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH.
County of Jerome
City of LaBelle

Registration District No. 2040
Primary Registration District No. 92
(No. _____, _____ St.)

File No. 4642
Registered No. 32

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

Baby Gough (no name)

If death occurred in a hospital, institution or camp give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX M 4. COLOR OR RACE White 5. SINGLE, MARRIED, WIDOWED OR DIVORCED. Babe
(Write the word.)

6. DATE OF BIRTH Feb 26 1913
(Month) (Day) (Year)

7. AGE _____ yrs. _____ mos. _____ ds. IF LESS than 1 day how many _____ hrs. or _____ min?

8. OCCUPATION

(a) Trade, profession or particular kind of work
(b) General nature of industry business or establishment in which employed (or employer)

9. BIRTHPLACE
(State or Country)

Idaho

10. NAME OF FATHER

Mrs. J. Gough

11. BIRTHPLACE OF FATHER
(State or Country)

Utah

12. MAIDEN NAME OF MOTHER

Moranda Jenkins

13. BIRTHPLACE OF MOTHER
(State or Country)

Utah

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Mrs. J. Gough
(Address) LaBelle Ida

15.

Filed Apr 10 1913 Ray Fisher
Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH

Feb. 26 1913
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from

Feb 26 1913, to Feb 26 1913

that I last saw him alive on Feb 26 1913

and that death occurred on the date stated above, at 8 P. M.

The CAUSE OF DEATH* was as follows:

5 mo. Ultra-gestation

(Duration) _____ yrs. _____ mos. _____ ds.

Contributory (Secondary)

(Duration) _____ yrs. _____ mos. _____ ds.

(Signed) H. A. Anderson M. D.

Feb 26 1913 (Address) Highway 200

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place _____ In the _____
of death _____ yrs. _____ mos. _____ ds. State _____ yrs. _____ mos. _____ ds.

Where was disease contracted,
If not at place of death?

Former or usual residence.

19. PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

LaBelle Feb 27 1913

20. UNDERTAKER

ADDRESS

Friends LaBelle

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Form V. S. No. 5. 12½ M. 7-24-11

CERTIFICATE OF DEATH

1. PLACE OF DEATH.
County of Princeton
City of Dubois

Registration District No. 9
Primary Registration District No. 2040
(No. _____, _____ St.)

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics
File No. 4647
Registered No. 57

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

Frank Troy

If death occurred in a hospital, institution or camp give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX M 4. COLOR OR RACE W 5. SINGLE, MARRIED, WIDOWED OR DIVORCED. Single
(Write the word.)

6. DATE OF BIRTH 1 Nov 17 1888
(Month) (Day) (Year)

7. AGE 26 yrs. 29 mos. 29 ds. IF LESS than 1 day how many hrs. or min?

8. OCCUPATION

(a) Trade, profession or particular kind of work.
(b) General nature of industry business or establishment in which employed (or employer)

Tanner

9. BIRTHPLACE

(State or Country)

Mea.

10. NAME OF FATHER

Alva Troy

11. BIRTHPLACE OF FATHER

(State or Country)

Mich.

12. MAIDEN NAME OF MOTHER

Mary Barker

13. BIRTHPLACE OF MOTHER

(State or Country)

Ida.

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

Geo. F. Troy

(Address)

Dubois - Ida

15.

Filed

Apr 10 1913

Ray H. Fisher

Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH

Nov 13 1913
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from 191 to 191

that I last saw him alive on 191 and that death occurred on the date stated above, at 4 P. M.

The CAUSE OF DEATH* was as follows:

Back broken by falling tree.

(Duration) _____ yrs. _____ mos. _____ ds.

Contributory (Secondary)

(Duration) _____ yrs. _____ mos. _____ ds.

(Signed) N. Physician L. D. Key M. D.

Nov 13 1913 (Address) Dubois, Idaho

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place _____ In the _____
of death _____ yrs. _____ mos. _____ ds. State _____ yrs. _____ mos. _____ ds.

Where was disease contracted, If not at place of death?

Former or usual residence _____

19. PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

Dubois - Ida.

Nov 13 1913

20. UNDERTAKER

ADDRESS

L. H. Hunt

Ida. Falls

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
N. B.—Every item of information should be carefully supplied. AGE should be state EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Form V. S. No. 5. 10M. 6-20-11.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH.

Registration District No. 20County of ElmorePrimary Registration District No. 2021City of Glenn's Ferry

(No. _____ St.)

File No. 4648Registered No. 15

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

Eric Anderson

If death occurred in a hospital, institution or camp give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX

4. COLOR OR RACE

5. SINGLE, MARRIED, WIDOWED OR DIVORCED.

MalewhiteSingle
(Write the word.)

6. DATE OF BIRTH

(Month) _____ (Day) _____ (Year) _____

7. AGE

IF LESS than 1 day

how many _____ hrs. or _____ min. >

_____ yrs. _____ mos. _____ ds.

8. OCCUPATION

(a) Trade, profession or particular kind of work

laborer

(b) General nature of industry business or establishment in which employed (or employer)

9. BIRTHPLACE

(State or Country)

Norway & Sweden

10. NAME OF FATHER

11. BIRTHPLACE OF FATHER

(State or Country)

12. MAIDEN NAME OF MOTHER

13. BIRTHPLACE OF MOTHER

(State or Country)

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

H. H. Easton coroner

(Address)

W. H. McCalla,

15.

Filed

4/181913W. B. Masher

Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

April

(Month)

17th

(Day)

1913

(Year)

17. I HEREBY CERTIFY, That I attended deceased from

191____, to 191____

that I last saw h_____ alive on 191____,

and that death occurred on the date stated above, at _____ M.

The CAUSE OF DEATH* was as follows:

Alcoholism (acute)

(Duration) _____ yrs. _____ mos. _____ ds.

Contributory
(Secondary)

(Duration) _____ yrs. _____ mos. _____ ds.

(Signed)

H. H. Easton coroner4/18 1913 (Address) W. H. McCalla, Ida.

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death _____ yrs. _____ mos. _____ ds. State _____ yrs. _____ mos. _____ ds.

Where was disease contracted,

If not at place of death?

Former or

usual residence

19. PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

Glenns Ferry cemetery4/18 1913

20. UNDERTAKER

ADDRESS

H. H. Easton coronerW. H. McCalla

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Form V. S. No. 5. 10M. 6-20-11.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH.

Registration District No. 20

County of Elmore

Primary Registration District No. 2020

City of Minidoka

(No. _____ St.)

File No. 4649

Registered No. 13

If death occurs away from usual residence, give facts called for under special information.

If death occurred in a hospital, institution or camp give its NAME instead of street and number.

2. FULL NAME Thomas M. Lynch

PERSONAL AND STATISTICAL PARTICULARS

3. SEX

4. COLOR OR RACE 5. SINGLE, MARRIED, WIDOWED OR DIVORCED.

M

W

(Write the word.)

6. DATE OF BIRTH

July

25

1911

(Month)

(Day)

(Year)

7. AGE

1

yrs.

9

mos.

ds.

IF LESS than 1 day
how many hrs. or
..... min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work

(b) General nature of industry business or establishment in which employed (or employer)

9. BIRTHPLACE

(State or Country)

Idaho

10. NAME OF FATHER

Burgess M. Lynch

11. BIRTHPLACE OF FATHER

(State or Country)

Idaho

12. MAIDEN NAME OF MOTHER

Catherine Walsh

13. BIRTHPLACE OF MOTHER

(State or Country)

Idaho

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) W. L. Frazer

(Address) Minidoka

15.

Filed April 26th 1913

B. W. Mather

Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

4

(Month)

25

(Day)

1913

(Year)

17. I HEREBY CERTIFY, That I attended deceased from

4-17 1913, to 4-25 1913

that I last saw him alive on 4-25 1913,

and that death occurred on the date stated above, at 1 P. M.

The CAUSE OF DEATH* was as follows:

Enteritis, Pneumonia with effusion

(Duration) yrs. mos. 12 ds.

Contributory (Secondary)

(Duration) yrs. mos. ds.

(Signed) W. L. Frazer M. D.

4-26 1913 (Address) Minidoka

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted,

If not at place of death?

Former or

usual residence.

19. PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

Mountain Home

April 27th 1913

20. UNDERTAKER

ADDRESS

J. M. Cowen

Mountain Home

WHITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

N. B.—Every item of information should be carefully supplied. AGE should be state EXACTLY. Exact state-

Form V. S. No. 5. 1

1. PLACE OF DEATH. Registration District No. 2021 Bureau of Vital Statistics
 County of Elmore Primary Registration District No. 2021 File No. 1659
 City of Elmer's Ferry (No. _____, St.) Registered No. 14
 If death occurs away from usual residence, give facts called for under special information. 2. FULL NAME Not known
 If death occurred in a hospital, institution or camp give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX Male 4. COLOR OR RACE white 5. SINGLE, MARRIED, WID-
 OWED OR DIVORCED. Not known
 (Write the word.)

6. DATE OF BIRTH Not known
 (Month) (Day) (Year)

7. AGE about not known IF LESS than 1 day
4.0 yrs. — mos. — ds. how many — hrs. or
— min.)

8. OCCUPATION

(a) Trade, profession or particular kind of work
 (b) General nature of industry business or establishment in which employed (or employer) not known

9. BIRTHPLACE (State or Country) not known

10. NAME OF FATHER not known

11. BIRTHPLACE OF FATHER (State or Country) not known

12. MAIDEN NAME OF MOTHER not known

13. BIRTHPLACE OF MOTHER (State or Country) not known

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) H. H. Ector
 (Address) Watahoma, Ida

15. Bev Mather
J. W. Davis M. D.
 Local Registrar
 Filed April 19th 1913

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH Not known probably about Apr 12th 1913
 (Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from
 191—, to 191—

that I last saw h — alive on 191—

and that death occurred on the date stated above, at — M.

The CAUSE OF DEATH* was as follows:

drowned in Snake River

(Duration) — yrs. — mos. — ds.

Contributory (Secondary) —

(Duration) — yrs. — mos. — ds.

(Signed) H. H. Ector M. D.

Apr 19 1913 (Address) Watahoma, Ida

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death — yrs. — mos. — ds. In the State — yrs. — mos. — ds.

Where was disease contracted.

If not at place of death?

Former or usual residence —

19. PLACE OF BURIAL OR REMOVAL, DATE OF BURIAL

King Hill, Ida

April 19th 1913

20. UNDERTAKER

H. H. Ector coroner

ADDRESS

Watahoma

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Form V. S. No. 5. 12½ M. 7-24-11

CERTIFICATE OF DEATH

1. PLACE OF DEATH. Registration District No. 15
County of Idaho Primary Registration District No. 2064
City of Kenilworth (No. _____ St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

Edwin Randall

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

File No. 1151Registered No. 52

If death occurred in a hospital, institution or camp give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX Male 4. COLOR OR RACE White 5. SINGLE, MARRIED, WIDOWED OR DIVORCED. Widower
(Write the word.)

6. DATE OF BIRTH Dec. 26, 1835
(Month) (Day) (Year)

7. AGE 77 yrs. 4 mos. 3 ds. IF LESS than 1 day how many _____ hrs. or _____ min?

8. OCCUPATION
(a) Trade, profession or particular kind of work. Farmer
(b) General nature of industry business or establishment in which employed (or employer)

9. BIRTHPLACE
(State or Country) Illinois

10. NAME OF FATHER Jesse Randall

11. BIRTHPLACE OF FATHER
(State or Country) New York

12. MAIDEN NAME OF MOTHER Sarah Bridall

13. BIRTHPLACE OF MOTHER
(State or Country) Ohio

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) V. A. Randall
(Address) Heary Idaho

15. Filed April 30, 1913 J. E. Hoyt
Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH April 29, 1913
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from April 24th, 1913, to April 29th, 1913, that I last saw him alive on April 29th, 1913 and that death occurred on the date stated above, at 4 P. M. The CAUSE OF DEATH* was as follows:

Uraemic Poisoning

(Duration) _____ yrs. _____ mos. 7 ds.
Contributory (Secondary) chronic cystitis

(Duration) 10 yrs. _____ mos. _____ ds.
(Signed) W. A. Randall M. D.
April 30th, 1913. (Address) Kenilworth Idaho

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place In the
of death _____ yrs. _____ mos. _____ ds. State _____ yrs. _____ mos. _____ ds.
Where was disease contracted,
If not at place of death? _____
Former or
usual residence _____

19. PLACE OF BURIAL OR REMOVAL Good Ida DATE OF BURIAL Apr 30, 1913

20. UNDERTAKER D. J. Rowlands ADDRESS Kenilworth Ida

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Form V. S. No. 5. 12½ M. 7-24-11

CERTIFICATE OF DEATH

1. PLACE OF DEATH. Registration District No. 15
County of Latah Primary Registration District No. 2064
City of near Kendrick (No. _____, _____ St.)

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics
File No. 4652
Registered No. 51

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Mrs. Senishia Donica

If death occurred in a hospital, institution or camp give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX F 4. COLOR OR RACE W 5. SINGLE, MARRIED, WIDOWED OR DIVORCED. Married
(Write the word.)

6. DATE OF BIRTH Feb 7 1867
Feb 13 1913
(Month) (Day) (Year)

7. AGE 45 yrs. 4 mos. 13 ds. IF LESS than 1 day how many _____ hrs. or _____ min?

8. OCCUPATION

(a) Trade, profession or particular kind of work.

(b) General nature of industry business or establishment in which employed (or employer)

Housewife

9. BIRTHPLACE

(State or Country)

Kentucky

10. NAME OF FATHER

Franklin Long

11. BIRTHPLACE OF FATHER

(State or Country)

Ky

12. MAIDEN NAME OF MOTHER

Turner

13. BIRTHPLACE OF MOTHER

(State or Country)

Ky

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

Joe Donica (son)

(Address)

Southwick Id.

15.

Filed April 14 1913J. E. Hoyt
Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH

April 13 1913
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from April 2 1913, to April 13 1913

that I last saw h. er. alive on April 10 1913

and that death occurred on the date stated above, at 10 P M.

The CAUSE OF DEATH* was as follows:

cerebral hemorrhage

(Duration) _____ yrs. _____ mos. 11 ds.

Contributory arterio-sclerosis +
(Secondary) nephritis several years

(Duration) _____ yrs. _____ mos. _____ ds.

(Signed) J. E. Hoyt M. D.

April 14 1913 (Address) Kendrick Id.

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place _____ In the _____
of death _____ yrs. _____ mos. _____ ds. State _____ yrs. _____ mos. _____ ds.

Where was disease contracted,

If not at place of death?

Former or

usual residence.

19. PLACE OF BURIAL OR REMOVAL DATE OF BURIAL

Southwick Id. April 15 1913

20. UNDERTAKER

ADDRESS

none

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Form V. S. No. 5. 12½ M. 7-24-11

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH. Registration District No. 15
County of Latah Primary Registration District No. 2063
City of Genesee (No. _____, _____ St.)

File No. 4654-8
Registered No. 58

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

Thomas Lenehan

If death occurred in a hospital, institution or camp give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX male 4. COLOR OR RACE white 5. SINGLE, MARRIED, WIDOWED OR DIVORCED
married
(Write the word.)

6. DATE OF BIRTH June 20 1896
(Month) (Day) (Year)

7. AGE 67 yrs. 8 mos. 4 ds. IF LESS than 1 day
how many _____ hrs. or _____ min?

8. OCCUPATION

(a) Trade, profession or particular kind of work. Farmer.
(b) General nature of industry business or establishment in which employed (or employer)

9. BIRTHPLACE

(State or Country) Ireland

10. NAME OF FATHER

Corneal Lenehan

11. BIRTHPLACE OF FATHER

(State or Country) Ireland

12. MAIDEN NAME OF MOTHER

Margaret Foley.

13. BIRTHPLACE OF MOTHER

(State or Country) Ireland

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Genesee Ida(Address) Mrs. A. Murphy

15.

Filed 3-5- 1913W. J. Jones
Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH

March 4 1913
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from July 19 1912, to March 4 1913
that I last saw him alive on Feb 28 1913
and that death occurred on the date stated above, at 8 P.M.

The CAUSE OF DEATH* was as follows:

Chronic Interstitial Nephritis

(Duration) 2 yrs. _____ mos. _____ ds.

Contributory Sarcoma, jaw.
(Secondary)

(Duration) _____ yrs. 7 mos. 15 ds.

(Signed) J. M. Call M. D.
March 5, 1913 (Address) Genesee Idaho

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place _____ yrs. _____ mos. _____ ds. In the _____

of death. _____ yrs. _____ mos. _____ ds. State _____ yrs. _____ mos. _____ ds.

Where was disease contracted, If not at place of death? _____

Former or usual residence. _____

19. PLACE OF BURIAL OR REMOVAL DATE OF BURIAL

Catholic Cemetery 3/6 1913

20. UNDERTAKER ADDRESS

J. E. Lambert Genesee

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Form V. S. No. 5. 12½M.7-24-11

CERTIFICATE OF DEATH

1. PLACE OF DEATH. Registration District No. 13
County of Bacon Primary Registration District No. 7063
City of Genesee (No. _____, St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Bette Ellen Moore Ellis

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics
File No. 4654
Registered No. 59

If death occurred in a hospital, institution or camp give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX Female 4. COLOR OR RACE White 5. SINGLE, MARRIED, WIDOWED OR DIVORCED. widow
(Write the word.)

6. DATE OF BIRTH August 14 1841
(Month) (Day) (Year)

7. AGE 72 yrs. 2 mos. 5 ds. IF LESS than 1 day how many _____ hrs. or _____ min?

8. OCCUPATION

(a) Trade, profession or particular kind of work. Housewife

(b) General nature of industry business or establishment in which employed (or employer)

9. BIRTHPLACE

(State or Country) Tennessee10. NAME OF FATHER Moore

11. BIRTHPLACE OF FATHER

(State or Country) Tennessee

12. MAIDEN NAME OF MOTHER

13. BIRTHPLACE OF MOTHER

(State or Country) Tennessee

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

(Address) Mrs C. of Abrams Hellyer

15.

Filed apr 14 1913

W. H. Ehem
Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH

April 13 1913
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from April 7 1913, to April 13 1913
that I last saw her alive on April 13 1913
and that death occurred on the date stated above, at 8 A.M.

The CAUSE OF DEATH* was as follows:

myocarditis(Duration) 7 yrs. — mos. — ds.

Contributory (Secondary)

Hemiplegia

(Duration) — yrs. — mos. — ds.

(Signed)

James C. Ellis M. D.
April 14 1913 (Address) Genesee Idaho

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; (2) whether ACCIDENTAL, SUICIDAL OR HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place

In the

of death _____ yrs. _____ mos. _____ ds. State _____ yrs. _____ mos. _____ ds.

Where was disease contracted,

If not at place of death?

Former or

usual residence.

19. PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

Calvin V. Hays apr 15 1913

20. UNDERTAKER

ADDRESS

J. E. Raccobart Genesee Idaho

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics
File No. 4655
Registered No. 56

1. PLACE OF DEATH.

Registration District No. 13County of SatahPrimary Registration District No. 2127City of Jolietta

(No. _____, _____ St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

Larima C. Adams

If death occurred in a hospital, institution or camp give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX

Female

4. COLOR OR RACE

White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED.

Married
(Write the word.)

6. DATE OF BIRTH

Sept, 27th, 1862
(Month) (Day) (Year)

7. AGE

50 yrs. 6 mos. 30 ds.

IF LESS than 1 day
how many _____ hrs. or
_____ min?

8. OCCUPATION

(a) Trade, profession or particular kind of work
(b) General nature of industry business or establishment in which employed (or employer)

Housewife

9. BIRTHPLACE

(State or Country)

Leavenworth, Kans.

10. NAME OF FATHER

R. D. Mc Camish

11. BIRTHPLACE OF FATHER

(State or Country)

Memphis, Tenn.

12. MAIDEN NAME OF MOTHER

Mary E. Rogers

13. BIRTHPLACE OF MOTHER

(State or Country)

Kansas

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

John Adams

(Address)

15.

Filed April 26 1913S. A. Roe
Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH

Sept, 26, 1913
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from

August 1912, to April 25, 1913that I last saw her alive on April 25, 1913and that death occurred on the date stated above, at 29 M.

The CAUSE OF DEATH* was as follows:

Bright's DiseaseProbable (Duration) 2 yrs. - mos. - ds.

Contributory (Secondary)

Rheumatism(Duration) 20 yrs. - mos. - ds.

(Signed)

S. A. Roe - M. D.April 26 1913 (Address) Jolietta, Mo.

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place

In the

of death _____ yrs. _____ mos. _____ ds. State _____ yrs. _____ mos. _____ ds.

Where was disease contracted,

If not at place of death?

Former or

usual residence.

19. PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

Jolietta, Mo., Apr. 27 1913

20. UNDERTAKER

ADDRESS

J. C. Groseclose

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PRI-
CIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact state-
ment of OCCUPATION is very important. See instructions on back of certificate.

Form V. S. No. 5. 12½ M. 7-24-11

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics
File No. **4656**
Registered No. **56**

1. PLACE OF DEATH. Registration District No. **15**
County of **Satah** Primary Registration District No. **2127**
City of **Julietta**, (No. _____, St.)

If death occurs away from us-
ual residence, give facts called
for under special information.

2. FULL NAME **William C Cochran**

If death occurred in a hospital, in-
stitution or camp give its NAME
instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX **male** 4. COLOR OR RACE **white** 5. SINGLE, MARRIED, WID-
OWED OR DIVORCED. **married**
(Write the word.)

6. DATE OF BIRTH **Oct 24 1890**
(Month) (Day) (Year)

7. AGE **72 yrs. 4 mos. 15 ds.** IF LESS than 1 day
how many hrs. or min?

8. OCCUPATION
(a) Trade, profession or particular kind of work. **Farmer**
(b) General nature of industry business or establishment in which employed (or employer)

9. BIRTHPLACE **Ohio**
(State or Country)

10. NAME OF FATHER **Wm Cochran**

11. BIRTHPLACE OF FATHER
(State or Country)

12. MAIDEN NAME OF MOTHER

13. BIRTHPLACE OF MOTHER
(State or Country)

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) _____
(Address) _____

15. Filed **Mar. 12 1913** **S. A. Roe**
Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH **March 11 1913**
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from
Dec. 19 1912, to **Mar 10 1913**
that I last saw him alive on **March 10 1913**
and that death occurred on the date stated above, at **3 a. M.**

The CAUSE OF DEATH* was as follows:

Angina Pectoris
(Duration) _____ yrs. _____ mos. _____ ds.
Contributory **Cancer of Bladder**
(Secondary)
(Duration) **2** yrs. _____ mos. _____ ds.
(Signed) **S. A. Roe, M. D.**
Mar. 12 1913 (Address) **Julietta, Ida.**

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place _____ In the _____
of death _____ yrs. _____ mos. _____ ds. State _____ yrs. _____ mos. _____ ds.
Where was disease contracted,
If not at place of death? _____
Former or
usual residence _____

19. PLACE OF BURIAL OR REMOVAL **Julietta, Ida.** DATE OF BURIAL **3/12 1913**

20. UNDERTAKER **J. C. Groseclose,** ADDRESS **Julietta, Ida.**

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Form V. S. No. 5. 12½ M. 7-24-11

CERTIFICATE OF DEATH

1. PLACE OF DEATH. Registration District No. 15
County of Butte Primary Registration District No. 2066
City of Butte (No. St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

Eric Nølger Osterlund

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

File No. 465
Registered No. 57

If death occurred in a hospital, institution or camp give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX 4. COLOR OR RACE 5. SINGLE, MARRIED, WIDOWED OR DIVORCED.

Male

White

Single
(Write the word.)

6. DATE OF BIRTH

Aug.

23

1913

(Month)

(Day)

(Year)

7. AGE

yrs. 6 mos. 16 ds.

IF LESS than 1 day
how many hrs. or min?

8. OCCUPATION

(a) Trade, profession or particular kind of work
(b) General nature of industry business or establishment in which employed (or employer)

9. BIRTHPLACE

(State or Country)

Idaho

10. NAME OF FATHER

FATHER

Eric Alfred Osterlund

11. BIRTHPLACE OF FATHER

(State or Country)

Sweden

12. MAIDEN NAME OF MOTHER

OF MOTHER

Eugenia Osterlund

13. BIRTHPLACE OF MOTHER

(State or Country)

Sweden

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

Parents

(Address)

Butte

15.

Filed April 9 1913

J. R. Thompson
Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH

April

9

1913

(Month)

(Day)

(Year)

17. I HEREBY CERTIFY, That I attended deceased from

April 7

1913

to

April 8

1913

that I last saw him alive on

April 8

1913

and that death occurred on the date stated above, at 9:15 M.

The CAUSE OF DEATH* was as follows:

Strangulated Hernia
(Acute Intestinal Obstruction)

(Duration) yrs. mos. 2 ds.

Contributory

(Secondary)

(Duration) yrs. mos. ds.

(Signed)

J. R. Thompson

M. D.

19

(Address)

Butte

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; (2) whether ACCIDENTAL, SUICIDAL OR HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place

In the

of death yrs. mos. ds. State yrs. mos. ds.

Where was disease contracted,

If not at place of death?

Former or

usual residence.

19. PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

Butte Cemetery

April 9 1913

20. UNDERTAKER

ADDRESS

Parents

Butte

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Form V. S. No. 5 20M.1-16-12

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH

Registration District No. 2068 15

County of Latah

Primary Registration District No. 75 2068

City of Beary

(No.)

St.)

File No. 465

Registered No. 53

If death occurs away from usual residence, give facts called for under special information.

2 FULL NAME not named

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX

4. COLOR OR RACE

5. SINGLE, MARRIED, WIDOWED OR DIVORCED.

M

White

single
(Write the word.)

6. DATE OF BIRTH

Apr. 6

1913
(Month) (Day) (Year)

7. AGE

4 1/2 mo. foetus
yrs. mos. ds.

IF LESS than 1 day
how many hrs. or
mins.?

8. OCCUPATION

(a) Trade, profession or particular kind of work

(b) General nature of industry, business, or establishment in which employed (or employer)

9. BIRTHPLACE

(State or Country)

Idaho

10. NAME OF FATHER

Levi Shortridge

11. BIRTHPLACE OF FATHER

(State or Country)

Idaho

12. MAIDEN NAME OF MOTHER

Maud Walton

13. BIRTHPLACE OF MOTHER

(State or Country)

Arka

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

R. C. Faust

(Address)

Beary, Ida.

15.

Filed 4/7

191 3

R. C. Faust
Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

Apr. 6
(Month) (Day)

1913
(Year)

17. I HEREBY CERTIFY, That I attended deceased from

Apr. 6 1913, to 1913

that I last saw h alive on 1913

and that death occurred on the date stated above, at 6:30 M.

The CAUSE OF DEATH* was as follows:

miscarriage

(Duration) yrs. mos. ds.

Contributory (Secondary) placenta previa

& a fall

(Duration) yrs. mos. ds.

(Signed) R. C. Faust M. D.

4/7 1913 (Address) Beary

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death

.....yrs.mos.days.

In the State

.....yrs.mos.days.

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

Avon Cemetery

4/8 1913

20. UNDERTAKER

ADDRESS

none

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Form V. S. No. 5. 12½ M. 7-24-11

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics
File No. 4659
Registered No. 54

1. PLACE OF DEATH. Registration District No. 15
County of Latah Primary Registration District No. 1008
City of Moscow (No. _____, _____ St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Elizabeth Rosecrans

If death occurred in a hospital, institution or camp give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX Female 4. COLOR OR RACE white 5. SINGLE, MARRIED, WIDOWED OR DIVORCED. mar
(Write the word.)

6. DATE OF BIRTH October 24 1883
(Month) (Day) (Year)

7. AGE 89 yrs. 6 mos. 8 ds. IF LESS than 1 day how many _____ hrs. or _____ min?

8. OCCUPATION
(a) Trade, profession or particular kind of work. housewife
(b) General nature of industry business or establishment in which employed (or employer)

9. BIRTHPLACE (State or Country) Lincoln Co Ohio

10. NAME OF FATHER Joseph Dickey

11. BIRTHPLACE OF FATHER Rockingham Co Va.
(State or Country) Don't know

12. MAIDEN NAME OF MOTHER Catharine Seilan

13. BIRTHPLACE OF MOTHER Rockingham Co Va
(State or Country)

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Richd Burke
(Address) Moscow Idaho

15. May 3 1913 J. F. Rae
Filed Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH May 3 1913
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from April 28 1913, to May 3 1913
that I last saw her alive on May 2 1913
and that death occurred on the date stated above, at 89 M.
The CAUSE OF DEATH* was as follows:
Pneumonia

(Duration) _____ yrs. _____ mos. 3 ds.

Contributory (Secondary)

(Duration) _____ yrs. _____ mos. _____ ds.
(Signed) W. H. Caruthers M. D.
May 3 1913 (Address) Moscow, Id.

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place In the
of death _____ yrs. _____ mos. _____ ds. State _____ yrs. _____ mos. _____ ds.
Where was disease contracted,
If not at place of death?
Former or
usual residence _____

19. PLACE OF BURIAL OR REMOVAL Skaloussa Dr. DATE OF BURIAL 1913

20. UNDERTAKER E. C. Stutz ADDRESS Moscow

Form V. S. No. 5 20M.1-16-12

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH,

Registration District No. 15County of LatahPrimary Registration District No. 1008City of Moscow

(No. _____, _____ St.)

File No. 1569Registered No. 150

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

Elizabeth Galton

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX

Female

4. COLOR OR RACE

White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED.

Widow
(Write the word.)

6. DATE OF BIRTH

August 24th 1874
(Month) (Day) (Year)

7. AGE

38 yrs. _____ mos. _____ ds.IF LESS than 1 day
how many _____ hrs. or
_____ mins.?

8. OCCUPATION

(a) Trade, profession or

particular kind of work

Retired

(b) General nature of industry

business, or establishment in

which employed (or employer)

9. BIRTHPLACE

(State or Country)

New York

10. NAME OF FATHER

Eggs Porges

11. BIRTHPLACE OF FATHER

(State or Country)

New York

12. MAIDEN NAME OF MOTHER

Lettie London

13. BIRTHPLACE OF MOTHER

(State or Country)

Conn.

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

Dr. E. Melugin

(Address)

Moscow

15.

Filed

Mar. 20

1913

J. M. Fisher

Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

Mar.18

1913

(Month)

(Day)

(Year)

17. I HEREBY CERTIFY, That I attended deceased from

1913, to

Mar. 18

1913.

that I last saw him alive on About "Mar. 1" 1913.and that death occurred on the date stated above, at 11 P.M.

The CAUSE OF DEATH* was as follows:

Arterio Sclerosis

(Duration)

2 yrs.

mos.

ds.

Contributory

(Secondary)

(Duration)

yrs.

mos.

ds.

(Signed)

W. H. Carithers

M. D.

19

(Address)

Moscow, Idaho

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place

of death

_____ yrs.

_____ mos.

_____ days.

In the

State

_____ yrs.

_____ mos.

_____ days.

Where was disease contracted if not at place of death?

Former or

usual residence

19. PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

Moscow, IdahoMar. 20 1913

20. UNDERTAKER

ADDRESS

Geo. M. M. M.Moscow, Idaho

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Form V. S. No. 5 20M.1-16-12

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH.

Registration District No. 16

County of Latah

Primary Registration District No. 1008

City of Moscow

(No. St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Peter H. Egan

File No. 460

Registered No. 49

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX

male

4. COLOR OR RACE

White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED.

married
(Write the word.)

6. DATE OF BIRTH

April 26 1831
(Month) (Day) (Year)

7. AGE

82 yrs. 11 mos. 18 ds.

IF LESS than 1 day
how many hrs. or
mins.?

8. OCCUPATION

(a) Trade, profession or particular kind of work

Retired Farmer

(b) General nature of industry business, or establishment in which employed (or employer)

9. BIRTHPLACE

(State or Country)

Norway

10. NAME OF FATHER

Halvor Ingrobretson

11. BIRTHPLACE OF FATHER

(State or Country)

Norway

12. MAIDEN NAME OF MOTHER

Karen Tordalson

13. BIRTHPLACE OF MOTHER

(State or Country)

Norway

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

P. H. Egan

(Address)

Moscow

15.

Filed

March 15 1913 S. F. Rae

Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH

March 14 1913
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from

1912, to 3/14 1913

that I last saw him alive on Jan 1913

and that death occurred on the date stated above, at 2 P.M.

The CAUSE OF DEATH was as follows:

apoplexy & Senility

(Duration) yrs. mos. and ds.

Contributory
(Secondary)

Old age

(Duration) yrs. mos. ds.

(Signed)

March 15 1913

(Address)

S. F. Rae

M. D.

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death yrs. mos. days. In the State yrs. mos. days.

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

Moscow Ida

3/18 1913

20. UNDERTAKER

ADDRESS

Geo. Stutz

Moscow Ida

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Form V. S. No. 5 20M.1-16-12

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH

Registration District No. 15

County of Latah

Primary Registration District No. 1008

City of Moscow

(No. St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Eath M. Houshine

File No. 1602

Registered No. 46

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX

4. COLOR OR RACE

5. SINGLE, MARRIED, WIDOWED OR DIVORCED.

Female White

Married
(Write the word.)

6. DATE OF BIRTH

July 24 1888
(Month) (Day) (Year)

7. AGE

24 yrs. mos. ds.

IF LESS than 1 day
how many hrs. or mins.?

8. OCCUPATION

(a) Trade, profession or particular kind of work

(b) General nature of industry, business, or establishment in which employed (or employer)

Housewife

9. BIRTHPLACE

(State or Country)

Missouri

10. NAME OF FATHER

Harriet Haermath

11. BIRTHPLACE OF FATHER

(State or Country)

Ohio

12. MAIDEN NAME OF MOTHER

Alva Carter

13. BIRTHPLACE OF MOTHER

(State or Country)

Missouri

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

(Address)

H. P. Bennett

15.

Filed

March 7 1913

Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH

March 6 1913
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from March 5 1913, to March 6 1913, that I last saw her alive on March 6 1913, and that death occurred on the date stated above, at 4.9 A.M.

The CAUSE OF DEATH* was as follows:

Complication following child birth. Contributory. uremia
(Duration) yrs. mos. ds.

Contributory
(Secondary)

(Duration) yrs. mos. ds.
(Signed) Chas. L. Guitman M. D.
March 1913 (Address) Moscow Idaho

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death yrs. mos. days. In the State yrs. mos. days.

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

Moscow

March 7 1913

20. UNDERTAKER

ADDRESS

Geo. Shultz

Moscow

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Form V. S. No. 5 20M.1-16-12

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH.

Registration District No. 15

County of Latah

Primary Registration District No. 1008

City of Moscow

(No. _____, St.)

File No. 1008

Registered No. 47

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

Grace Sawyer

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX

girl

4. COLOR OR RACE

White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED.

(Write the word.)

6. DATE OF BIRTH

March 1st 1913
(Month) (Day) (Year)

7. AGE

1 yrs. 4 mos. 4 ds.

IF LESS than 1 day
how many hrs. or
..... mins.?

8. OCCUPATION

(a) Trade, profession or particular kind of work

(b) General nature of industry business, or establishment in which employed (or employer)

9. BIRTHPLACE

(State or Country)

Moscow Idaho

10. NAME OF FATHER

Earl Sawyer

11. BIRTHPLACE OF FATHER

(State or Country)

Missouri

12. MAIDEN NAME OF MOTHER

Lula Peterson

13. BIRTHPLACE OF MOTHER

(State or Country)

Indiana

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

Earl B Sawyer

(Address)

Moscow

15.

Filed

Mar 5th 1913

W. M. Pringle
(Deputy) Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH

March 5 1913
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from

Mar 2 1913, to March 5 1913

that I last saw her alive on March 5 1913

and that death occurred on the date stated above, at 1 A.M.

The CAUSE OF DEATH* was as follows:

Bronchitis Acute

(Duration) yrs. mos. 0 ds.

Contributory
(Secondary)

(Duration) yrs. mos. ds.

(Signed) Joseph Aspray M. D.

Mar 5 1913 (Address) Joseph Aspray

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death yrs. mos. days. In the State yrs. mos. days.

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL

Moscow

DATE OF BURIAL

March 5 1913

20. UNDERTAKER

Geo Stutz

ADDRESS

Moscow

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Form V. S. No. 5 20M.1-16-12

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH
County of Latah
City of Moscow

Registration District No. 15
Primary Registration District No. 1008
(No. _____ St.)

File No. 155-48
Registered No. _____

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Josephine Frances Carraher
If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX Female 4. COLOR OR RACE White 5. SINGLE, MARRIED, WIDOWED OR DIVORCED. Single
(Write the word.)

6. DATE OF BIRTH Aug 15 1891
(Month) (Day) (Year)

7. AGE 21 yrs. _____ mos. _____ ds.
IF LESS than 1 day how many _____ hrs. or _____ mins.?

8. OCCUPATION
(a) Trade, profession or particular kind of work none
(b) General nature of industry business, or establishment in which employed (or employer) _____

9. BIRTHPLACE New York City
(State or Country)

10. NAME OF FATHER Thomas Carraher

11. BIRTHPLACE OF FATHER Ireland
(State or Country)

12. MAIDEN NAME OF MOTHER Nichols

13. BIRTHPLACE OF MOTHER Germany
(State or Country)

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Edw. V. Carraher
(Address) W. 3rd street

Filed Aug 15 1913 D. F. Rae
Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH march 14 1913
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from _____ 191____, to _____ 191____, that I last saw h_____ alive on _____ 191____, and that death occurred on the date stated above, at 7 A.M.

The CAUSE OF DEATH* was as follows:
Was found dead in bed no evidences of suicide or foul play death undoubtedly due to natural causes heart failure or apoplexy
(Duration) _____ yrs. _____ mos. _____ ds.
Contributory Mentally Deranged
(Secondary)
(Duration) 2 1/2 yrs. _____ mos. _____ ds.
(Signed) Joseph Aspray M. D.
Mar 15 1913 (Address) Moscow Idaho

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death _____ yrs. _____ mos. _____ days. In the State _____ yrs. _____ mos. _____ days.
Where was disease contracted if not at place of death? _____
Former or usual residence _____

19. PLACE OF BURIAL OR REMOVAL Pokeween Ranch DATE OF BURIAL Mar. 16 1913
20. UNDERTAKER George Stutz ADDRESS Moscow

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Form V. S. No. 5 20M.1-16-12

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH. Registration District No. 15
County of Latah Primary Registration District No. 1008
City of Moscow (No. _____ St.)

File No. 1004
Registered No. 43

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Joyce L Scheyer

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX ♀ 4. COLOR OR RACE W 5. SINGLE, MARRIED, WIDOWED OR DIVORCED. single
(Write the word.)

6. DATE OF BIRTH Dec 19 1905
(Month) (Day) (Year)

7. AGE 7 yrs. 2 mos. 12 ds. IF LESS than 1 day how many hrs. or mins.?

8. OCCUPATION
(a) Trade, profession or particular kind of work
(b) General nature of industry business, or establishment in which employed (or employer)

9. BIRTHPLACE
(State or Country) Moscow Idaho

10. NAME OF FATHER John C Scheyer

11. BIRTHPLACE OF FATHER
(State or Country) Prussia

12. MAIDEN NAME OF MOTHER Louise C Clark

13. BIRTHPLACE OF MOTHER
(State or Country) Germany

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) John C Scheyer
(Address) Moscow

15. Filed Mar 14 1913 L M Linker
(Signature) Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH March 3 1913
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from 1913 to 1913, that I last saw h. alive on March 3 1913, and that death occurred on the date stated above, at 8 A.M.

The CAUSE OF DEATH* was, as follows:

Diphtheria.

(Duration) yrs. mos. 2 1/2 ds.
Contributory (Secondary)

(Duration) yrs. mos. ds.
(Signed) Joseph Ashray M. D.
Mar 3 1913 (Address) Moscow Idaho

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death yrs. mos. days. In the State yrs. mos. days.

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL Moscow DATE OF BURIAL March 4 1913

20. UNDERTAKER Brooklyn ADDRESS Moscow

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Form V. S. No. 5 20M.1-16-12

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics
File No. 4607
Registered No. 44

1. PLACE OF DEATH
County of Latah
City of Moscow
Registration District No. 15
Primary Registration District No. 1008
(No. _____ St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME George W. Coleman

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX Male 4. COLOR OR RACE White 5. SINGLE, MARRIED, WIDOWED OR DIVORCED. Widower
(Write the word.)

6. DATE OF BIRTH Feb. 12 1828
(Month) (Day) (Year)

7. AGE 85 yrs. 17 mos. 17 ds.
IF LESS than 1 day
how many _____ hrs. or
_____ mins.?

8. OCCUPATION
(a) Trade, profession or particular kind of work Retired
(b) General nature of industry, business, or establishment in which employed (or employer)

9. BIRTHPLACE
(State or Country) Ohio

10. NAME OF FATHER John Coleman

11. BIRTHPLACE OF FATHER
(State or Country) Virginia

12. MAIDEN NAME OF MOTHER Storck

13. BIRTHPLACE OF MOTHER
(State or Country) Virginia

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Mrs. Sig. Coleman
(Address) Moscow, Ida.

15. Filed Mar. 4 1913 L. W. Curtis
(Signature) Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH March 1 1913
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from Feb. 24 1913, to March 1 1913, that I last saw him alive on March 1 1913, and that death occurred on the date stated above, at _____ M.

The CAUSE OF DEATH* was as follows:

Senility

(Duration) _____ yrs. _____ mos. _____ ds.
Contributory
(Secondary)

(Duration) _____ yrs. _____ mos. _____ ds.
(Signed) Chas. L. Giffman M. D.
Ph. L. H. C.
19 _____ (Address)

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death _____ yrs. _____ mos. _____ days. In the State _____ yrs. _____ mos. _____ days.

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL Moscow DATE OF BURIAL March 5 1913

20. UNDERTAKER Geo. Stoltz ADDRESS Moscow

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Form V. S. No. 5 20M.1-16-12

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH
County of Latah
City of Moscow

Registration District No. 15
Primary Registration District No. 1008
(No. _____ St.)

File No. 166
Registered No. 42

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Nels Vernon Carlson

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX m 4. COLOR OR RACE White 5. SINGLE, MARRIED, WIDOWED OR DIVORCED. single
(Write the word.)

6. DATE OF BIRTH April 15th 1913
(Month) (Day) (Year)

7. AGE _____ yrs. _____ mos. 3 ds.
IF LESS than 1 day how many _____ hrs. or _____ mins.?

8. OCCUPATION
(a) Trade, profession or particular kind of work _____
(b) General nature of industry business, or establishment in which employed (or employer) _____

9. BIRTHPLACE (State or Country) Moscow

10. NAME OF FATHER John Lawrence Carlson

11. BIRTHPLACE OF FATHER (State or Country) Minnesota

12. MAIDEN NAME OF MOTHER Selma Berglund

13. BIRTHPLACE OF MOTHER (State or Country) South Dak.

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) J. L. Carlson
(Address) Moscow,

15. Filed Apr 19 1913 D. F. Raa
Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH April 18 1913
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from April 15 1913, to April 17 1913, that I last saw him alive on April 17 1913, and that death occurred on the date stated above, at 4.4 M.

The CAUSE OF DEATH* was as follows:

(Duration) yrs. mos. ds.
Contributory Pneumonia
(Secondary)
(Duration) yrs. mos. ds.
(Signed) Charles L. Giffman M. D.
19 _____ (Address) Per T. H. C. Moscow.

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death _____ yrs. _____ mos. _____ days. In the State _____ yrs. _____ mos. _____ days.
Where was disease contracted if not at place of death? _____
Former or usual residence _____

19. PLACE OF BURIAL OR REMOVAL Moscow DATE OF BURIAL April 20 1913

20. UNDERTAKER Geo Stettin ADDRESS Moscow

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Form V. S. No. 5. 12½ M. 7-24-11

CERTIFICATE OF DEATH

1. PLACE OF DEATH
County of *Idaho*
City of *Moscow*

Registration District No. *15*
Primary Registration District No. *1008*
(No. _____ St.)

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

File No. *4609*
Registered No. *40*

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME *Harland H. Abeling*

If death occurred in a hospital, institution or camp give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX *Male* 4. COLOR OR RACE *White* 5. SINGLE, MARRIED, WIDOWED OR DIVORCED. *Single*
(Write the word.)

6. DATE OF BIRTH *Oct* *Thirtieth* *1913*
(Month) (Day) (Year)

7. AGE _____ yrs. *6* mos. *20* ds. IF LESS than 1 day how many _____ hrs. or _____ min?

8. OCCUPATION

(a) Trade, profession or particular kind of work.
(b) General nature of industry business or establishment in which employed (or employer)

9. BIRTHPLACE
(State or Country) *Moscow*

10. NAME OF FATHER *Howard G. Abeling*

11. BIRTHPLACE OF FATHER
(State or Country) *Montana*

12. MAIDEN NAME OF MOTHER *Leila Le. Page*

13. BIRTHPLACE OF MOTHER
(State or Country) *Iowa*

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) *H. G. Abeling*
(Address) *Moscow*

15. Filed *Apr 16 1913* *J. F. Rae*
Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH *April* *15* *1913*
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from *April 5* *1913*, to *April 15* *1913* that I last saw him alive on *April 15* *1913* and that death occurred on the date stated above, at *9 A. M.*

The CAUSE OF DEATH* was as follows:

Gastro-Enteritis

(Duration) _____ yrs. _____ mos. *10* ds.

Contributory (Secondary) *None*

(Duration) _____ yrs. _____ mos. _____ ds.

(Signed) *Joseph Aspray* M. D.
April 16 *1913* (Address) *Moscow Idaho*

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place _____ In the _____
of death _____ yrs. _____ mos. _____ ds. State _____ yrs. _____ mos. _____ ds.
Where was disease contracted,
If not at place of death? _____
Former or
usual residence _____

19. PLACE OF BURIAL OR REMOVAL DATE OF BURIAL

Moscow *Apr 16* *1913*

20. UNDERTAKER ADDRESS

Geo. Shelly *Moscow*

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Form V. S. No. 5. 12½M.7-24-11

CERTIFICATE OF DEATH

1. PLACE OF DEATH Salok Registration District No. 157
 County of moscow Primary Registration District No. 1008
 City of moscow (No. _____, St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Elisabeth Micky

State of Idaho
 BOARD OF HEALTH
 Bureau of Vital Statistics
 File No. 4679
 Registered No. 41

If death occurred in a hospital, institution or camp give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX M. 4. COLOR OR RACE White 5. SINGLE, MARRIED, WIDOWED OR DIVORCED. Married
 (Write the word.)

6. DATE OF BIRTH Dec 14 1888
 (Month) (Day) (Year)

7. AGE 84 yrs. 3 mos. 28 ds. IF LESS than 1 day how many _____ hrs. or _____ min?

8. OCCUPATION

(a) Trade, profession or particular kind of work. House Wife
 (b) General nature of industry business or establishment in which employed (or employer)

9. BIRTHPLACE

(State or Country) Penn

10. NAME OF FATHER

John Glassley

11. BIRTHPLACE OF FATHER

(State or Country) Penn

12. MAIDEN NAME OF MOTHER

Elisabeth Matter

13. BIRTHPLACE OF MOTHER

(State or Country) Penn

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) H. B. Micky
 (Address) Moscow

15.

Filed Apr 12 1913 S. F. Rac
 Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH April 11 1913
 (Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from April 7 1913, to April 11 1913, that I last saw her alive on April 11 1913 and that death occurred on the date stated above, at 11 P.M.

The CAUSE OF DEATH* was as follows:

Paralysis

..... (Duration) yrs. mos. ds.

Contributory (Secondary)

..... (Duration) yrs. mos. ds.

(Signed) W. A. Adams M. D.

..... 19..... (Address) Moscow

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place In the
 of death yrs. mos. ds. State yrs. mos. ds.
 Where was disease contracted,
 If not at place of death?
 Former or
 usual residence

19. PLACE OF BURIAL OR REMOVAL DATE OF BURIAL

Moscow April 11 1913
 20. UNDERTAKER ADDRESS

Geo Stetz Moscow

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Form V. S. No. 5. 12½ M. 7-24-11

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics
File No. 4671
Registered No. 39

1. PLACE OF DEATH. Registration District No. 15
County of Salata Primary Registration District No. 1008
City of Moscow (No. _____, _____ St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Francis May Ruthrauff

If death occurred in a hospital, institution or camp give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX Female 4. COLOR OR RACE White 5. SINGLE, MARRIED, WIDOWED OR DIVORCED. Married
(Write the word.)

6. DATE OF BIRTH May 9 1882
(Month) (Day) (Year)

7. AGE 30 yrs. 11 mos. 16 ds. IF LESS than 1 day how many _____ hrs. or _____ min?

8. OCCUPATION
(a) Trade, profession or particular kind of work Housewife
(b) General nature of industry business or establishment in which employed (or employer)

9. BIRTHPLACE
(State or Country) Idaho

10. NAME OF FATHER Joseph H. Miller

11. BIRTHPLACE OF FATHER Don't know
(State or Country)

12. MAIDEN NAME OF MOTHER Miss Tripp

13. BIRTHPLACE OF MOTHER not known
(State or Country)

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Andrew J. ...
(Address) ...

15. Apr 26 1913 S. F. Rae
Filed Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH April 25 1913
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from once April 1913, to 1913
that I last saw her alive on April 24 1913
and that death occurred on the date stated above, at _____ M.

The CAUSE OF DEATH* was as follows:
Acute nephritis

_____ (Duration) _____ yrs. _____ mos. 7 ds.
Contributory (Secondary) _____

_____ (Duration) _____ yrs. _____ mos. _____ ds.
(Signed) Chas. L. Giffman M. D.
_____ 19 _____ (Address)

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place _____ In the _____
of death _____ yrs. _____ mos. _____ ds. State _____ yrs. _____ mos. _____ ds.
Where was disease contracted, _____
If not at place of death? _____
Former or _____
usual residence _____

19. PLACE OF BURIAL OR REMOVAL Moscow DATE OF BURIAL Apr 26 1913

20. UNDERTAKER Geo. Shultz ADDRESS Moscow

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Form V. S. No. 5. 12½ M. 7-24-11

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics
File No. 4672
Registered No. 34

1. PLACE OF DEATH.
County of Latah
City of Moscow

Registration District No. 15
Primary Registration District No. 1008
(No. , St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME William K. Jameson

If death occurred in a hospital, institution or camp give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX male
4. COLOR OR RACE white
5. SINGLE, MARRIED, WIDOWED OR DIVORCED. Widower
(Write the word.)

6. DATE OF BIRTH March 4 1896
(Month) (Day) (Year)

7. AGE 77 yrs. 20 mos. 20 ds.
IF LESS than 1 day how many.....hrs. or min?

8. OCCUPATION
(a) Trade, profession or particular kind of work. Medical doctor
(b) General nature of industry business or establishment in which employed (or employer)

9. BIRTHPLACE
(State or Country) Edinburgh Scotland

10. NAME OF FATHER James Jameson

11. BIRTHPLACE OF FATHER
(State or Country) Scotland

12. MAIDEN NAME OF MOTHER

13. BIRTHPLACE OF MOTHER
(State or Country) Scotland

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) F. A. David
(Address) Moscow Idaho

15. Filed Mar 25 1913
Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH
Mch. 24 1913
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from
Mch. 23 1913, to Mch. 24 1913
that I last saw him alive on Mch. 24 1913
and that death occurred on the date stated above, at 29 M.

The CAUSE OF DEATH* was as follows:
Hemorrhage from duodenum

(Duration) 2 yrs. mos. ds.

Contributory (Secondary)
(Duration) yrs. mos. ds.

(Signed) W. H. Caruthers M. D.
Mch. 16 1913 (Address) Moscow Id.

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place In the
of death.....yrs.....mos.....ds. State.....yrs.....mos.....ds.
Where was disease contracted,
If not at place of death?
Former or usual residence.

19. PLACE OF BURIAL OR REMOVAL DATE OF BURIAL
Moscow, Idaho. Mar. 25 1913

20. UNDERTAKER ADDRESS
Geo. M. H. Moscow

Form V. S. No. 5. 12½ M. 7-24-11

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics
File No. 4673
Registered No. 35

1. PLACE OF DEATH. Registration District No. 15
County of Catch Primary Registration District No. 1008
City of Moscow (No. _____ St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

Robert Grunwood

If death occurred in a hospital, institution or camp give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX Female 4. COLOR OR RACE White 5. SINGLE, MARRIED, WIDOWED OR DIVORCED Married

6. DATE OF BIRTH May 10 1879
(Month) (Day) (Year)

7. AGE 83 yrs. 10 mos. 21 ds. IF LESS than 1 day how many hrs. or min?

8. OCCUPATION Housewife
(a) Trade, profession or particular kind of work
(b) General nature of industry business or establishment in which employed (or employer)

9. BIRTHPLACE Royakoke Pa.
(State or Country)

10. NAME OF FATHER James Altie

11. BIRTHPLACE OF FATHER _____
(State or Country)

12. MAIDEN NAME OF MOTHER _____

13. BIRTHPLACE OF MOTHER _____
(State or Country)

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Lulu Grunwood
(Address) Moscow Ida.

15. Filed Mar. 28 1913 D. K. Litchell
Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH Mar. 24 1913
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from Mar. 23 1913, to Mar. 24 1913 that I last saw her alive on Mar. 24 1913 and that death occurred on the date stated above, at 9 P. M.

The CAUSE OF DEATH* was as follows:

Pneumonia
(Duration) 4 or 5 days yrs. mos. ds.

Contributory (Secondary) _____
(Duration) _____ yrs. mos. ds.
(Signed) W. H. Barntine M. D.
Mar. 25 1913 (Address) Moscow Ida.

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place In the
of death yrs. mos. ds. State yrs. mos. ds.
Where was disease contracted,
If not at place of death?
Former or
usual residence

19. PLACE OF BURIAL OR REMOVAL Moscow Ida. DATE OF BURIAL April 2 1913
20. UNDERTAKER Geo. L. Litchell ADDRESS Moscow

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Form V. S. No. 5. 12½ M. 7-24-11

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics
File No. **4674**
Registered No. **36**

1. PLACE OF DEATH. Registration District No. **15**
County of **Gatah** Primary Registration District No. **1008**
City of **Moscow** (No. _____ St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

R. M. Storey

If death occurred in a hospital, institution or camp give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX **Male** 4. COLOR OR RACE **White** 5. SINGLE, MARRIED, WIDOWED OR DIVORCED. **Single**
(Write the word.)

6. DATE OF BIRTH **Oct 13 1886**
(Month) (Day) (Year)

7. AGE **27** yrs. **6** mos. **16** ds. IF LESS than 1 day how many _____ hrs. or _____ min?

8. OCCUPATION
(a) Trade, profession or particular kind of work. **None**
(b) General nature of industry business or establishment in which employed (or employer)

9. BIRTHPLACE (State or Country) **Mo**

10. NAME OF FATHER **Millard T. Storey**

11. BIRTHPLACE OF FATHER (State or Country) **Mo**

12. MAIDEN NAME OF MOTHER **Allie Perce**

13. BIRTHPLACE OF MOTHER (State or Country) **Mo**

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) **Mrs M. Storey**
(Address) **Moscow**

15. **Apr 27 1913** **J. F. Rae**
Filed Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH **April 28 1913**
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from **April 26 1913**, to **April 27 1913** that I last saw him alive on **April 27 1913** and that death occurred on the date stated above, at **2 A. M.**
The CAUSE OF DEATH* was as follows:
Epileptic convulsion

(Duration) **20** yrs. **2** mos. **2** ds.
Contributory **Epilepsy**
(Secondary)
(Duration) **20** yrs. **2** mos. **2** ds.
(Signed) **Joseph Aspray M. D.**
April 29 1913 (Address) **Moscow Ida**

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place In the
of death _____ yrs. _____ mos. _____ ds. State _____ yrs. _____ mos. _____ ds.
Where was disease contracted,
If not at place of death?
Former or
usual residence _____

19. PLACE OF BURIAL OR REMOVAL **Demose** DATE OF BURIAL **April 30 1913**

20. UNDERTAKER **Geo Stolz** ADDRESS **Moscow**

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Form V. S. No. 5. 12½ M. 7-24-11

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics
File No. 4675
Registered No. 37

1. PLACE OF DEATH
County of Latah
City of Moscow

Registration District No. 13
Primary Registration District No. 1008
(No. , St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Andrew J. Headrick

If death occurred in a hospital, institution or camp give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX Male 4. COLOR OR RACE White 5. SINGLE, MARRIED, WIDOWED OR DIVORCED. Widower
(Write the word.)

6. DATE OF BIRTH Jan 6 1835
(Month) (Day) (Year)

7. AGE 78 yrs. 4 mos. 21 ds.
IF LESS than 1 day how many hrs. or min?

8. OCCUPATION Retired
(a) Trade, profession or particular kind of work
(b) General nature of industry business or establishment in which employed (or employer)

9. BIRTHPLACE Ida
(State or Country)

10. NAME OF FATHER Jesie Headrick

11. BIRTHPLACE OF FATHER don't know
(State or Country)

12. MAIDEN NAME OF MOTHER "

13. BIRTHPLACE OF MOTHER "
(State or Country)

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) J. J. Headrick
(Address) Moscow

15. Apr 28 1913 J. F. R.
Filed Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH April 27 1913
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from Jan 1912, to April 27 1913.
that I last saw him alive on April 26 1913.
and that death occurred on the date stated above, at 6 P. M.
The CAUSE OF DEATH* was as follows:

Mitral Insufficiency
(Duration) 2 yrs. mos. ds.
Contributory Rheumatism
(Secondary)

(Signed) W. H. Carithers M. D.
April 28 1913 (Address) Moscow

*State the DISEASE CAUSING DEATH; or in death from VIOLENT CAUSES, state (1) MEANS OF INJURY; (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place In the
of death yrs. mos. ds. State yrs. mos. ds.
Where was disease contracted,
If not at place of death?
Former or
usual residence.

19. PLACE OF BURIAL OR REMOVAL DATE OF BURIAL

Bucan Cemetery April 21 1913

20. UNDERTAKER ADDRESS
Geo. Stutz Moscow

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Form V. S. No. 5 20M.1-16-12

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH. Registration District No. 15
County of Salas Primary Registration District No. 1008
City of Moscow (No. _____ St.)
If death occurs away from usual residence, give facts called for under special information. 2. FULL NAME Arny Underdahl

File No. 1038
Registered No. 38

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX Male 4. COLOR OR RACE White 5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.)
6. DATE OF BIRTH April 25 1913
(Month) (Day) (Year)

7. AGE 14 yrs. 14 mos. 14 ds.
IF LESS than 1 day how many _____ hrs. or _____ mins.?

8. OCCUPATION Infant
(a) Trade, profession or particular kind of work
(b) General nature of industry business, or establishment in which employed (or employer)

9. BIRTHPLACE Moscow, Ida.
(State or Country)

10. NAME OF FATHER P. J. Underdahl

11. BIRTHPLACE OF FATHER Norway
(State or Country)

12. MAIDEN NAME OF MOTHER Booker

13. BIRTHPLACE OF MOTHER Norway
(State or Country)

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) E. Underdahl

(Address) Moscow, Ida.

15. Filed Apr 25 1913 J. F. Rae
Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH April 25 1913
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from April 25 1913, to 1913, that I last saw her alive on April 25 1913, and that death occurred on the date stated above, at M.

The CAUSE OF DEATH* was as follows:

Sick fever
(Duration) _____ yrs. _____ mos. _____ ds.

Contributory (Secondary) _____

(Duration) _____ yrs. _____ mos. _____ ds.
(Signed) Chas. L. Gritman M. D.
19 _____ (Address) Moscow

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death _____ yrs. _____ mos. _____ days. In the State _____ yrs. _____ mos. _____ days.

Where was disease contracted if not at place of death?

Former or usual residence _____

19. PLACE OF BURIAL OR REMOVAL Moscow DATE OF BURIAL April 27 1913

20. UNDERTAKER Geo. H. H. H. ADDRESS Moscow

MARG. RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Form V. S. No. 5. 12½ M. 7-24-11

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics
File No. 29
Registered No. 4047

1. PLACE OF DEATH. Registration District No. 15
County of Latah Primary Registration District No. 1008
City of Moscow (No. _____, _____ St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Johannes Johanson

If death occurred in a hospital, institution or camp give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX Male 4. COLOR OR RACE White 5. SINGLE, MARRIED, WIDOWED OR DIVORCED. Married

6. DATE OF BIRTH June 1824
(Month) (Day) (Year)

7. AGE 85 10 ds.
yrs. mos. ds. IF LESS than 1 day how many hrs. or min?

8. OCCUPATION

(a) Trade, profession or particular kind of work.
(b) General nature of industry, business or establishment in which employed (or employer)

Laborer

9. BIRTHPLACE

(State or Country)

Sweden

10. NAME OF FATHER

Hans Hansson

11. BIRTHPLACE OF FATHER

(State or Country)

Sweden

12. MAIDEN NAME OF MOTHER

Martha Andersdotter

13. BIRTHPLACE OF MOTHER

(State or Country)

Sweden

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

(Address)

J. Aspray

15. Apr 15 1913

Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH April 14 1913
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased on April 10 1913, to April 18 1913 that I last saw him alive on April 10 1913 and that death occurred on the date stated above, at 9 A.M.

The CAUSE OF DEATH* was as follows:

Epilepsy and General Debility

(Duration) yrs. mos. 5 ds.

Contributory (Secondary)

(Duration) yrs. mos. ds.

(Signed) Joseph Aspray M. D.
April 18 1913 (Address) Moscow, Idaho

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place In the
of death. yrs. mos. ds. State. yrs. mos. ds.
Where was disease contracted,
If not at place of death?
Former or usual residence.

19. PLACE OF BURIAL OR REMOVAL DATE OF BURIAL

Moscow April 18 1913

20. UNDERTAKER ADDRESS

Geo. Stutz Moscow

MARGIN RESERVED FOR BINDING
WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Form V. S. No. 5 20M.1-16-12

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH

Registration District No. 15

County of Booth

Primary Registration District No. 1008

City of Moscow

(No. _____, St.)

File No. 1674

Registered No. 30

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Mrs. Hannah Anderson

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX

F. m.

4. COLOR OR RACE

White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED.

Widow
(Write the word.)

6. DATE OF BIRTH

Mar

10

1853

(Month)

(Day)

(Year)

7. AGE

60

yrs.

mos.

ds.

IF LESS than 1 day
how many _____ hrs. or
_____ mins.?

8. OCCUPATION

(a) Trade, profession or particular kind of work

House Wife

(b) General nature of industry business, or establishment in which employed (or employer)

9. BIRTHPLACE

(State or Country)

Norway

10. NAME OF FATHER

Peter Peterson

11. BIRTHPLACE OF FATHER

(State or Country)

Norway

12. MAIDEN NAME OF MOTHER

13. BIRTHPLACE OF MOTHER

(State or Country)

Norway

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Miss Maud Anderson

(Address) _____

15.

Filed Mar 20 1913

S. H. Pishel
(Seal) Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH

Feb

19

1913

(Month)

(Day)

(Year)

17. I HEREBY CERTIFY, That I attended deceased from

Jan. 15

1913, to

Feb 17

1913.

that I last saw her alive on March 14 1913.

and that death occurred on the date stated above, at 2-0 A.M.

The CAUSE OF DEATH* was as follows:

Tuberculosis of Lungs

(Duration) 6 yrs. about mos. ds.

Contributory
(Secondary)

(Duration) _____ yrs. _____ mos. _____ ds.

(Signed) J. H. Clarke M. D.

19 (Address) _____

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death _____ yrs. _____ mos. _____ days. In the State _____ yrs. _____ mos. _____ days.

Where was disease contracted if not at place of death? _____

Where or usual residence _____

19. PLACE OF BURIAL OR REMOVAL DATE OF BURIAL

Moscow Idaho

Mar 20 1913

20. UNDERTAKER

See Heltz

ADDRESS

Moscow

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Form V. S. No. 5. 12½ M. 7-24-11

CERTIFICATE OF DEATH

1. PLACE OF DEATH.
County of Salah
City of Moscow

Registration District No. 15
Primary Registration District No. 75/808
(No. _____, _____ St.)

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics
File No. 4679
Registered No. 31

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Mary Hansen

If death occurred in a hospital, institution or camp give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX Female 4. COLOR OR RACE White 5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.)

6. DATE OF BIRTH Dec 22 1835
(Month) (Day) (Year)

7. AGE 77 yrs. 2 mos. 21 ds. IF LESS than 1 day how many _____ hrs. or _____ min?

8. OCCUPATION
(a) Trade, profession or particular kind of work. House Wife
(b) General nature of industry business or establishment in which employed (or employer)

9. BIRTHPLACE (State or Country) Denmark

10. NAME OF FATHER Adam Mogensen

11. BIRTHPLACE OF FATHER (State or Country) Denmark

12. MAIDEN NAME OF MOTHER Gordy Mogensen

13. BIRTHPLACE OF MOTHER (State or Country) Denmark

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Mary Hansen
(Address) Moscow

15. Apr 13 1913 57 Rm
Filed _____ Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH April 12 1913
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from Feb. 19 1913, to April 11 1913 that I last saw her alive on April 11 1913 and that death occurred on the date stated above, at 5 P. M.

The CAUSE OF DEATH* was as follows:
Paralysis - arterio sclerosis

(Duration) _____ yrs. _____ mos. _____ ds.
Contributory (Secondary)

(Duration) _____ yrs. _____ mos. _____ ds.
(Signed) Chas. L. Guitman M. D.
Per L. H. C.
_____ 19 _____ (Address)

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place _____ In the _____
of death _____ yrs. _____ mos. _____ ds. State _____ yrs. _____ mos. _____ ds.
Where was disease contracted,
If not at place of death?
Former or
usual residence _____

19. PLACE OF BURIAL OR REMOVAL Moscow DATE OF BURIAL Apr 14 1913
20. UNDERTAKER Guthrie ADDRESS Moscow

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Form V. S. No. 5. 12½ M. 7-24-11

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH. Registration District No. 15
County of Latah Primary Registration District No. 1008
City of Moscow (No. _____, _____ St.)

File No. 4689
Registered No. 32

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

Anna Mary Frei

If death occurred in a hospital, institution or camp give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX Female 4. COLOR OR RACE White 5. SINGLE, MARRIED, WIDOWED OR DIVORCED Married

6. DATE OF BIRTH May 28 1840
(Month) (Day) (Year)

7. AGE 72 yrs. 10 mos. 4 ds.
IF LESS than 1 day how many _____ hrs. or _____ min?

8. OCCUPATION

(a) Trade, profession or particular kind of work
(b) General nature of industry business or establishment in which employed (or employer)

Housewife

9. BIRTHPLACE

(State or Country)

Switzerland

10. NAME OF FATHER

Brupper

11. BIRTHPLACE OF FATHER

(State or Country)

Switzerland

12. MAIDEN NAME OF MOTHER

13. BIRTHPLACE OF MOTHER

(State or Country)

Switzerland

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

(Address)

Samuel Frei
Collins Idaho

15.

Filed Apr 2 1913

W. A. Reibel
(Seal) Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH

April 2 1913
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from

Mar 28 1913, to April 1 1913

that I last saw him alive on Mar 30 1913

and that death occurred on the date stated above, at 2 A. M.

The CAUSE OF DEATH* was as follows:

Arteriosclerosis

..... (Duration) yrs. mos. ds.

Contributory (Secondary)

advanced age

..... (Duration) yrs. mos. ds.

(Signed) J. H. Clarke M. D.

16 (Address)

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place In the

of death yrs. mos. ds. State yrs. mos. ds.

Where was disease contracted,

If not at place of death?

Former or

usual residence

19. PLACE OF BURIAL OR REMOVAL DATE OF BURIAL

Moscow, Idaho Apr 2 1913

20. UNDERTAKER

ADDRESS

Geo. Petty

Moscow

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Form V. S. No. 5. 12½ M. 7-24-11

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH.

Registration District No. 15

County of Boateh

Primary Registration District No. 1008

City of Moscow

(No. , St.)

File No. 468

Registered No. 33

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Ellis Eldred Orcutt

If death occurred in a hospital, institution or camp give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX

m

4. COLOR OR RACE

white

5. SINGLE, MARRIED, WIDOWED OR DIVORCED.

(Write the word.)

6. DATE OF BIRTH

June 1
(Month)

12 1904
(Day) (Year)

7. AGE

28 yrs. 9 mos. 18 ds.

IF LESS than 1 day
how many hrs. or min?

8. OCCUPATION

- (a) Trade, profession or particular kind of work
(b) General nature of industry business or establishment in which employed (or employer)

9. BIRTHPLACE

(State or Country)

Moscow

10. NAME OF FATHER

R. G. Orcutt

11. BIRTHPLACE OF FATHER

(State or Country)

Washington

12. MAIDEN NAME OF MOTHER

Gertrude D. Bolt

13. BIRTHPLACE OF MOTHER

(State or Country)

Missouri

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

Mrs. F. D. Orcutt

(Address)

Moscow, Idaho

15.

Filed

Mar. 21 1913

L. H. Leibel
Deputy Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH

Mar. 30 1913
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from Mar. 26 1913, to Mar. 28 1913

that I last saw him alive on Mar. 28 1913
and that death occurred on the date stated above, at 3 P. M.
The CAUSE OF DEATH* was as follows:

Unknown to me.

(Duration) yrs. mos. 14 ds.

Contributory (Secondary)

(Duration) yrs. mos. ds.

(Signed) W. H. Carothers M. D.

April 1 1913. (Address) Moscow, Idaho

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place In the
of death yrs. mos. ds. State yrs. mos. ds.

Where was disease contracted,

If not at place of death?

Former or

usual residence.

19. PLACE OF BURIAL OR REMOVAL DATE OF BURIAL

Moscow

April 1 1913

20. UNDERTAKER

ADDRESS

Geo. Steltz

Moscow

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Form V. S. No. 5 20M.1-16-12

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH.

Registration District No.

County of

Primary Registration District No.

City of

(No., St.)

File No. 1689

Registered No. 21

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Irene Anderson

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX

Female

4. COLOR OR RACE

White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED.

Child
(Write the word.)

6. DATE OF BIRTH

January

17

1913

(Month)

(Day)

(Year)

7. AGE

3 yrs. 3 mos. 3 ds.

IF LESS than 1 day
how many hrs. or
..... mins.?

8. OCCUPATION

(a) Trade, profession or particular kind of work
(b) General nature of industry, business, or establishment in which employed (or employer)

Child

9. BIRTHPLACE

(State or Country)

Lincoln, Ida

10. NAME OF FATHER

Ambrase Anderson

11. BIRTHPLACE OF FATHER

(State or Country)

England

12. MAIDEN NAME OF MOTHER

Annie Schofield

13. BIRTHPLACE OF MOTHER

(State or Country)

England

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

(Address)

B. E. Newwoody
Idaho Falls

15.

Filed April 11 1913

Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH

April

11

1913

(Month)

(Day)

(Year)

17. I HEREBY CERTIFY, That I attended deceased from

191

to

191

that I last saw h. — alive on — 191—

and that death occurred on the date stated above, at — M.

The CAUSE OF DEATH* was as follows:

Contributory
(Secondary)

(Duration)

3 yrs. 3 mos. 3 ds.

(Signed)

(Duration)

3 yrs. 3 mos. 3 ds.

April 11, 1913

(Address)

Idaho Falls

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place

of death yrs. mos. days.

In the

State yrs. mos. days.

Where was disease contracted if not at place of death?

Former or usual residence.

19. PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

Lincoln

4 / 13 1913

20. UNDERTAKER

ADDRESS

B. E. Newwoody

Idaho Falls

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Form V. S. No. 5 20M.1-16-12

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH.

Registration District No. 7

County of Blaine

Primary Registration District No. 2017

File No. 4683

City of Idaho Falls

(No.)

St.)

Registered No.

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Mrs. Bridget Palmer

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX Female

4. COLOR OR RACE White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED. Married
(Write the word.)

6. DATE OF BIRTH X X 1851
(Month) (Day) (Year)

7. AGE 62 yrs. X mos. X ds.

IF LESS than 1 day
how many hrs. or
 mins.?

8. OCCUPATION

(a) Trade, profession or particular kind of work at Home

(b) General nature of industry business, or establishment in which employed (or employer)

9. BIRTHPLACE Ireland
(State or Country)

10. NAME OF FATHER McGonigle

11. BIRTHPLACE OF FATHER Ireland
(State or Country)

12. MAIDEN NAME OF MOTHER

13. BIRTHPLACE OF MOTHER Ireland
(State or Country)

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Warren Palmer

(Address) Idaho Falls

15. Filed Apr 17 1913

Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH April 11 1913
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from April 11th 1913, to April 10th 1913, that I last saw his alive on April 10th 1913 and that death occurred on the date stated above, at 5 a M.

The CAUSE OF DEATH* was as follows:

Bronchial asthma
chronic for 20 years
acute stage

7 days (Duration) yrs. mos. ds.

Contributory chronic bronchial
(Secondary)

asthma (Duration) 20 yrs. mos. ds.

(Signed) Thomas C. Williams M. D.

April 14, 1913 (Address) Idaho Falls Idaho

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death yrs. mos. days. In the State yrs. mos. days.

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL Idaho Falls

DATE OF BURIAL 4-14 1913

20. UNDERTAKER B. B. Woodward

ADDRESS Idaho Falls

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Form V. S. No. 5. 12½M. 7-24-11

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH. Registration District No. 7
County of Bonneville Primary Registration District No. 2009
City of Willow Creek (No. _____, _____ St.)

File No. 4684
Registered No. 27

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Engine Burkdale

If death occurred in a hospital, institution or camp give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX Male 4. COLOR OR RACE White 5. SINGLE, MARRIED, WIDOWED OR DIVORCED. Married
(Write the word.)

6. DATE OF BIRTH Mar 18 1913
(Month) (Day) (Year)

7. AGE _____ yrs. _____ mos. 17 ds. IF LESS than 1 day how many _____ hrs. or _____ min.

8. OCCUPATION
(a) Trade, profession or particular kind of work. Baker
(b) General nature of industry business or establishment in which employed (or employer)

9. BIRTHPLACE Idaho
(State or Country)

10. NAME OF FATHER J. M. Barkdall

11. BIRTHPLACE OF FATHER Kentucky
(State or Country)

12. MAIDEN NAME OF MOTHER Annie Bates

13. BIRTHPLACE OF MOTHER Utah
(State or Country)

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) J. M. Barkdall
(Address) Willow Creek

15. Apr 10 1913 Ray H. Fisher
Filed _____ Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH Apr 4 1913
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from Apr 3 1913, to Apr 4 1913 that I last saw him alive on Apr 3 1913 and that death occurred on the date stated above, at 1200 M.
The CAUSE OF DEATH* was as follows:

Acute Indigestion

_____ (Duration) _____ yrs. _____ mos. _____ ds.

Contributory (Secondary) Convulsions

_____ (Duration) _____ yrs. _____ mos. _____ ds.

(Signed) Annie Palmer M. D.
Apr 4 1913 (Address) Regley, Ida

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place _____ In the _____
of death _____ yrs. _____ mos. _____ ds. State _____ yrs. _____ mos. _____ ds.
Where was disease contracted, _____
If not at place of death? _____
Former or _____
usual residence _____

19. PLACE OF BURIAL OR REMOVAL DATE OF BURIAL

Willow Creek Apr 5 1913

20. UNDERTAKER ADDRESS

Friends Willow Creek

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Form V. S. No. 5 20M.1-16-12

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH

Registration District No. _____

County of _____

Primary Registration District No. _____

City of _____

(No. _____)

(St. _____)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

File No. _____

Registered No. _____

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX

4. COLOR OR RACE

5. SINGLE, MARRIED, WIDOWED OR DIVORCED.

6. DATE OF BIRTH

7. AGE

IF LESS than 1 day
how many _____ hrs. or
_____ mins.?

8. OCCUPATION

- (a) Trade, profession or particular kind of work
(b) General nature of industry business, or establishment in which employed (or employer)

9. BIRTHPLACE

(State or Country)

10. NAME OF FATHER

11. BIRTHPLACE OF FATHER

(State or Country)

12. MAIDEN NAME OF MOTHER

13. BIRTHPLACE OF MOTHER

(State or Country)

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

(Address)

15.

Filed _____

1913 _____

Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

17.

I HEREBY CERTIFY, That I attended deceased from _____

_____ 1913, to _____ 1913,

that I last saw him alive on _____ 1913,

and that death occurred on the date stated above, at _____ M.

The CAUSE OF DEATH* was as follows:

(Duration) _____ yrs. _____ mos. _____ days

Contributory
(Secondary)

(Duration) _____ yrs. _____ mos. _____ ds.

(Signed)

_____ M. D.
(Address) _____

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death _____ yrs. _____ mos. _____ days. In the State _____ yrs. _____ mos. _____ days.

Where was disease contracted if not at place of death?

Former or usual residence.

19. PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

20. UNDERTAKER

ADDRESS

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Form V. S. No. 5 20M.1-16-12

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH.

Registration District No. 7

County of Bonneville

Primary Registration District No. 2027

City of Idaho Falls

(No. _____, _____ St.)

File No. 4687

Registered No. 27

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

Jackson

(2nd time)

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX

Male

4. COLOR OR RACE

White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED.

Single
(Write the word.)

6. DATE OF BIRTH

April 23 1913
(Month) (Day) (Year)

7. AGE

_____ yrs. _____ mos. 10 ds.

IF LESS than 1 day
how many _____ hrs. or
_____ mins.?

8. OCCUPATION

(a) Trade, profession or particular kind of work

(b) General nature of industry business, or establishment in which employed (or employer)

9. BIRTHPLACE

(State or Country)

Idaho Falls

10. NAME OF FATHER

Harvey Jackson

11. BIRTHPLACE OF FATHER

(State or Country)

Kansas

12. MAIDEN NAME OF MOTHER

John E. New

13. BIRTHPLACE OF MOTHER

(State or Country)

Utah

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

H. E. Jackson

(Address)

Idaho Falls

15.

Filed

May

1913

[Signature]
Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH

May 5 1913
(Month) (Day) (Year)

17. I HEREBY CERTIFY That I attended deceased from

April 25 1913, to May 5 1913,

that I last saw him alive on May 5 1913,

and that death occurred on the date stated above, at 10 P. M.

The CAUSE OF DEATH* was as follows:

Malnutrition

(Duration) _____ yrs. _____ mos. _____ ds.

Contributory
(Secondary)

(Duration) _____ yrs. _____ mos. _____ ds.

(Signed)

May 7 1913 (Address) Idaho Falls, Id.

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death _____ yrs. _____ mos. _____ days. In the State _____ yrs. _____ mos. _____ days.

Where was disease contracted if not at place of death?

Former or usual residence _____

19. PLACE OF BURIAL OR REMOVAL

Idaho Falls

DATE OF BURIAL

May 7 1913

20. UNDERTAKER

G. H. Hunt

ADDRESS

Idaho Falls

MARGIN RESERVED FOR BINDING
WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Form V. S. No. 5 20M.1-16-12

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH.

Registration District No. 12027

County of Bonneville

Primary Registration District No. 12027

File No. 4684

City of _____

(No. _____ St.)

Registered No. _____

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Donald Jacobson

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX

male

4. COLOR OR RACE

White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED.

(Write the word.)

6. DATE OF BIRTH

May

11

1911

(Month)

(Day)

(Year)

7. AGE

1 8 yrs. 11 mos. 19 ds.

IF LESS than 1 day
how many hrs. or
..... mins.?

8. OCCUPATION

(a) Trade, profession or particular kind of work

(b) General nature of industry business, or establishment in which employed (or employer)

9. BIRTHPLACE

(State or Country)

Idaho Falls Idaho

10. NAME OF FATHER

Gustav Jacobson

11. BIRTHPLACE OF FATHER

(State or Country)

Utah

12. MAIDEN NAME OF MOTHER

Eliy Jane Oskden

13. BIRTHPLACE OF MOTHER

(State or Country)

Idaho

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Gustav Jacobson

(Address) Idaho Falls

15.

Filed May 2 1913

Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH

(Month)

(Day)

May 1

1913

17. I HEREBY CERTIFY, That I attended deceased from

May 1 1913, to May 1 1913,

that I last saw him alive on May 1 1913.

and that death occurred on the date stated above, at Idaho Falls.

The CAUSE OF DEATH* was as follows:

Enteritis

(Duration)

yrs.

mos.

ds.

Contributory
(Secondary)

(Duration)

yrs.

mos.

ds.

(Signed)

072 1913 (Address) Idaho Falls Idaho

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place

of death

yrs.

mos.

days.

In the

State

yrs.

mos.

days.

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL

Idaho Falls Idaho

DATE OF BURIAL

May 4 1913

20. UNDERTAKER

Linwood J. J. J.

ADDRESS

Idaho Falls

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Form V. S. No. 5 20M.1-16-12

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH.

Registration District No. 7

County of

Primary Registration District No. 2221

City of

(No. 1 St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

Geo. Wm. Godfrey

File No. 4689

Registered No. 25

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX

Male

4. COLOR OR RACE

White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED.

Married
(Write the word.)

6. DATE OF BIRTH

Nov. 7, 1865

(Month)

(Day)

(Year)

7. AGE

47 yrs. 6 mos. 1 ds.

IF LESS than 1 day
how many hrs. or mins.?

8. OCCUPATION

(a) Trade, profession or particular kind of work

Farmer

(b) General nature of industry business, or establishment in which employed (or employer)

9. BIRTHPLACE

(State or Country)

Utah

10. NAME OF FATHER

Chas. Godfrey

11. BIRTHPLACE OF FATHER

(State or Country)

England

12. MAIDEN NAME OF MOTHER

Sophia C. Liffa

13. BIRTHPLACE OF MOTHER

(State or Country)

England

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

(Address)

Geo. Wm. Godfrey
Union Idaho

15.

Filed

May 7, 1913

1913

Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH

May 6th 1913

(Month)

(Day)

(Year)

17. I HEREBY CERTIFY, That I attended deceased from

MAY 6th 1913, toMay 6th 1913,that I last saw him alive on May 4th 1913,

and that death occurred on the date stated above, at M.

The CAUSE OF DEATH* was as follows:

Cerebral hemorrhage

(Duration) yrs. mos. ds.

Contributory

(Secondary)

(Duration) yrs. mos. ds.

(Signed)

May 6th 1913 (Address) Ogden, Idaho

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death yrs. mos. days. In the State yrs. mos. days.

Where was disease contracted if not at place of death?

Former or usual residence.

19. PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

Union Idaho

May 7, 1913

20. UNDERTAKER

ADDRESS

G. H. Hunt

Idaho Falls

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Form V. S. No. 5. 12½ M. 7-24-11

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics
File No. 18911
Registered No. 264

1. PLACE OF DEATH. Registration District No. 2118
County of Boonville Primary Registration District No. 2118
City of Boonville-Mission (No. _____, St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Mary Anna Daniel

If death occurred in a hospital, institution or camp give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX Female 4. COLOR OR RACE Indian 5. SINGLE, MARRIED, WIDOWED OR DIVORCED. married
(Write the word.)
6. DATE OF BIRTH March 1892
(Month) (Day) (Year)

7. AGE 21 yrs. — mos. — ds. IF LESS than 1 day
how many hrs. or min?

8. OCCUPATION

(a) Trade, profession or particular kind of work. Housewife
(b) General nature of industry business or establishment in which employed (or employer)

9. BIRTHPLACE

(State or Country)

Kalispell

10. NAME OF FATHER

Pikaski Kie

11. BIRTHPLACE OF FATHER

(State or Country)

Kalispell

12. MAIDEN NAME OF MOTHER

Christine

13. BIRTHPLACE OF MOTHER

(State or Country)

Kalispell

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Father, Karama(Address) Boonville, Idaho

15.

Filed April 10 1913

S. D. Newman
Sup. J. L. Taylor
Int. Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH

March 31 1913
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from March 27 1913, to March 31 1913 that I last saw him alive on March 27 1913 and that death occurred on the date stated above, at 3 A.M. The CAUSE OF DEATH* was as follows:

Pneumonia with
abscess

(Duration) yrs. mos. 4 ds.
Contributory Pulmonary Tuberculosis
(Secondary)

(Duration) 1 yrs. — mos. — ds.
(Signed) J. R. Ballard M. D.
March 31 1913 (Address) Boonville, Idaho

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place In the
of death yrs. mos. ds. State yrs. mos. ds.
Where was disease contracted,
If not at place of death?
Former or
usual residence.....

19. PLACE OF BURIAL OR REMOVAL DATE OF BURIAL

20. UNDERTAKER

ADDRESS

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Form V. S. No. 5. 12½ M. 7-24-11

CERTIFICATE OF DEATH

1. PLACE OF DEATH.
County of _____
City of _____

Registration District No. _____
Primary Registration District No. _____
(No. _____, St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME *Eliza Annell*

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

File No. *1691*
Registered No. *267*

If death occurred in a hospital, institution or camp give its name instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX *Female* 4. COLOR OR RACE *White* 5. SINGLE, MARRIED, WIDOWED OR DIVORCED. *Widow*
(Write the word.)

6. DATE OF BIRTH *Mar 6 1840*
(Month) (Day) (Year)

7. AGE *73* yrs. *27* mos. *27* ds. IF LESS than 1 day how many hrs. or min?

8. OCCUPATION
(a) Trade, profession or particular kind of work. *none*
(b) General nature of industry business or establishment in which employed (or employer)

9. BIRTHPLACE (State or Country) *U.S.*

10. NAME OF FATHER

11. BIRTHPLACE OF FATHER (State or Country)

12. MAIDEN NAME OF MOTHER

13. BIRTHPLACE OF MOTHER (State or Country)

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) *Beidle*
(Address) *Sgt Lake*

15. *4/10* 191*0* *S. H. Truman*
Filed Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH *March 30*
(Month) (Day)

17. I HEREBY CERTIFY, That I attended deceased *one* 191*2*, to *Mar 30*

that I last saw him alive on *Mar 28* and that death occurred on the date stated above, at *8:30*

The CAUSE OF DEATH* was as follows:

Familial debility

(Duration) yrs. mos. Contributory (Secondary) *Valvular heart disease*

(Duration) *several* yrs. mos. (Signed) *Dr. H. H. Smith*
*39 (Address) *Smith Lake*

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state MEANS OF INJURY; (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions or Recent Residents.)

At place of death yrs. mos. ds. State yrs. mos. Where was disease contracted, If not at place of death? Former or usual residence.

19. PLACE OF BURIAL OR REMOVAL DATE OF BURIAL

Sgt. Lake *3/31* 191*0*
20. UNDERTAKER *Klopp* ADDRESS *Pasternak*

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Form V. S. No. 2 20M.1-16-12

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH.

Registration District No.

County of *Kootenai*

Primary Registration District No. *1003*

City of *Camden*

(No. St.)

File No. *469*

Registered No. *263*

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

John Stone

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX

male

4. COLOR OR RACE

white

5. SINGLE, MARRIED, WIDOWED OR DIVORCED.

married
(Write the word.)

6. DATE OF BIRTH

1883
(Month) (Day) (Year)

7. AGE

28 yrs. mos. ds.

IF LESS than 1 day
how many hrs. or
..... mins.

8. OCCUPATION

(a) Trade, profession or particular kind of work

millwright

(b) General nature of industry business, or establishment in which employed (or employer)

9. BIRTHPLACE

(State or Country)

Wisconsin

10. NAME OF FATHER

W W Stone

11. BIRTHPLACE OF FATHER

(State or Country)

Wis

12. MAIDEN NAME OF MOTHER

Mary Lapond

13. BIRTHPLACE OF MOTHER

(State or Country)

Wis

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

father

(Address)

C. W. A

15.

Filed

4-10

191*3*

S. S. Schuman
Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH

John Stone
March 29

(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from

only on call 191*3*, to *1913*

that I last saw him alive on *March 29* 191*3*

and that death occurred on the date stated above, at *6 P. M.*

The CAUSE OF DEATH* was as follows:

Caught in machinery of mill leading to shoulder & ribs fractured broken

(Duration) yrs. mos. ds.

Contributory (Secondary)

(Duration) yrs. mos. ds.

(Signed)

A. Hunt

M. D.

19 (Address) *Camden Idaho*

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death yrs. mos. days. In the State yrs. mos. days.

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

Xmas

Mar 31 1913

20. UNDERTAKER

ADDRESS

S. S. Schuman

C. W. A

Exact state-
ment of OCCUPATION is very important. See instructions on back of certificate.

Form V. S. No. 5. 12½ M. 7-24-11

CERTIFICATE OF DEATH

1. PLACE OF DEATH.

County of Posterior
City of Spit Lake

Registration District No. 12

Primary Registration District No. 2007

(No. _____, _____ St.)

BOARD OF HEALTH
Bureau of Vital Statistics

File No. 4693

Registered No. 2621

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

Virgil Forest Wilson

If death occurred in a hospital, institution or camp give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX

Male

4. COLOR OR RACE

White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED.

Single
(Write the word.)

6. DATE OF BIRTH

June

10

1912

(Month)

(Day)

(Year)

7. AGE

9 yrs.

18 mos.

ds.

IF LESS than 1 day
how many _____ hrs. or
_____ min.

8. OCCUPATION

(a) Trade, profession or particular kind of work.

(b) General nature of industry business or establishment in which employed (or employer)

Infant

9. BIRTHPLACE

(State or Country)

Mo

10. NAME OF FATHER

JW Wilson

11. BIRTHPLACE OF FATHER

(State or Country)

Mo

12. MAIDEN NAME OF MOTHER

Lula May Caldwell

13. BIRTHPLACE OF MOTHER

(State or Country)

Ark

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

E S Brindle

(Address)

Sp Lake Id

15.

Filed 4/10 1913

J S Stowell
Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH

Mar

28

1913

(Month)

(Day)

(Year)

17. I HEREBY CERTIFY, That I attended deceased from

Mar 24

1913

to Mar 28

1913

that I last saw him alive on Mar 28 1913

and that death occurred on the date stated above, at 10 A. M.

The CAUSE OF DEATH* was as follows:

Pneumonia

(Duration)

yrs.

mos.

ds.

Contributory
(Secondary)

Infantile paralysis when 3 mo old

(Duration)

yrs.

mos.

ds.

(Signed)

E S Brindle

M. D.

19

(Address)

Spit Lake

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place

In the

of death _____ yrs. _____ mos. _____ ds. State _____ yrs. _____ mos. _____ ds.

Where was disease contracted,

If not at place of death?

Former or

usual residence.

19. PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

Sp L.

Mar 29 1913

20. UNDERTAKER

ADDRESS

Klopf now

Postleau

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

1. PLACE OF DEATH. Registration District No. 2118
County of Lincoln Primary Registration District No. 2118
City of Dumont (No. _____, _____ St.)

BOARD OF HEALTH
Bureau of Vital Statistics
File No. 469+
Registered No. 261

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

Louis Gustagen

If death occurred in a hospital, institution or camp give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX

Male

Indian

4. COLOR OR RACE

5. SINGLE, MARRIED, WIDOWED OR DIVORCED.

Single
(Write the word.)

6. DATE OF BIRTH

March

(Month)

27

(Day)

1913

(Year)

7. AGE

16 yrs.

— mos.

— ds.

IF LESS than 1 day
how many _____ hrs. or
_____ min?

8. OCCUPATION

(a) Trade, profession or particular kind of work

School boy

(b) General nature of industry business or establishment in which employed (or employer)

9. BIRTHPLACE

(State or Country)

Reservation

10. NAME OF FATHER

Joseph Gustagen

11. BIRTHPLACE OF FATHER

(State or Country)

Spokane Reservation

12. MAIDEN NAME OF MOTHER

Mary Rose Sebastian

13. BIRTHPLACE OF MOTHER

(State or Country)

Reservation

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

Marta Gustagen

(Address)

Dumont, Ida

15.

Filed

April 10
April 29 1913

W. J. Longley
Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH

March

(Month)

27

(Day)

1913

(Year)

17. I HEREBY CERTIFY, That I attended deceased from

August 1912, to March 15 1913

that I last saw him alive on March 15 1913

and that death occurred on the date stated above, at 11 P. M.

The CAUSE OF DEATH* was as follows:

Pulmonary Tuberculosis

(Duration) — yrs. 17 mos. — ds.

Contributory
(Secondary)

(Duration) — yrs. — mos. — ds.

(Signed) J. R. Ballard M. D.

March 29 1913 (Address) Dumont, Ida

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place

In the

of death. — yrs. — mos. — ds. State. — yrs. — mos. — ds.

Where was disease contracted,

If not at place of death?

Former or

usual residence.

19. PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

None

March 29 1913

20. UNDERTAKER

ADDRESS

1. PLACE OF DEATH.

Registration District No. 19County of KootenaiPrimary Registration District No. 1003City of Coeur d'Alene

(No. _____, _____ St.)

File No. 4695Registered No. 260

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

Mattie Varnum

If death occurred in a hospital, institution or camp give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX

Female

4. COLOR OR RACE

White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED.

Married
(Write the word.)

6. DATE OF BIRTH

March261883

(Month)

(Day)

(Year)

7. AGE

30

yrs.

0

mos.

0

ds.

IF LESS than 1 day
how many _____ hrs. or
_____ min?

8. OCCUPATION

- (a) Trade, profession or particular kind of work
-
- (b) General nature of industry business or establishment in which employed (or employer)

Housewife

9. BIRTHPLACE

(State or Country)

Ind.

10. NAME OF FATHER

Peter McKee

11. BIRTHPLACE OF FATHER

(State or Country)

Ind.

12. MAIDEN NAME OF MOTHER

Lula Yazbe

13. BIRTHPLACE OF MOTHER

(State or Country)

Ind.

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

H. E. Samson

(Address)

15.

Filed

4/101919

Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH

March271913

(Month)

(Day)

(Year)

17. I HEREBY CERTIFY, That I attended deceased from

March 81913,to March 261913that I last saw him alive on March 26 1913

and that death occurred on the date stated above, at _____ M.

The CAUSE OF DEATH* was as follows:

Pulmonary tuberculosis

(Duration)

1 yrs.

mos.

ds.

Contributory
(Secondary)

(Duration)

yrs.

mos.

ds.

(Signed)

John C. Wood M. D.March 27, 1913

(Address)

Coeur d'Alene, Ida.

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place

In the

of death

yrs.

mos.

ds.

State

yrs.

mos.

ds.

Where was disease contracted,

If not at place of death?

Former or

usual residence.

19. PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

Forest cemetery3/281913

20. UNDERTAKER

ADDRESS

Cassidy & NelsonCoeur d'Alene

WHITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Form V. S. No. 5. 12½ M. 7-24-11

CERTIFICATE OF DEATH

1. PLACE OF DEATH. Registration District No. 2118 19
County of Butte Primary Registration District No. 2118
City of Butte (No. _____, _____ St.)

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

File No. 169
Registered No. 568

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

Victorio

If death occurred in a hospital, institution or camp give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX 4. COLOR OR RACE 5. SINGLE, MARRIED, WIDOWED OR DIVORCED.

Female

Indian

Married
(Write the word.)

6. DATE OF BIRTH

Shout

1823

(Month)

(Day)

(Year)

7. AGE

90 yrs. _____ mos. _____ ds.

IF LESS than 1 day
how many _____ hrs. or
_____ min?

8. OCCUPATION

(a) Trade, profession or particular kind of work.

Housewife

(b) General nature of industry business or establishment in which employed (or employer)

9. BIRTHPLACE

(State or Country)

Nehalemilko

10. NAME OF FATHER

Unknown

11. BIRTHPLACE OF FATHER

(State or Country)

Unknown

12. MAIDEN NAME OF MOTHER

Unknown

13. BIRTHPLACE OF MOTHER

(State or Country)

Unknown

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

Father

(Address)

Butte, Idaho

15.

4/10

J. D. Greenway

Filed

4/10

1913

Geo. J. Engle
Int. Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH

March

12

1913

(Month)

(Day)

(Year)

17. I HEREBY CERTIFY, That I attended deceased from

191

to

191

that I last saw him alive on

191

and that death occurred on the date stated above, at

M.

The CAUSE OF DEATH* was as follows:

Senility no medical attendance

(Duration)

yrs.

mos.

ds.

Contributory
(Secondary)

(Duration)

yrs.

mos.

ds.

(Signed)

M. D.

19

(Address)

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place

In the

of death _____ yrs. _____ mos. _____ ds. State _____ yrs. _____ mos. _____ ds.

Where was disease contracted,

If not at place of death?

Former or

usual residence.

19. PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

Indian Cemetery

March 19 1913

20. UNDERTAKER

ADDRESS

None

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Form V. S. No. 5 20M.1-16-12

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH.

Registration District No. 12

County of Butte

Primary Registration District No. 1003

City of Coeur d'Alene

(No. _____, St.)

File No. 1697

Registered No. 208

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

Eliza Cabel

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX

Female

4. COLOR OR RACE

White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED.

Widow
(Write the word.)

6. DATE OF BIRTH

1853
(Month) (Day) (Year)

7. AGE

60 yrs. mos. ds.

IF LESS than 1 day
how many hrs. or mins.?

8. OCCUPATION

(a) Trade, profession or particular kind of work

(b) General nature of industry business, or establishment in which employed (or employer)

9. BIRTHPLACE

(State or Country)

Maryland

10. NAME OF FATHER

11. BIRTHPLACE OF FATHER

(State or Country)

12. MAIDEN NAME OF MOTHER

13. BIRTHPLACE OF MOTHER

(State or Country)

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

(Address)

John Wood
Coeur d'Alene

15.

Filed

4/10

1913

J. D. Cabel

Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH

March 16 1913
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from

Mar. 5 1913, to Mar. 16 1913,
that I last saw her alive on Mar. 16 1913

and that death occurred on the date stated above, at 5 P. M.

The CAUSE OF DEATH* was as follows:

Scarlet Pneumonia

(Duration) yrs. mos. 9 ds.

Contributory (Secondary)

Scarlet gripe

(Duration) yrs. mos. 7 ds.

(Signed)

John Wood M. D.
Mar. 17 1913 (Address) Coeur d'Alene

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death. yrs. mos. days. In the State. yrs. mos. days.

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

Batholom Idaho Mar 19 1913

20. UNDERTAKER

ADDRESS

J. D. Cabel

C. D. Cabel

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Form V. S. No. 5 20M.1-16-12

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH.

Registration District No. 12

County of Kootenai

Primary Registration District No. 2057

City of Garnett

(No. _____ St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

Infant Evans

File No. 469

Registered No. 257

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX

M

4. COLOR OR RACE

W

5. SINGLE, MARRIED, WIDOWED OR DIVORCED.

S. (Write the word.)

6. DATE OF BIRTH

Mon. 14 1913
(Month) (Day) (Year)

7. AGE

_____ yrs. _____ mos. 16 ds.

IF LESS than 1 day
how many _____ hrs. or
_____ mins.

8. OCCUPATION

(a) Trade, profession or particular kind of work

Infant

(b) General nature of industry business, or establishment in which employed (or employer)

9. BIRTHPLACE

(State or Country)

New Garnett

10. NAME OF FATHER

A. S. Evans

11. BIRTHPLACE OF FATHER

(State or Country)

N. Dak

12. MAIDEN NAME OF MOTHER

Norah Reynolds

13. BIRTHPLACE OF MOTHER

(State or Country)

Iowa

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

A. S. Evans

(Address)

Garnett

15.

Filed

4/30

1913

S. S. Drumm

Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH

Mon. 29 1913
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from

_____ 191____, to _____ 191____,
that I last saw him alive on _____ 191____,

and that death occurred on the date stated above, at _____ M.

The CAUSE OF DEATH* was as follows:

No Phosphorus. No Cause Known except premature Birth

(Duration) _____ yrs. _____ mos. _____ ds.

Contributory (Secondary)

Premature

(Duration) _____ yrs. _____ mos. _____ ds.

(Signed)

S. S. Drumm M. D.

6/30 1913 (Address)

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death _____ yrs. _____ mos. _____ days. In the State _____ yrs. _____ mos. _____ days.

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL

Garnett

DATE OF BURIAL

3/31 1913

20. UNDERTAKER

Robt. Evans

ADDRESS

R

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Form V. S. No. 5 20M.1-16-12

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH.

Registration District No. 12

County of _____

Primary Registration District No. 1003

City of _____

(No. _____ St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

Lambert Preston

File No. 4699

Registered No. 256

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX

male

4. COLOR OR RACE

white

5. SINGLE, MARRIED, WIDOWED OR DIVORCED.

single
(Write the word.)

6. DATE OF BIRTH

1913
(Month) (Day) (Year)

7. AGE

2 yrs. 2 mos. 2 ds.

IF LESS than 1 day
how many _____ hrs. or
_____ mins.?

8. OCCUPATION

(a) Trade, profession or particular kind of work
(b) General nature of industry, business, or establishment in which employed (or employer)

9. BIRTHPLACE

(State or Country)

Coventry, Alabama

10. NAME OF FATHER

Gilbert Preston

11. BIRTHPLACE OF FATHER

(State or Country)

Canada

12. MAIDEN NAME OF MOTHER

Mary Thompson

13. BIRTHPLACE OF MOTHER

(State or Country)

Canada

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

Edith

(Address)

1005 X road

15.

Filed

4/10

1913

J. D. Green

Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

March 11 1913
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from

Jan 30 1913, to Mar 11 1913,

that I last saw him alive on Mar 10 1913,

and that death occurred on the date stated above, at M

The CAUSE OF DEATH* was as follows:

Marasmus

(Duration) 2 yrs. 2 mos. 2 ds.

Contributory
(Secondary)

(Duration) 2 yrs. 2 mos. 2 ds.

(Signed)

Mar 11/1913 (Address) Coventry, Alabama

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death _____ yrs. _____ mos. _____ days. In the State _____ yrs. _____ mos. _____ days.

Where was disease contracted if not at place of death?

Former or usual residence _____

19. PLACE OF BURIAL OR REMOVAL

Funeral Home

DATE OF BURIAL

March 11 1913

20. UNDERTAKER

J. D. Green

ADDRESS

Coventry

MARGIN RESERVED FOR BINDING
WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

County of <u>Boston</u> City of <u>Cour D'Alene</u>		Primary Registration District No. <u>1003</u> (No. _____, St.)		File No. <u>1201</u> Registered No. <u>250</u>	
If death occurs away from usual residence, give facts called for under special information.					
2. FULL NAME <u>Thomas B Carroll</u>					
Bureau of Vital Statistics					
PERSONAL AND STATISTICAL PARTICULARS			MEDICAL CERTIFICATE OF DEATH.		
3. SEX <u>Male</u>		4. COLOR OR RACE <u>White</u>		5. SINGLE, MARRIED, WIDOWED OR DIVORCED. <u>Married</u> (Write the word.)	
6. DATE OF BIRTH <u>Feb 18</u> 191 <u>3</u> (Month) (Day) (Year)					
7. AGE <u>73</u> yrs. <u>0</u> mos. <u>0</u> ds. IF LESS than 1 day how many <u>0</u> hrs. or <u>0</u> min?					
8. OCCUPATION (a) Trade, profession or particular kind of work <u>Retire d.</u> (b) General nature of industry business or establishment in which employed (or employer) _____					
9. BIRTHPLACE <u>Canada</u> (State or Country)					
10. NAME OF FATHER <u>Thomas Carroll</u>					
11. BIRTHPLACE OF FATHER <u>Canada</u> (State or Country)					
12. MAIDEN NAME OF MOTHER _____					
13. BIRTHPLACE OF MOTHER <u>Canada</u> (State or Country)					
14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE (Informant) <u>Mrs E E Graham</u> (Address) <u>1028 Latrobe Ave</u>					
15. Filed <u>4/10</u> 191 <u>3</u> <u>D S Greenman</u> Local Registrar					
16. DATE OF DEATH <u>March 8</u> 191 <u>3</u> (Month) (Day) (Year)					
17. I HEREBY CERTIFY, That I attended deceased from <u>Feb 18</u> 191 <u>3</u> , to <u>Mar 8</u> 191 <u>3</u> that I last saw him alive on <u>Feb 26</u> 191 <u>3</u> and that death occurred on the date stated above, at <u>12:30</u> M. The CAUSE OF DEATH* was as follows: <u>Senility.</u>					
_____ (Duration) _____ yrs. _____ mos. _____ ds.					
Contributory (Secondary) _____ (Duration) _____ yrs. _____ mos. _____ ds.					
(Signed) <u>J. D. Green</u> M. D. <u>Mar 8</u> 191 <u>3</u> (Address) <u>Cour d'Alene Ida</u>					
*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.					
18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.) At place _____ In the _____ of death _____ yrs. _____ mos. _____ ds. State _____ yrs. _____ mos. _____ ds. Where was disease contracted, _____ If not at place of death? _____ Former or usual residence _____					
19. PLACE OF BURIAL OR REMOVAL <u>Cat Cem Cour d'Alene</u> DATE OF BURIAL <u>3/9</u> 191 <u>3</u>					
20. UNDERTAKER <u>Cassidy & Nelson</u> ADDRESS <u>Cour d'Alene</u>					

WHITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Form V. S. No. 5. 12½ M. 7-24-11

1. PLACE OF DEATH. Registration District No. 5118
County of Boone Primary Registration District No. 2118
City of Desmet, Idaho (No. _____, _____ St.)

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

File No. 4701
Registered No. 254

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Meademus

If death occurred in a hospital, institution or camp give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX Male 4. COLOR OR RACE Indian 5. SINGLE, MARRIED, WIDOWED OR DIVORCED. married
(Write the word.)

6. DATE OF BIRTH March 1888
(Month) (Day) (Year)

7. AGE 60 yrs. 5 mos. 5 ds. IF LESS than 1 day how many hrs. or min?

8. OCCUPATION
(a) Trade, profession or particular kind of work. Farmhand
(b) General nature of industry business or establishment in which employed (or employer) _____

9. BIRTHPLACE (State or Country) Reservation

10. NAME OF FATHER Cyprian

11. BIRTHPLACE OF FATHER (State or Country) Not known

12. MAIDEN NAME OF MOTHER Not known

13. BIRTHPLACE OF MOTHER (State or Country) Not known

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Jim Meademus
(Address) Desmet, Idaho

15. Apr 10, 1913
Filed Apr 10 1913
J. D. Greaney
Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH March 8 1913
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from Baby 23 1913, to March 7 1913
that I last saw him alive on March 7 1913
and that death occurred on the date stated above, at 10 a. m.

The CAUSE OF DEATH* was as follows:

Chasmania
(Duration) _____ yrs. _____ mos. 6 ds.

Contributory (Secondary) Hepatitis

(Signed) J. R. Ballard M. D.
March 10, 1913 (Address) Desmet Idaho

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place In the
of death yrs. mos. ds. State yrs. mos. ds.
Where was disease contracted,
If not at place of death?
Former or
usual residence.....

19. PLACE OF BURIAL OR REMOVAL DATE OF BURIAL
Mar 10 1913

20. UNDERTAKER ADDRESS
none

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Form V. S. No. 5 20M.1-16-12

CERTIFICATE

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH. Registration District No. 72
County of Asotin Primary Registration District No. 2051
City of Post Falls R.T.D. (No. , St.)
File No. 470
Registered No. 253
If death occurs away from usual residence, give facts called for under special information. 2. FULL NAME Alexander Peters
If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX Male 4. COLOR OR RACE White 5. SINGLE, MARRIED, WIDOWED OR DIVORCED. Married (Use word.)

6. DATE OF BIRTH 1858
(Month) (Day) (Year)

7. AGE 75 yrs. mos. ds.
IF LESS than 1 day how many hrs. or mins.?

8. OCCUPATION
(a) Trade, profession or particular kind of work Farmer
(b) General nature of industry, business, or establishment in which employed (or employer)

9. BIRTHPLACE
(State or Country) Scotland

10. NAME OF FATHER Alex Peters

11. BIRTHPLACE OF FATHER
(State or Country) Scotland

12. MAIDEN NAME OF MOTHER

13. BIRTHPLACE OF MOTHER
(State or Country) Scotland

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) John Peters
(Address) Post Falls

15. Filed 4/10 1913 J.S. Sweeney
Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH Mar 5 1913
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from Apr 4 1913, to Mar 5 1913, that I last saw him alive on Apr 5 1913, and that death occurred on the date stated above, at PM.

THE CAUSE OF DEATH* was as follows:
Obstruction of Bowels
version
(Duration) yrs. mos. 3 ds.

Contributory (Secondary) eye
(Duration) yrs. mos. ds.
(Signed) J.S. Sweeney M. D.
3/6 1913 (Address) Post Falls

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death yrs. mos. days. In the State yrs. mos. days.
Where was disease contracted if not at place of death?

Former or usual residence.

19. PLACE OF BURIAL OR REMOVAL Post Falls DATE OF BURIAL 3/6 1913

20. UNDERTAKER Klopf ADDRESS Post Falls

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Form V. S. No. 5. 12½ M. 7-24-11

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics
File No. 4704
Registered No. 23

1. PLACE OF DEATH. Registration District No. 2
County of Bear Lake Primary Registration District No. 2091
City of Bloomington (No. _____ St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

Oliver W. Sanford

If death occurred in a hospital, institution or camp give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX Male 4. COLOR OR RACE white 5. SINGLE, MARRIED, WIDOWED OR DIVORCED. single
(Write the word.)

6. DATE OF BIRTH April 23 1913
(Month) (Day) (Year)

7. AGE 8 yrs. 2 mos. 2 ds. IF LESS than 1 day how many _____ hrs. or _____ min?

8. OCCUPATION

(a) Trade, profession or particular kind of work. Relig
(b) General nature of industry business or establishment in which employed (or employer)

9. BIRTHPLACE

(State or Country) Bloomington

10. NAME OF FATHER

Oliver Sanford

11. BIRTHPLACE OF FATHER

(State or Country) St. Louis Mo.

12. MAIDEN NAME OF MOTHER

Ida Diamond

13. BIRTHPLACE OF MOTHER

(State or Country) Bloomington

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Stanley Sanford

(Address) Bloomington

15.

Filed May 2 1913

ADC only
Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH April 25 1913
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from April 19 1913 to April 20 1913
that I last saw him alive on April 25 1913
and that death occurred on the date stated above, at 12 M.

The CAUSE OF DEATH* was as follows:

Pneumonia

(Duration) _____ yrs. _____ mos. 10 ds.

Contributory (Secondary) Measles

(Duration) _____ yrs. _____ mos. 3 ds.

(Signed) ADC only M. D.

April 20 1913 (Address) Pat's

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place _____ In the _____
of death _____ yrs. _____ mos. _____ ds. State _____ yrs. _____ mos. _____ ds.
Where was disease contracted, _____
If not at place of death? _____
Former or _____
usual residence. _____

19. PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

Bloomington Ida April 27 1913

20. UNDERTAKER

ADDRESS

None

—

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Form V. S. No. 5. 12½ M. 7-24-11

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH. Registration District No. 24
County of Bear Lake Primary Registration District No. 2094
City of Ovid (No. _____ St.)

File No. 1703
Registered No. 29

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

Mrs. Laurine Christoffersen

If death occurred in a hospital, institution or camp give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX Female 4. COLOR OR RACE white 5. SINGLE, MARRIED, WIDOWED OR DIVORCED. Married
(Write the word.)
6. DATE OF BIRTH April 21 1913
(Month) (Day) (Year)

7. AGE 75 yrs. 3 mos. 29 ds. IF LESS than 1 day how many _____ hrs. or _____ min?

8. OCCUPATION
(a) Trade, profession or particular kind of work. House work
(b) General nature of industry business or establishment in which employed (or employer) Married

9. BIRTHPLACE
(State or Country) Denmark

10. NAME OF FATHER Hans Andersen

11. BIRTHPLACE OF FATHER
(State or Country) Slagelse, Saa

12. MAIDEN NAME OF MOTHER Annie Olsen

13. BIRTHPLACE OF MOTHER
(State or Country) Denmark

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Philemon Lindsey
(Address) Ovid, Idaho

15. Filed May 8 1913 A. P. Cooley
Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH April 21 1913
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from _____ 191____, to _____ 191____

that I last saw her alive on _____ 191____

and that death occurred on the date stated above, at 1:15 P. M.

The CAUSE OF DEATH* was as follows:

Senility

(Duration) 1 yrs. _____ mos. _____ ds.

Contributory (Secondary) _____

(Duration) _____ yrs. _____ mos. _____ ds.

(Signed) J. H. Hayward M. D.
Apr. 23 1913 (Address) Paris, Idaho

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place _____ In the _____
of death _____ yrs. _____ mos. _____ ds. State _____ yrs. _____ mos. _____ ds.
Where was disease contracted, _____
If not at place of death? _____
Former or _____
usual residence _____

19. PLACE OF BURIAL OR REMOVAL Ovid Idaho DATE OF BURIAL 4-23 1913

20. UNDERTAKER Name ADDRESS _____

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Form V, S. No. 5. 12½ M. 7-24-11

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH. Registration District No. 24
County of Bear Lake Primary Registration District No. 2098
City of Montpelier (No. _____, St.)

File No. 4705
Registered No. 19

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

Ruben S. Amell

If death occurred in a hospital, institution or camp give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX Male 4. COLOR OR RACE White 5. SINGLE, MARRIED, WIDOWED OR DIVORCED Divorced
(Write the word.)

6. DATE OF BIRTH Sept. 6th 1851
(Month) (Day) (Year)

7. AGE 62 yrs. 6 mos. 28 ds. IF LESS than 1 day
how many _____ hrs. or _____ min?

8. OCCUPATION

(a) Trade, profession or particular kind of work
(b) General nature of industry business or establishment in which employed (or employer)

Laborer
Rooming House

9. BIRTHPLACE

(State or Country)

London, England

10. NAME OF FATHER

Ruben Amell

11. BIRTHPLACE OF FATHER

(State or Country)

London, England

12. MAIDEN NAME OF MOTHER

Jennie Jones

13. BIRTHPLACE OF MOTHER

(State or Country)

South Wales

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

(Address)

J. M. Johnson Jr.
Montpelier, Ida.

15.

Filed 4-26-1913

A. C. Cooley
Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH

Mich 4 1913
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from _____ 191____, to _____ 191____

that I last saw h_____ alive on _____ 191____

and that death occurred on the date stated above, at 3 P.M.

The CAUSE OF DEATH* was as follows:

Sudden rupture of abdomen
(Wife accidental, suicidal or homicidal is unknown)

(Duration) _____ yrs. _____ mos. _____ ds.

Contributory
(Secondary)

(Duration) _____ yrs. _____ mos. _____ ds.

(Signed)

J. M. Johnson Jr. M. D.
3-6-1913 (Address) Montpelier, Ida.

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place _____ In the _____
of death _____ yrs. _____ mos. _____ ds. State _____ yrs. _____ mos. _____ ds.

Where was disease contracted,

If not at place of death?

Former or

usual residence.

19. PLACE OF BURIAL OR REMOVAL DATE OF BURIAL

Montpelier, Ida. Mar. 7, 1913

20. UNDERTAKER

ADDRESS

Wm. Walker Coatelli, Ida.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Form V. S. No. 5. 12½ M. 7-24-11

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics
File No. 4707
Registered No. 22

1. PLACE OF DEATH. Registration District No. 24
County of Bear Lake Primary Registration District No. 2093
City of Laramie (No. St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Clifford Wallentine

If death occurred in a hospital, institution or camp give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX Male 4. COLOR OR RACE W 5. SINGLE, MARRIED, WIDOWED OR DIVORCED. Single (Write the word.)

6. DATE OF BIRTH Aug 15 1901 (Month) (Day) (Year)

7. AGE 11 yrs. 8 mos. 7 ds. IF LESS than 1 day how many hrs. or min?

8. OCCUPATION (a) Trade, profession or particular kind of work. Farmer (b) General nature of industry business or establishment in which employed (or employer)

9. BIRTHPLACE Single Idaho (State or Country)

10. NAME OF FATHER C. Anthony Wallentine

11. BIRTHPLACE OF FATHER Bear Lake Co. (State or Country)

12. MAIDEN NAME OF MOTHER Elizabeth Brown

13. BIRTHPLACE OF MOTHER Scotland (State or Country)

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE (Informant) F. W. Passer (Address) Paris, Idaho

15. Filed May 8 1913 A. D. Cooley Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH April 24 1913 (Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from April 19, 1913, to April 24, 1913 that I last saw him alive on April 24, 1913 and that death occurred on the date stated above, at 9:26 M.

The CAUSE OF DEATH* was as follows: Appendicitis with intestinal obstruction.

(Duration) yrs. mos. ds. Contributory (Secondary) Intestinal obstruction

(Duration) yrs. mos. ds. (Signed) A. D. Cooley M. D. April 25, 1913 (Address) Paris, Idaho

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; (2) whether ACCIDENTAL, SUICIDAL OR HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place In the of death yrs. mos. ds. State yrs. mos. ds. Where was disease contracted, If not at place of death? Former or usual residence.

19. PLACE OF BURIAL OR REMOVAL DATE OF BURIAL Laramie, Idaho Apr. 27, 1913

20. UNDERTAKER ADDRESS None

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Form V. S. No. 5. 12½ M. 7-24-11

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH
County of Bear Lake
City of Liberty

Registration District No. 24
Primary Registration District No. 2093
(No. _____, _____ St.)

File No. 4708
Registered No. 21

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

Wallace Wayne Hymas

If death occurred in a hospital, institution or camp give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX M. 4. COLOR OR RACE White 5. SINGLE, MARRIED, WIDOWED OR DIVORCED. Single
(Write the word.)

6. DATE OF BIRTH June 29 1910
(Month) (Day) (Year)

7. AGE 2 yrs. 11 mos. 19 ds.
IF LESS than 1 day how many _____ hrs. or _____ min?

8. OCCUPATION
(a) Trade, profession or particular kind of work. None
(b) General nature of industry business or establishment in which employed (or employer)

9. BIRTHPLACE Liberty, Idaho
(State or Country)

10. NAME OF FATHER William Thomas Hymas

11. BIRTHPLACE OF FATHER Liberty, Idaho
(State or Country)

12. MAIDEN NAME OF MOTHER Sarah Jane Wifom

13. BIRTHPLACE OF MOTHER Paris, Idaho
(State or Country)

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Wm Hymas - Father
(Address) Liberty, Idaho

15. Filed May 8 1913 A. C. Cooley
Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH April 18 1913
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from March 21 1913 to April 1 1913 that I last saw him alive on April 1 1913 and that death occurred on the date stated above, at 10:50 M.

The CAUSE OF DEATH* was as follows:

Cerebro-spinal fever

(Duration) _____ yrs. _____ mos. 29 ds.

Contributory (Secondary)

(Duration) _____ yrs. _____ mos. _____ ds.
(Signed) J. W. Hayward M. D.
4/19 - 1913 (Address) Paris, Idaho

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death _____ yrs. _____ mos. _____ ds. In the State _____ yrs. _____ mos. _____ ds.
Where was disease contracted, If not at place of death? _____
Former or usual residence. _____

19. PLACE OF BURIAL OR REMOVAL Liberty, Idaho DATE OF BURIAL 4-20 1913

20. UNDERTAKER _____ ADDRESS _____

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Form V. S. No. 5. 10M. 6-20-11.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH. Registration District No. 27
County of Latah Primary Registration District No. 2116
City of Northfork Idaho (No. 11 St.)

File No. 4709Registered No. 12

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

Hessy Brown

If death occurred in a hospital, institution or camp give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX Male 4. COLOR OR RACE White 5. SINGLE, MARRIED, WIDOWED OR DIVORCED. Married
(Write the word.)

6. DATE OF BIRTH December 1881
(Month) (Day) (Year)

7. AGE 61 yrs. 4 mos. 13 ds. IF LESS than 1 day how many.....hrs. or min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work
(b) General nature of industry business or establishment in which employed (or employer)

Rancher

9. BIRTHPLACE
(State or Country)

Idaho

10. NAME OF FATHER

James Brown

11. BIRTHPLACE OF FATHER
(State or Country)

Ohio

12. MAIDEN NAME OF MOTHER

Orilla Cuthom

13. BIRTHPLACE OF MOTHER
(State or Country)

Virginia

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Mrs Mary L Brown
(Address) Salmon Idaho

15. 4/19 1913 O. Stratton
Filed Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH April 17 1913
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from 191 to 191

that I last saw h. seen alive on 191

and that death occurred on the date stated above, at — M.

The CAUSE OF DEATH* was as follows:

Homicidal gunshot rounds.

(Duration) yrs. mos. ds.

Contributory
(Secondary)

(Duration) yrs. mos. ds.

(Signed) W. C. Daehler M. D. 4/19 1913 (Address) Salmon Idaho

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and 2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions Transients or Recent Residents.)

At place of death. yrs. mos. ds. State. yrs. mos. ds.

Where was disease contracted.

If not at place of death?

Former or

usual residence.

19. PLACE OF BURIAL OR REMOVAL DATE OF BURIAL

Salmon IdahoApril 22 1913

20. UNDERTAKER

W. C. Daehler

ADDRESS

Salmon Idaho

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Form V. S. No. 5. 12½ M. 7-24-11

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics
File No. 4710
Registered No. 13

1. PLACE OF DEATH. Registration District No. 27
County of Blaine Primary Registration District No. 2116
City of Salmon (No. _____, St. _____)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

Angie May Edson

If death occurred in a hospital, institution or camp give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX Female 4. COLOR OR RACE White 5. SINGLE, MARRIED, WIDOWED OR DIVORCED. married
(Write the word.)

6. DATE OF BIRTH Sept. 13 1861
(Month) (Day) (Year)

7. AGE 53 yrs. 7 mos. 5 ds. IF LESS than 1 day
how many _____ hrs. or _____ min?

8. OCCUPATION

(a) Trade, profession or particular kind of work. Housewife
(b) General nature of industry business or establishment in which employed (or employer) _____

9. BIRTHPLACE

(State or Country) Oregon

10. NAME OF FATHER

John Fryer

11. BIRTHPLACE OF FATHER

(State or Country) Ido.

12. MAIDEN NAME OF MOTHER

Diana Landers

13. BIRTHPLACE OF MOTHER

(State or Country) Ido.

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Maidene Edson Pierce
(Address) Salmon, Ida.

15.

Filed 4/19 1913 O. B. Stratton
Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH

April 18 1913
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from Mar. 28 1913, to April 18 1913
that I last saw her alive on April 18 1913
and that death occurred on the date stated above, at 10:30 M.

The CAUSE OF DEATH* was as follows:

Polycystic degeneration of kidneys probably suggested (autopsy)

(Duration) 15 yrs. _____ mos. _____ ds.

Contributory (Secondary) _____

(Duration) _____ yrs. _____ mos. _____ ds.

(Signed) O. B. Stratton M. D.
4/19 1913 (Address) Salmon, Ida.

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place _____ In the _____
of death _____ yrs. _____ mos. _____ ds. State _____ yrs. _____ mos. _____ ds.

Where was disease contracted, _____

If not at place of death? _____

Former or _____

usual residence. _____

19. PLACE OF BURIAL OR REMOVAL

Salmon, Ida.

DATE OF BURIAL

4/20 1913

20. UNDERTAKER

N. C. Doehler

ADDRESS

Salmon

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Form V. S. No. 5. 12½M.7-24-11

CERTIFICATE OF DEATH

1. PLACE OF DEATH.

County of Fernhi
City of Salmon

Registration District No. 27Primary Registration District No. 2116

(No. _____, _____ St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

Dora Rusk

State of Idaho

BOARD OF HEALTH
Bureau of Vital StatisticsFile No. 4711Registered No. 14

If death occurred in a hospital, institution or camp give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX

Female White

4. COLOR OR RACE

5. SINGLE, MARRIED, WIDOWED OR DIVORCED.

Married
(Write the word.)

6. DATE OF BIRTH

February 20 1886
(Month) (Day) (Year)

7. AGE

27 yrs. 2 mos. _____ ds.

IF LESS than 1 day
how many _____ hrs. or
_____ min?

8. OCCUPATION

- (a) Trade, profession or particular kind of work
(b) General nature of industry business or establishment in which employed (or employer)

Nurse wife

9. BIRTHPLACE

(State or Country)

Idaho

10. NAME OF FATHER

Joseph Daniel

11. BIRTHPLACE OF FATHER

(State or Country)

Arkansas

12. MAIDEN NAME OF MOTHER

Cora Lee

13. BIRTHPLACE OF MOTHER

(State or Country)

Illinois

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

W. D. Rusk

(Address)

Salmon Idaho

15.

Filed

4/201913W. D. Rusk
Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH

April 1913
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from April 18 1913, to April 19 1913

that I last saw her alive on April 19 1913

and that death occurred on the date stated above, at 9 A.M.

The CAUSE OF DEATH* was as follows:

Organic heart disease

(Duration) 8 yrs. _____ mos. _____ ds.

Contributory
(Secondary)

(Duration) _____ yrs. _____ mos. _____ ds.

(Signed)

D. S. Wright M. D.
Apr 20 1913 (Address) Salmon

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place _____ In the _____
of death _____ yrs. _____ mos. _____ ds. State _____ yrs. _____ mos. _____ ds.

Where was disease contracted,

If not at place of death?

Former or

usual residence

19. PLACE OF BURIAL OR REMOVAL DATE OF BURIAL

Salmon Idaho April 21 1913

20. UNDERTAKER

ADDRESS

Wm. C. Doebler Salmon Ida

Form V. S. No. 5. 12½

1. PLACE OF DEATH. Registration District No. 11
County of Lehigh Primary Registration District No. 2116
City of Sullivan (No. _____, St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Maxwell Eugene Smith

Bureau of Vital Statistics

File No. 4712

Registered No. 15

If death occurred in a hospital, institution or camp give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX male 4. COLOR OR RACE white 5. SINGLE, MARRIED, WIDOWED OR DIVORCED. married
(Write the word.)

6. DATE OF BIRTH October 22 1871
(Month) (Day) (Year)

7. AGE 41 yrs. 0 mos. 0 ds. IF LESS than 1 day how many _____ hrs. or _____ min?

8. OCCUPATION Mice promoter
(a) Trade, profession or particular kind of work.
(b) General nature of industry business or establishment in which employed (or employer)

9. BIRTHPLACE Poughkeepsie N.Y.
(State or Country)

10. NAME OF FATHER Amos K. Smith

11. BIRTHPLACE OF FATHER Do not know
(State or Country)

12. MAIDEN NAME OF MOTHER Cordelia Allen

13. BIRTHPLACE OF MOTHER New York
(State or Country)

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Mrs. Maxine E. Smith
(Address) Sullivan, N.Y.

15. 4/25 1913 John L. Smith
Filed Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH 4 (Month) 25 (Day) 1913 (Year)

17. I HEREBY CERTIFY, That I attended deceased from _____ 191____, to _____ 191____
that I last saw him alive on April 25 1913
and that death occurred on the date stated above, at 3.49 M.

The CAUSE OF DEATH* was as follows:
accidental electrocution

_____ (Duration) _____ yrs. _____ mos. _____ ds.

Contributory (Secondary) _____

_____ (Duration) _____ yrs. _____ mos. _____ ds.

(Signed) O. B. Stratton M. D.
4/25 1913 (Address) Sullivan, N.Y.

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place _____ In the _____
of death _____ yrs. _____ mos. _____ ds. State _____ yrs. _____ mos. _____ ds.
Where was disease contracted, _____
If not at place of death? _____
Former or _____
usual residence _____

19. PLACE OF BURIAL OR REMOVAL DATE OF BURIAL
Sullivan City, N.Y. _____ 191____

20. UNDERTAKER ADDRESS
W. C. Dorker Sullivan, N.Y.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Form V. S. No. 5. 12½ M. 7-24-11

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH.
County of Lemhi
City of Ten day

Registration District No. 27
Primary Registration District No. 21156
(No. _____ St.)

File No. 4713
Registered No. 11

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

Joseph Pattel

If death occurred in a hospital, institution or camp give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX m. 4. COLOR OR RACE white 5. SINGLE, MARRIED, WIDOWED OR DIVORCED. single
(Write the word.)

6. DATE OF BIRTH

Aug. 24 1911
(Month) (Day) (Year)

7. AGE

1 yrs. 7 mos. 20 ds.

IF LESS than 1 day
how many hrs. or
..... min?

8. OCCUPATION

(a) Trade, profession or particular kind of work.
(b) General nature of industry business or establishment in which employed (or employer)

9. BIRTHPLACE

(State or Country) Lemhi Co. Idaho

10. NAME OF FATHER

Fred B. Pattel

11. BIRTHPLACE OF FATHER

(State or Country) Idaho

12. MAIDEN NAME OF MOTHER

Phoebe Snook

13. BIRTHPLACE OF MOTHER

(State or Country) Idaho

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Chas F. Hammer, M.D.

(Address) Solomon Ida

15.

Filed 4/14 1913

O. B. Stratton
Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH

Apr. 13 1913
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from

Apr. 13 1913, to Apr. 13 1913

that I last saw him alive on Apr. 13 1913

and that death occurred on the date stated above, at 11 P.M.

The CAUSE OF DEATH* was as follows:

Pneumonia

(Duration) 3 mos. 1 ds.

Contributory (Secondary) Elbow colitis

(Duration) 7 yrs. 2 mos. 1 ds.

(Signed) Chas F. Hammer, M.D.

Apr. 14 1913 (Address) Solomon Ida

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place _____ In the _____
of death. _____ yrs. _____ mos. _____ ds. State. _____ yrs. _____ mos. _____ ds.

Where was disease contracted,

If not at place of death?

Former or

usual residence.

19. PLACE OF BURIAL OR REMOVAL DATE OF BURIAL

Ten day Cemetery Idaho April 14 1913

20. UNDERTAKER

ADDRESS

Charles Snook

acting as such.

Ten day Ida

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK--THIS IS A PERMANENT RECORD. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Form V. S. No. 5. 10M. 6-20-11.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics
File No. 4714

1. PLACE OF DEATH Registration District No. 27
County of Blaine Primary Registration District No. 2116
City of Salmon (No. _____ St.)

Registered No. 10
If death occurred in a hospital, institution or camp give its NAME instead of street and number.

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME George R Williams

PERSONAL AND STATISTICAL PARTICULARS

3. SEX Male 4. COLOR OR RACE White 5. SINGLE, MARRIED, WIDOWED OR DIVORCED. Single
(Write the word.)

6. DATE OF BIRTH June 25 1869
(Month) (Day) (Year)

7. AGE 42 yrs. 10 mos. ds. IF LESS than 1 day how many _____ hrs. or _____ min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work Grouty Mining
(b) General nature of industry, business or establishment in which employed (or employer)

9. BIRTHPLACE England
(State or Country)

10. NAME OF FATHER James Williams

11. BIRTHPLACE OF FATHER England
(State or Country)

12. MAIDEN NAME OF MOTHER Do not know

13. BIRTHPLACE OF MOTHER England
(State or Country)

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Mrs. Elbing Blake
(Address) Salmon Idaho.

15. Filed 4/12 1916 A. P. Stratton
Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH April 12 1913
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from 191 to 191
that I last saw h. _____ alive on _____ 191

and that death occurred on the date stated above, at _____ M

The CAUSE OF DEATH* was as follows:

Bright's Disease

(Duration) several yrs. mos. d.
Contributory (Secondary) Not in attendance for several months.

(Duration) _____ yrs. mos. d.
(Signed) W. L. Whitcomb M.
19 (Address)

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state MEANS OF INJURY; and 2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death _____ yrs. _____ mos. _____ ds. In the State _____ yrs. _____ mos. _____ ds.
Where was disease contracted?
If not at place of death?
Former or usual residence.

19. PLACE OF BURIAL OR REMOVAL DATE OF BURIAL

Salmon Cemetery April 13
20. UNDERTAKER ADDRESS

J. M. C. Doebl Salmon Idaho

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Form V. S. No. 5. 12½ M. 7-24-11

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH. Registration District No. 10
County of Idaho Primary Registration District No. 2044
City of Mont Idaho (No. _____, St.)

File No. 4715
Registered No. 126

If death occurs away from usual residence, give facts called for under special information.

If death occurred in a hospital, institution or camp give its NAME instead of street and number.

2. FULL NAME

Freddie Smith

PERSONAL AND STATISTICAL PARTICULARS

3. SEX 4. COLOR OR RACE 5. SINGLE, MARRIED, WIDOWED OR DIVORCED.

Male White (Write the word.)

6. DATE OF BIRTH

Mar 25 1913
(Month) (Day) (Year)

7. AGE

0 yrs. 0 mos. 21 ds.

IF LESS than 1 day
how many hrs. or
..... min?

8. OCCUPATION

(a) Trade, profession or particular kind of work.
(b) General nature of industry business or establishment in which employed (or employer)

9. BIRTHPLACE

(State or Country)

Idaho

10. NAME OF FATHER

R. L. Smith

11. BIRTHPLACE OF FATHER

(State or Country)

Tenn.

12. MAIDEN NAME OF MOTHER

Rhoda McLean

13. BIRTHPLACE OF MOTHER

(State or Country)

Arkansas

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

(Address)

Mr. L. Smith
Mont Idaho

15.

Filed April 16 1913

John L. Rains
Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH

April 16 1913
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from

Apr 15 1913, to 1913

that I last saw him alive on Apr 15 1913

and that death occurred on the date stated above, at 3 A.M.

The CAUSE OF DEATH* was as follows:

Convulsions

(Duration) 0 yrs. 0 mos. 3 ds.

Contributory
(Secondary)

(Duration) yrs. mos. ds.

(Signed) W. H. Warner M. D.

4-16-1913 (Address) Grangeville Idaho

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place In the
of death yrs. mos. ds. State yrs. mos. ds.

Where was disease contracted,

If not at place of death?

Former or

usual residence.

19. PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

Mont Idaho Cemetery

April 16 1913

20. UNDERTAKER

ADDRESS

W. E. Graham

Grangeville

Every item of information should be carefully supplied. AGE should be state EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Form V. S. No. 5. 10M. 6-20-11.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics
File No. **4716**
Registered No. **127**

1. PLACE OF DEATH.

Registration District No. **10**

County of **Idaho**

Primary Registration District No. **1001**

City of **Grangerille**

(No. _____, _____ St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

Jim (Chinaman)

If death occurred in a hospital, institution or camp give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

MEDICAL CERTIFICATE OF DEATH

3. SEX

Male

4. COLOR OR RACE

Mongolian

5. SINGLE, MARRIED, WIDOWED OR DIVORCED.

Single
(Write the word.)

6. DATE OF BIRTH

Unknown

(Month) (Day) (Year)

7. AGE

about 65 years

IF LESS than 1 day
how many hrs. or min.

8. OCCUPATION

(a) Trade, profession or particular kind of work
(b) General nature of industry business or establishment in which employed (or employer)

Laborer

9. BIRTHPLACE

(State or Country)

China

10. NAME OF FATHER

11. BIRTHPLACE OF FATHER

(State or Country)

12. MAIDEN NAME OF MOTHER

13. BIRTHPLACE OF MOTHER

(State or Country)

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

Jesse L. Rains

(Address)

Grangerille Idaho

15.

Filed **April 14 1913**

Jesse F. Rains

Local Registrar

16. DATE OF DEATH

April 4
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from

March 26 1913, to **April 12 1913**

that I last saw him alive on **April 12 1913**

and that death occurred on the date stated above, at **2 a. M.**

The CAUSE OF DEATH* was as follows:

Pulmonary Tuberculosis

(Duration) **Unknown** yrs. mos. ds.

Contributory
(Secondary)

(Duration) _____ yrs. mos. ds.

(Signed) **Jesse L. Rains** M. D.

April 14 1913 (Address) **Grangerille**

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death _____ yrs. mos. ds. In the State _____ yrs. mos. ds.

Where was disease contracted,

If not at place of death?

Former or usual residence.

19. PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

Cairie View Cemetery

April 16 1913

20. UNDERTAKER

ADDRESS

E. L. Hancock

Grangerille

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Form V. S. No. 5. 12½ M. 7-24-11

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics
File No. 471
Registered No. 128

1. PLACE OF DEATH.

Registration District No. 10County of IdahoPrimary Registration District No. 2044City of Grangerille

(No. _____, _____ St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

John E. Beede

If death occurred in a hospital, institution or camp give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX

Male

4. COLOR OR RACE

White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED.

Widowed

(Write the word.)

6. DATE OF BIRTH

Feb21899

(Month)

(Day)

(Year)

7. AGE

86 - 2 - 5

yrs. mos. ds.

IF LESS than 1 day
how many hrs. or min?

8. OCCUPATION

(a) Trade, profession or particular kind of work.

Canvaser

(b) General nature of industry business or establishment in which employed (or employer)

9. BIRTHPLACE

(State or Country)

10. NAME OF FATHER

11. BIRTHPLACE OF FATHER

(State or Country)

12. MAIDEN NAME OF MOTHER

13. BIRTHPLACE OF MOTHER

(State or Country)

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

(Address)

H. B. Bledsoe (Coroner), J. P. Haines (Sheriff)
J. L. Haines (C. Dispenser) Grangerille

15.

Filed

April 20 193

Rose L. Haines
Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH

April71913

(Month)

(Day)

(Year)

17. I HEREBY CERTIFY, That I ~~attended deceased from~~
duly investigated the death of deceased
191 to 191

that I last saw h. alive on 191

and that death occurred on the date stated above, at N.

The CAUSE OF DEATH* was as follows:

Deceased found dead in this
County. Death in all probability
from natural causes

(Duration) yrs. mos. ds.

Contributory
(Secondary)

(Duration) yrs. mos. ds.

(Signed)

Henry B. Bledsoe M. D.

Apr. 8, 1913 (Address) Coroner, Idaho County

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death yrs. mos. ds. State yrs. mos. ds.

Where was disease contracted,

If not at place of death?

Former or

usual residence.

19. PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

Harper, Idaho4/10 1913

20. UNDERTAKER

ADDRESS

E. H. HainesGrangerille

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Form V. S. No. 5 20M.1-16-12

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH.

Registration District No. 10

County of Idaho

Primary Registration District No. 2101

City of Stites

(No. , St.)

File No. 171

Registered No. 179

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

Jakob King

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX

M

4. COLOR OR RACE

White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED.

married (Add the word.)

6. DATE OF BIRTH

Oct

18

1829

(Month)

(Day)

(Year)

7. AGE

83

yrs.

6

mos.

ds.

IF LESS than 1 day
how many hrs. or
..... mins.?

8. OCCUPATION

(a) Trade, profession or particular kind of work

retired farmer

(b) General nature of industry business, or establishment in which employed (or employer)

9. BIRTHPLACE

(State or Country)

Indiana

10. NAME OF FATHER

Not Known

11. BIRTHPLACE OF FATHER

(State or Country)

Germany

12. MAIDEN NAME OF MOTHER

Bright Wessers

13. BIRTHPLACE OF MOTHER

(State or Country)

Germany

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

W. B. Swineheart

(Address)

Stites P.O. Idaho

15.

Filed

April 18 1913

3

H. F. Schaefer

Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH

April

18

1913

(Month)

(Day)

(Year)

17. I HEREBY CERTIFY, That I attended deceased from

April 13 1913

to April 18 1913

that I last saw him alive on April 18 1913

and that death occurred on the date stated above, at 11:45 A.M.

The CAUSE OF DEATH* was as follows:

acute obstruction of small intestine - resulting in general peritonitis

(Duration) yrs. mos. 5 ds.

Contributory

(Secondary)

(Duration) yrs. mos. ds.

(Signed)

H. F. Schaefer M.D.

Apr. 18 1913

(Address) Stites Idaho

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place

of death yrs. mos. days.

In the

State yrs. mos. days.

Where was disease contracted if not at place of death?

Former or

usual residence

19. PLACE OF BURIAL OR REMOVAL DATE OF BURIAL

Battle Bridge Cemetery

April 19 1913

20. UNDERTAKER

None

ADDRESS

-

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Form V. S. No. 5 20M.1-16-12

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH.

Registration District No. 2042 10County of IdahoPrimary Registration District No. 2042File No. 4719City of Cottonwood

(No. _____, St.)

Registered No. 130

If death occurs away from usual residence, give facts called for under special information.

2.

FULL NAME

Fred Roy Blackburn

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX

4. COLOR OR RACE

5. SINGLE, MARRIED, WIDOWED OR DIVORCED.

maleWhiteMarried

6. DATE OF BIRTH

Sept171898

(Month)

(Day)

(Year)

7. AGE

25

yrs.

7

mos.

4

ds.

IF LESS than 1 day
how many _____ hrs. or
_____ mins.?

8. OCCUPATION

(a) Trade, profession or particular kind of work

Farmer

(b) General nature of industry, business, or establishment in which employed (or employer)

9. BIRTHPLACE

(State or Country)

Cottonwood

10. NAME OF FATHER

W.W. Blackburn

11. BIRTHPLACE OF FATHER

(State or Country)

N. Carolina

12. MAIDEN NAME OF MOTHER

Franklin A. Hawell

13. BIRTHPLACE OF MOTHER

(State or Country)

N. Carolina

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

W.W. Blackburn

(Address)

Cottonwood, Id.

15.

Filed

April 191913

Jose S. Rains
Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH

April 18th

(Month)

(Day)

1913
(Year)

17. I HEREBY CERTIFY, That I attended deceased from

April 13th1913

to

April 18th1913

that I last saw him alive on

April 18th1913

and that death occurred on the date stated above, at

9 P. M.

The CAUSE OF DEATH was as follows:

Croupous Pneumonia

(Duration)

yrs.

mos.

7 ds.

Contributory

(Secondary)

(Duration)

yrs.

mos.

ds.

(Signed)

J. H. Turner

M. D.

April 1913

(Address)

Cottonwood, Id.

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death

..... yrs. mos. days.

In the

State

..... yrs. mos. days.

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

Cottonwood, IdahoApril 23, 1913

20. UNDERTAKER

ADDRESS

Joseph W. BlackleyCottonwood, Id.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Form V. S. No. 5 20M.1-16-12

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH.

Registration District No. 28County of ShoshonePrimary Registration District No. 1011City of Wallace(No. Providence Hospital St.)File No. 1721Registered No. 27

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Infant of Hortense Hilliard

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX

male

4. COLOR OR RACE

white

5. SINGLE, MARRIED, WIDOWED OR DIVORCED.

single
(Write the word.)

6. DATE OF BIRTH

4 3 11 1913
(Month) (Day) (Year)

7. AGE

0 yrs. 0 mos. 0 ds. 4IF LESS than 1 day
how many hrs. or mins.?

8. OCCUPATION

(a) Trade, profession or particular kind of work none

(b) General nature of industry business, or establishment in which employed (or employer)

9. BIRTHPLACE

(State or Country) Wallace, Idaho.

10. NAME OF FATHER

not given

11. BIRTHPLACE OF FATHER

(State or Country) " "

12. MAIDEN NAME OF MOTHER

Hortense Hilliard

13. BIRTHPLACE OF MOTHER

(State or Country)

Kansas

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) L. H. Hilliard(Address) Gem, Idaho.

15.

Filed April 5,1913T. L. Lumsden
Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH

4 5 1913
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from

Apr 3 1913, to Apr 5 1913,that I last saw him alive on Apr 4 1913,and that death occurred on the date stated above, at 9 P. M.

The CAUSE OF DEATH* was as follows:

Asphyxia(Duration) yrs. mos. 4 ds.Contributory
(Secondary)

(Duration) yrs. mos. ds.

(Signed) Drs. Mowery M. D.4/5 1913 (Address) Wallace, Idaho.

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

Providence Hosp.

At place of death. yrs. mos. days. In the State. yrs. mos. days.

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL

Wallace, Idaho.

DATE OF BURIAL

4/5 1913

20. UNDERTAKER

Bruce G. Mordt

ADDRESS

Wallace,

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Form V. S. No. 5 20M.1-16-12

Call, moving

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH _____
Registration District No. _____
County of Shoshone Primary Registration District No. 1011
City of Prine Creek (No. _____) St. _____

File No. 4721
Registered No. 28

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME William James

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX male 4. COLOR OR RACE white 5. SINGLE, MARRIED, WIDOWED OR DIVORCED. single
(Write the word.)

6. DATE OF BIRTH _____
(Month) (Day) (Year)

7. AGE 18 yrs. - mos. - ds.
IF LESS than 1 day how many _____ hrs. or _____ mins.?

8. OCCUPATION

- (a) Trade, profession or particular kind of work _____
(b) General nature of industry business, or establishment in which employed (or employer) _____

student

9. BIRTHPLACE

(State or Country)

Washington

10. NAME OF FATHER

Sidney James

11. BIRTHPLACE OF FATHER

(State or Country)

Washington

12. MAIDEN NAME OF MOTHER

Alice Phipps

13. BIRTHPLACE OF MOTHER

(State or Country)

England

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

J. A. McGarrie

(Address)

Prine Creek, Ida

15.

Filed 4/81913

J. Leo Lutz
Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH

Apr61913

17. I HEREBY CERTIFY, That I attended deceased from Jan 1913, to Apr 6 1913, that I last saw him alive on Feb 26 1913, and that death occurred on the date stated above, at 10 P.M.

The CAUSE OF DEATH* was as follows:

Acute Parenchymatous Nephritis(Duration) yrs. 3 mos. ds.

Contributory (Secondary)

(Duration) yrs. mos. ds.

(Signed)

Apr 8 1913 (Address) Dr. W. W. Wallace, Ida

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death _____ yrs. _____ mos. _____ days. In the State _____ yrs. _____ mos. _____ days.

Where was disease contracted if not at place of death?

Former or usual residence _____

19. PLACE OF BURIAL OR REMOVAL DATE OF BURIAL

Wallace Idaho4/9 1913

20. UNDERTAKER

ADDRESS

Ward Undertaking Co Wallace

Form V. S. No. 5 20M.1-16-12

CERTIFICATE OF DEATH

 State of Idaho
 BOARD OF HEALTH
 Bureau of Vital Statistics

 1. PLACE OF DEATH
 County of Shoshone
 City of Wallace
 Registration District No. 28
 Primary Registration District No. 1011
 (No. _____ St.)

 File No. 4723
 Registered No. 30

If death occurs away from usual residence, give facts called for under special information.

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

 3. SEX male 4. COLOR OR RACE white 5. SINGLE, MARRIED, WIDOWED OR DIVORCED.
 (Write the word.)

 6. DATE OF BIRTH _____
 (Month) (Day) (Year)

 7. AGE 8 yrs. 11 mos. 20 ds.
 IF LESS than 1 day how many _____ hrs. or _____ mins.?

 8. OCCUPATION
 (a) Trade, profession or particular kind of work student
 (b) General nature of industry business, or establishment in which employed (or employer) _____

 9. BIRTHPLACE
 (State or Country) Burke Ida.

 10. NAME OF FATHER Patrick Sullivan

 11. BIRTHPLACE OF FATHER
 (State or Country) Lebogue Iowa

 12. MAIDEN NAME OF MOTHER Mollie Thomas

 13. BIRTHPLACE OF MOTHER
 (State or Country) Smithston Missouri

 14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
 (Informant) Patrick H. Sullivan
 (Address) Burke Ida.

 15. Filed 4/21/ 1913 T. Leo Dempsey
 Local Registrar

MEDICAL CERTIFICATE OF DEATH

 16. DATE OF DEATH April 19 1913
 (Month) (Day) (Year)

 17. I HEREBY CERTIFY, That I attended deceased from _____ 1913, to _____ 1913,
 that I last saw h. _____ alive on _____ 1913,
 and that death occurred on the date stated above, at 3 P.M.

The CAUSE OF DEATH* was as follows:

Accidental Drowning

(Duration) _____ yrs. _____ mos. _____ ds.

Contributory (Secondary) _____

(Duration) _____ yrs. _____ mos. _____ ds.

 (Signed) Dr. Mowery M. D.

 (Address) Wallace

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death _____ yrs. _____ mos. _____ days. In the State _____ yrs. _____ mos. _____ days.

Where was disease contracted if not at place of death? _____

Former or usual residence _____

 19. PLACE OF BURIAL OR REMOVAL Wallace Ida. DATE OF BURIAL Apr. 22 1913

 20. UNDERTAKER Ward's Undertaking Co. ADDRESS Wallace Ida.

Form V. S. No. 5 20M.1-16-12

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH

Registration District No. 22

County of Canyon

Primary Registration District No. 2007

City of Payette

(No. , St.)

File No. 4724

Registered No. 27

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

Infant Parks

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX

Female

4. COLOR OR RACE

White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED.

Single
(Write the word.)

6. DATE OF BIRTH

May 7 1913
(Month) (Day) (Year)

7. AGE

yrs. mos. ds.

IF LESS than 1 day
how many hrs. or mins.

8. OCCUPATION

(a) Trade, profession or particular kind of work

Infant

(b) General nature of industry business, or establishment in which employed (or employer)

9. BIRTHPLACE

(State or Country)

Idaho

10. NAME OF FATHER

B W Parks

11. BIRTHPLACE OF FATHER

(State or Country)

Missouri

12. MAIDEN NAME OF MOTHER

Mary Allen

13. BIRTHPLACE OF MOTHER

(State or Country)

Iowa

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

D. B. Parks

(Address)

Payette Ida

15.

Filed May 10 1913

J. R. W. Adair
Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH

May 7th 1913
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from May 7th 1913, to May 7th 1913, that I last saw her alive on May 7th 1913, and that death occurred on the date stated above, at 4 A.M.

The CAUSE OF DEATH* was as follows:

Child was born premature
Death due to underdevelopment
7th month child

(Duration) yrs. mos. ds.

Contributory
(Secondary)

(Duration) yrs. mos. ds.

(Signed) J. E. Crouch M. D.

S-7 1913 (Address) Payette Ida

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death yrs. mos. days. In the State yrs. mos. days.

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL DATE OF BURIAL

Payette Ida May 7 1913

20. UNDERTAKER ADDRESS

J. N. Adair Payette Ida

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Form V. S. No. 5 20M.1-16-12

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH.

Registration District No. 22

County of Canyon

Primary Registration District No. 2008

City of Payette

(No. Francis F. Hurd St.)

File No. 1725

Registered No. 85

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

Francis F. Hurd

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX

Male

4. COLOR OR RACE

White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED.

Married
(Write the word.)

6. DATE OF BIRTH

May 31 1834
(Month) (Day) (Year)

7. AGE

78 yrs. 10 mos. 25 ds.

IF LESS than 1 day
how many hrs. or
..... mins.?

8. OCCUPATION

(a) Trade, profession or particular kind of work

Farmer

(b) General nature of industry business, or establishment in which employed (or employer)

9. BIRTHPLACE

(State or Country)

New York

10. NAME OF FATHER

Perley P. Hurd

11. BIRTHPLACE OF FATHER

(State or Country)

New York

12. MAIDEN NAME OF MOTHER

Viola Curtis

13. BIRTHPLACE OF MOTHER

(State or Country)

New York

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

Willie C. Hurd

(Address)

Payette

15.

Filed

Apr 27 1913

S. R. Edwards
Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH

April 25 1913
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from

June 1 1913, to April 25 1913,
that I last saw him alive on April 25 1913,
and that death occurred on the date stated above, at 5 P. M.

The CAUSE OF DEATH* was as follows:

Diabetes mellitus

(Duration) One yrs. X mos. X ds.

Contributory
(Secondary)

(Duration) yrs. mos. ds.

(Signed)

O. H. Avery M. D.
4/27/1913 (Address) Payette, Ida

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death yrs. mos. days. In the State yrs. mos. days.

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

Payette, Ida Apr 27 1913

20. UNDERTAKER

ADDRESS

S. R. Adams Payette, Ida

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Form V. S. No. 5 20M.1-16-12

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH. Registration District No. 22
County of Canyon Primary Registration District No. 2009
City of New Plymouth (No. _____ St.)

File No. 4721
Registered No. 86

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Alfonso D. Helk

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX Male 4. COLOR OR RACE White 5. SINGLE, MARRIED, WIDOWED OR DIVORCED Married
(Write the word.)

6. DATE OF BIRTH May 9 1839
(Month) (Day) (Year)

7. AGE 73 yrs. 11 mos. 4 ds. IF LESS than 1 day how many hrs. or mins.

8. OCCUPATION
(a) Trade, profession or particular kind of work Retired Farmer
(b) General nature of industry business, or establishment in which employed (or employer) _____

9. BIRTHPLACE Iowa
(State or Country)

10. NAME OF FATHER Helk

11. BIRTHPLACE OF FATHER Kentucky
(State or Country)

12. MAIDEN NAME OF MOTHER Lee

13. BIRTHPLACE OF MOTHER Kentucky
(State or Country)

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) F. G. Helk
(Address) New Plymouth

15. Filed May 5 1913 Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH April 12 1913
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from 1913 to 1913, that I last saw him alive on 1913, and that death occurred on the date stated above, at M.
The CAUSE OF DEATH* was as follows:

Burns received from House Burning Down where Deceased was living
(Duration) _____ mos. _____ ds.
Contributory (Secondary) F. H. Robison
Coroner
(Duration) _____ yrs. _____ mos. _____ ds.
(Signed) M. B.
19 (Address) Maupia Ida

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL OR HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death _____ yrs. _____ mos. _____ days. In the State _____ yrs. _____ mos. _____ days.
Where was disease contracted if not at place of death? _____
Former or usual residence _____

19. PLACE OF BURIAL OR REMOVAL New Plymouth DATE OF BURIAL 4/14 1913

20. UNDERTAKER J. H. Adair ADDRESS Payette Ida

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Form V. S. No. 5 20M.1-16-12

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH.

Registration District No. 22County of CanyonPrimary Registration District No. 2009City of Payette

(No. _____ St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

Sarah Ann FullerFile No. 4727Registered No. 84

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX

Female

4. COLOR OR RACE

White

5. SINGLE, MARRIED, WID-

OWED OR DIVORCED
(Write the word.)

6. DATE OF BIRTH

Sept 3 1840
(Month) (Day) (Year)

7. AGE

72 yrs. 7 mos. 7 ds.IF LESS than 1 day
how many hrs. or
..... mins.?

8. OCCUPATION

(a) Trade, profession or particular kind of work

Housewife

(b) General nature of industry business, or establishment in which employed (or employer)

9. BIRTHPLACE

(State or Country)

Indiana

10. NAME OF FATHER

Michael Ephraim

11. BIRTHPLACE OF FATHER

(State or Country)

Not Known

12. MAIDEN NAME OF MOTHER

Not Known

13. BIRTHPLACE OF MOTHER

(State or Country)

Not Known

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

A. B. Fuller

(Address)

Fruitland, Idaho

15.

Filed

4/11/13

191

J. A. Woodward

Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH

April 10 1913
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from

Nov 1 1912 to April 10 1913,that I last saw her alive on April 4 1913,and that death occurred on the date stated above, at 5 P. M.

The CAUSE OF DEATH* was as follows:

Endocarditis
(Mitral insufficiency)(Duration) 2 yrs. _____ mos. _____ ds.Contributory
(Secondary)

(Duration) _____ yrs. _____ mos. _____ ds.

(Signed)

O. H. Avery, M. D.5/11 1913 (Address) Payette, Idaho

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL OR HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death _____ yrs. _____ mos. _____ days. In the State _____ yrs. _____ mos. _____ days.

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL DATE OF BURIAL

J. H. Aldair Apr 12 1913

20. UNDERTAKER

ADDRESS

Payette, Ida

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Form V. S. No. 5 20M.1-16-12

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH.

Registration District No. 17

County of Clearwater

Primary Registration District No. 2078

City of _____

(No. _____ St.)

File No. 4729

Registered No. 21

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

Frank Gertzo

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX

Male

4. COLOR OR RACE

White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED.

Single

6. DATE OF BIRTH

Apr

9

1913

(Month)

(Day)

(Year)

7. AGE

_____ yrs. _____ mos. 5 ds.

IF LESS than 1 day
how many _____ hrs. or
_____ mins.?

8. OCCUPATION

(a) Trade, profession or particular kind of work

(b) General nature of industry business, or establishment in which employed (or employer)

Baby

9. BIRTHPLACE

(State or Country)

Mar Co. Idaho

10. NAME OF FATHER

George Gertzo

11. BIRTHPLACE OF FATHER

(State or Country)

Germany

12. MAIDEN NAME OF MOTHER

Jessie Parker

13. BIRTHPLACE OF MOTHER

(State or Country)

Canada

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

Earl W. Hovener

(Address)

Co. Idaho

15.

Filed

April 30 1913

J. M. Smith
Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH

Apr 14

(Month)

(Day)

1913
(Year)

17. I HEREBY CERTIFY, That I attended deceased from Apr 9 1913, to Apr 13 1913, that I last saw him alive on Apr 13 1913 and that death occurred on the date stated above, at home

The CAUSE OF DEATH* was as follows:

Apparently atelectasis with
acute injury of brain
body.

(Duration)

yrs.

mos.

4 ds.

Contributory

(Secondary)

(Duration)

yrs.

mos.

ds.

(Signed)

Earl W. Hovener M. D.

Apr 14 1913 (Address) Co. Idaho

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place

of death

_____ yrs.

_____ mos.

_____ days.

In the

State

_____ yrs.

_____ mos.

_____ days.

Where was disease contracted if not at place of death?

Former or

usual residence.

19. PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

Idaho

Apr 15 1913

20. UNDERTAKER

ADDRESS

none

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Form V. S. No. 5. 12½ M. 7-24-11

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics
File No. 4733
Registered No. 13

1. PLACE OF DEATH. Registration District No. 32
County of Sevier Primary Registration District No. 2127
City of Winchester (No. _____, St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Caldona King

If death occurred in a hospital, institution or camp give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX Female 4. COLOR OR RACE White 5. SINGLE, MARRIED, WIDOWED OR DIVORCED. Married
(Write the word.)

6. DATE OF BIRTH November 6th 1865
(Month) (Day) (Year)

7. AGE 47 yrs. 5 mos. 21 ds. IF LESS than 1 day how many.....hrs. or.....min?

8. OCCUPATION
(a) Trade, profession or particular kind of work... Housewife
(b) General nature of industry business or establishment in which employed (or employer)

9. BIRTHPLACE
(State or Country) Mo.

10. NAME OF FATHER Gilbert Barnard

11. BIRTHPLACE OF FATHER
(State or Country) Kentucky

12. MAIDEN NAME OF MOTHER Ester Carney

13. BIRTHPLACE OF MOTHER
(State or Country) Ill

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) W. J. King
(Address) Winchester, Idaho

15. Filed 5-2- 1913 E. B. Rogers
Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH April 27th 1913
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from January 8th 1912, to April 27th 1913
that I last saw him alive on April 30 1913
and that death occurred on the date stated above, at 6 P.M.
The CAUSE OF DEATH* was as follows:
Chronic Interstitial Nephritis

(Duration) Six yrs. mos. ds.
Contributory (Secondary)
(Duration) yrs. mos. ds.
(Signed) E. B. Rogers M. D.
4-27-1913 (Address) Winchester

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place In the
of death yrs. mos. ds. State yrs. mos. ds.
Where was disease contracted,
If not at place of death?
Former or
usual residence
19. PLACE OF BURIAL OR REMOVAL DATE OF BURIAL
Woodlawn 4-29-1913
20. UNDERTAKER ADDRESS
none _____

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. N. B.—Every item of information should be carefully supplied. ~~NAME~~ should be state EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Form V. S. No. 5. 10M. 6-20-11.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH.
County of Blaine
City of Belleuve

Registration District No. 21
Primary Registration District No. 2072
(No. _____ St.)

File No. 1733
Registered No. 19

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

Mrs Anna Dupuy

If death occurred in a hospital, institution or camp give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX 4. COLOR OR RACE 5. SINGLE, MARRIED, WIDOWED OR DIVORCED.

Female white Widow
(Write the word.)

6. DATE OF BIRTH

(Month) (Day) (Year)

7. AGE

80 yrs. — mos. — ds. IF LESS than 1 day how many hrs. or min.?

8. OCCUPATION

(a) Trade, profession, or particular kind of work
(b) General nature of industry business, or establishment in which employed (or employer)

House wife

9. BIRTHPLACE

(State or Country)

✓

10. NAME OF FATHER

✓

11. BIRTHPLACE OF FATHER

(State or Country)

✓

12. MAIDEN NAME OF MOTHER

✓

13. BIRTHPLACE OF MOTHER

(State or Country)

✓

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

(Address)

R. B. French.

Belleuve

15.

Filed

Apr 25 1913

R. D. Harris
Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

Apr 19 1913
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from

Mch 2 1913, to Apr 19 1913

that I last saw her alive on Apr 19 1913,

and that death occurred on the date stated above, at 9:30 A. M.

The CAUSE OF DEATH* was as follows:

Senility

(Duration) 3 yrs. — mos. — ds.

Contributory (Secondary)

Bright's Disease

(Duration) 8 yrs. — mos. — ds.

(Signed)

O. J. Allen M. D.

19 (Address) Belleuve

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place

In the

of death yrs mos ds State yrs mos ds.

Where was Disease contracted,

If not at place of death?

Former or

usual residence.

19. PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

Belleuve Ida

4-21 1913

20. UNDERTAKER

ADDRESS

R. D. Harris

Hailey Ida

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Form V. S. No. 5. 10M. 6-20-11.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics
File No. 4734
Registered No. 18

1. PLACE OF DEATH.

Registration District No. 21County of BlainePrimary Registration District No. 2123City of Manassas

(No. _____, _____ St.)

Registered No. 18

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Nancy A. Butler

If death occurred in a hospital, institution or camp give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX

F

4. COLOR OR RACE

W

5. SINGLE, MARRIED, WIDOWED OR DIVORCED.

Unmarried
(Write the word.)

6. DATE OF BIRTH

March 4 1913
(Month) (Day) (Year)

7. AGE

60 yrs. 1 mos. 17 ds.

IF LESS than 1 day
how many _____ hrs. or
_____ min.?

8. OCCUPATION

(a) Trade, profession, or
particular kind of work

Housewife

(b) General nature of industry
business, or establishment in
which employed (or employer)

9. BIRTHPLACE

(State or Country)

Utah

10. NAME OF FATHER

John Smith

11. BIRTHPLACE OF FATHER

(State or Country)

Id

12. MAIDEN NAME OF MOTHER

Sarah Smith

13. BIRTHPLACE OF MOTHER

(State or Country)

Canada

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Wm W. Wray(Address) Manassas

15.

Filed

Apr 30 1913

Robert A. Singh
Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

April 21 1913
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from
4-13 1913, to 4-21 1913.

that I last saw him alive on 4-20 1913,

and that death occurred on the date stated above, at 6:40 A. M.

The CAUSE OF DEATH* was as follows:

Pneumonia

(Duration) _____ yrs. _____ mos. 9 ds.

Contributory
(Secondary)

(Duration) _____ yrs. _____ mos. _____ ds.

(Signed) Dee Watt O'Keefe M. D.

4-21 1913 (Address) Goldthorpe

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place _____ In the _____
of death _____ yrs. _____ mos. _____ ds. State _____ yrs. _____ mos. _____ ds.

Where was Disease contracted.

If not at place of death?

Former or

usual residence.

19. PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

Richfield Utah1913

20. UNDERTAKER

ADDRESS

HarrisHarley

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Form V. S. No. 5 20M.1-16-12

1. PLACE OF DEATH.

County of Ada

City of Boise

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

Registration District No. 2004

Primary Registration District No. 2004

(No. So. Boise St.)

Baby Carlton

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

File No. 4735

Registered No. 14430

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX

F

4. COLOR OR RACE

W.

5. SINGLE, MARRIED, WIDOWED OR DIVORCED.

Single
(Write the word.)

6. DATE OF BIRTH

April 18 1913
(Month) (Day) (Year)

7. AGE

 yrs. mos. ds.

IF LESS than 1 day
how many 12 hrs. or
 mins?

8. OCCUPATION

(a) Trade, profession or particular kind of work

none

(b) General nature of industry business, or establishment in which employed (or employer)

9. BIRTHPLACE

(State or Country) So Boise, Idaho

10. NAME OF FATHER

G. W. Carlton

11. BIRTHPLACE OF FATHER

Iowa

12. MAIDEN NAME OF MOTHER

Lucy J. Davis

13. BIRTHPLACE OF MOTHER

Utah

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) G. W. Carlton

(Address) So. Boise

15.

Filed 4-19 1913 C. S. McConnel
Apr. 24 - 1913 J. M. Taylor Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH

April 19 1913
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from April 18 1913, to April 19 1913, that I last saw her alive on April 18 1913

and that death occurred on the date stated above, at 4 A.M.

The CAUSE OF DEATH* was as follows:

Insurrection

(Duration) yrs. mos. 1 ds.

Contributory (Secondary)

(Duration) yrs. mos. ds.

(Signed)

4-19 1913 (Address) Boise, Idaho

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death yrs. mos. days. In the State yrs. mos. days.

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

Morris Hill Cemetery 4/20 1913

20. UNDERTAKER

ADDRESS

Schreiber Sidney Boise, Idaho

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Form V. S. No. 5 20M.1-16-12

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH.

Registration District No. 1

County of Ada

Primary Registration District No. 2004

City of Boise

(No. on Bench St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Samuel Shepard Ross

File No. 4736

Registered No. 101

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX

Male

4. COLOR OR RACE

White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED.

~~Single~~ the word.)

6. DATE OF BIRTH

January 18th 1875
(Month) (Day) (Year)

7. AGE

88 yrs. 3 mos. 6 ds.

IF LESS than 1 day
how many hrs. or mins.?

8. OCCUPATION

(a) Trade, profession or particular kind of work

Farmer

(b) General nature of industry business, or establishment in which employed (or employer)

9. BIRTHPLACE

(State or Country) New York

10. NAME OF FATHER

Daniel Ross

11. BIRTHPLACE OF FATHER

(State or Country) Mass. Shepard

12. MAIDEN NAME OF MOTHER

Jerusha Shepard

13. BIRTHPLACE OF MOTHER

(State or Country) Mass

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Bethuel S. Ross

(Address) Boise Idaho

15.

Filed 3-25 1913

J. M. Taylor
Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

April 24th 1913
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from

April 22 1913, to April 22 1913

that I last saw him alive on April 22 1913

and that death occurred on the date stated above, at 5 AM

The CAUSE OF DEATH* was as follows:

Old age (Senility)

(Duration) yrs. mos. ds.

Contributory (Secondary)

(Duration) yrs. mos. ds.

(Signed) L. P. McCalla M. D.

4/24/1913 (Address) Boise Idaho

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death yrs. mos. days. In the State yrs. mos. days.

Where was disease contracted if not at place of death?

Former or usual residence So. Boise Bench

19. PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

Chun Prairie, Wis. 4/25 1913

20. UNDERTAKER

ADDRESS

Schreiber & Sidenfeld Boise

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Form V. S. No. 5 20M.1-16-12

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH.

Registration District No. 1

County of Ada

Primary Registration District No. 2004

City of Boise

(No. Collector Station St.)

File No. 4737

Registered No. 32

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Curis Leo Quinton

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX

Male

4. COLOR OR RACE

White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED.

(Write the word.)

6. DATE OF BIRTH

Nov.
(Month)

26
(Day)

1911
(Year)

7. AGE

2 yrs. 5 mos. 4 ds.

IF LESS than 1 day
how many hrs. or
..... mins.?

8. OCCUPATION

(a) Trade, profession or particular kind of work

(b) General nature of industry business, or establishment in which employed (or employer)

9. BIRTHPLACE

(State or Country)

Boise

10. NAME OF FATHER

Legal adoption by Alfred Quinton

11. BIRTHPLACE OF FATHER

(State or Country)

Idaho

12. MAIDEN NAME OF MOTHER

13. BIRTHPLACE OF MOTHER

(State or Country)

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

Alfred Quinton

(Address)

Boise

15.

Filed

April 30 1913

1913

J. M. Layton
Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

April 30 1913
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from April 15 1913, to April 30 1913, that I last saw him alive on April 15 1913, and that death occurred on the date stated above, at 7:40 A.M.

The CAUSE OF DEATH* was as follows:

Heart failure

(Duration) yrs. mos. ds.

Contributory (Secondary)

(Duration) yrs. mos. ds.

(Signed)

E. O. Collier M.D.

4/30/1913 (Address) Boise

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death yrs. mos. days. In the State yrs. mos. days.

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL DATE OF BURIAL

Winona Hill Cemetery 5/1 1913

20. UNDERTAKER

ADDRESS

Schubert & Hidenfeld Boise

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Form V. S. No. 5. 10M. 6-20-11.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

File No. **4738**

Registered No. **93**

If death occurred in a hospital, institution or camp give its NAME instead of street and number.

1. PLACE OF DEATH.

Registration District No. **1**

County of **Ada**

Primary Registration District No. **2001**

City of **Star**

(No. **1**, St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

Gwendolin Davis

PERSONAL AND STATISTICAL PARTICULARS

3. SEX

FM

4. COLOR OR RACE

Co.

5. SINGLE, MARRIED, WIDOWED OR DIVORCED.

(Write the word.) **—**

6. DATE OF BIRTH

April 20 1913
(Month) (Day) (Year)

7. AGE

one yrs. **one** mos. **one** ds.
IF LESS than 1 day how many hrs. or min.?

8. OCCUPATION

(a) Trade, profession, or particular kind of work
(b) General nature of industry business, or establishment in which employed (or employer)

None

9. BIRTHPLACE

(State or Country)

Ada Co - Star.

10. NAME OF FATHER

Arthur Davis

11. BIRTHPLACE OF FATHER

(State or Country)

Hampfordshire Eng

12. MAIDEN NAME OF MOTHER

Mamie Bass

13. BIRTHPLACE OF MOTHER

(State or Country)

Idaho

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

Old Hall Rd

(Address)

Star Idaho

15.

Filed

Apr 22 1913

J. M. Taylor
Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

April 21 1913
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from

April 20 1913 to **Apr 21 1913**
that I last saw **her** alive on **Apr 21 1913**

and that death occurred on the date stated above, at **5 P.** M.

The CAUSE OF DEATH* was as follows:

Injuries during birth

(Duration) yrs. mos. **one** ds.

Contributory (Secondary)

(Duration) yrs. mos. ds.

(Signed)

Red Hall

19 (Address) **Star Idaho**

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place In the

of death yrs. mos. ds. State yrs. mos. ds.

Where was Disease contracted,

If not at place of death?

Former or

usual residence.

19. PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

Star Cemetery

Apr 22 1913

20. UNDERTAKER

ADDRESS

None Employed

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Form V. S. No. 5 20M.1-16-12

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH.

Registration District No. 1

County of Ada

Primary Registration District No. 2004

File No. 4739

City of

(No. men Holcomb School)

Registered No. 34

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Annie Shepherd

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX

Female

4. COLOR OR RACE

White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED.

Married (Write the word.)

6. DATE OF BIRTH

May 17 1845
(Month) (Day) (Year)

7. AGE

67 yrs. 11 mos. 13 ds.

IF LESS than 1 day
how many hrs. or mins.?

8. OCCUPATION

(a) Trade, profession or particular kind of work

Homekeeper

(b) General nature of industry, business, or establishment in which employed (or employer)

9. BIRTHPLACE

(State or Country)

Ohio

10. NAME OF FATHER

William Myers

11. BIRTHPLACE OF FATHER

(State or Country)

Ohio

12. MAIDEN NAME OF MOTHER

Margaret Mone

13. BIRTHPLACE OF MOTHER

(State or Country)

Mo.

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

Ed Shepherd

(Address)

Boise, Idaho

15.

Filed

May 27 1913

1913

J. Matlock

Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH

Apr 30 1913
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from Apr 23 1913, to Apr 30 1913,

that I last saw her alive on Apr 30 1913,

and that death occurred on the date stated above, at 7 P. M.

The CAUSE OF DEATH* was as follows:

Coronary Thrombosis

(Duration) yrs. mos. 7 ds.

Contributory (Secondary)

(Duration) yrs. mos. ds.

(Signed)

Edmund J. Barry, M. D.

Boise, Idaho (Address)

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death yrs. mos. days. In the State yrs. mos. days.

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL DATE OF BURIAL

Morris Hill Cemetery 5/2 1913

20. UNDERTAKER

ADDRESS

Sanborn & Sons, Boise

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. N. B.—Every item of information should be carefully supplied. AGE should be state EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Form V. S. No. 5. 10M. 6-20-11.

CERTIFICATE OF DEATH

 State of Idaho
 BOARD OF HEALTH
 Bureau of Vital Statistics

1. PLACE OF DEATH.

Registration District No. 1County of AdaPrimary Registration District No. 2003City of Meridian(No. R-1 St.)File No. 1741Registered No. 36

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

Roscoe Thomas Torrey

If death occurred in a hospital, institution or camp give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX

male

4. COLOR OR RACE

white

5. SINGLE, MARRIED, WIDOWED OR DIVORCED.

single
(Write the word.)

6. DATE OF BIRTH

Oct201893

(Month)

(Day)

(Year)

7. AGE

19

yrs.

4

mos.

10

ds.

 IF LESS than 1 day
 how many hrs. or
 min.

8. OCCUPATION

(a) Trade, profession or particular kind of work

Rancher

(b) General nature of industry business or establishment in which employed (or employer)

9. BIRTHPLACE

(State or Country)

Putnam Co Mo

10. NAME OF FATHER

Roscoe Torrey

11. BIRTHPLACE OF FATHER

(State or Country)

Putnam Co Mo

12. MAIDEN NAME OF MOTHER

Mary Francis Ellis

13. BIRTHPLACE OF MOTHER

(State or Country)

Putnam Co Mo

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

J. F. Neal

(Address)

Meridian

15.

Filed March 4th 1913May 8 1913E. L. SuttonJ. M. Taylor

Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

March 31913

(Month)

(Day)

(Year)

17. I HEREBY CERTIFY, That I attended deceased from

Dec. 29 1912 to March 3 1913that I last saw him alive on March 3 1913,and that death occurred on the date stated above, at 5:15 P.M.

The CAUSE OF DEATH* was as follows.

Typhoid Fever(Duration) yrs. 2 mos. 4 ds.Contributory
(Secondary)(Duration) yrs. 1 mos. 4 ds.

(Signed)

J. F. Neal M. D.March 4 1913 (Address) Meridian Idaho

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and 2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death yrs. mos. ds. State yrs. mos. ds.

Where was disease contracted.

If not at place of death?

Former or

usual residence.

19. PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

Meridian CemeteryMarch 5 1913

20. UNDERTAKER

ADDRESS

None

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Form V. S. No. 5. 12½ M. 7-24-11

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH.

Registration District No. 31County of CassiaPrimary Registration District No. 2125

City of _____

(No. _____, _____ St.)

File No. 4749Registered No. 18

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Mrs Anna L. Larson Sr

If death occurred in a hospital, institution or camp give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX

Female

4. COLOR OR RACE

White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED.

Widowed
(Write the word.)

6. DATE OF BIRTH

September 5th 1829
(Month) (Day) (Year)

7. AGE

83 yrs. 6 mos. 9 ds.IF LESS than 1 day
how many hrs. or
..... min?

8. OCCUPATION

(a) Trade, profession or particular kind of work.

Housework

(b) General nature of industry business or establishment in which employed (or employer)

9. BIRTHPLACE

(State or Country)

Ljungskorp Örebro Län
Sweden

10. NAME OF FATHER

Pher. Anderson

11. BIRTHPLACE OF FATHER

(State or Country)

Sweden

12. MAIDEN NAME OF MOTHER

13. BIRTHPLACE OF MOTHER

(State or Country)

Sweden

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

Lars P. Larson

(Address)

Island Idaho

15.

Filed Apr 22 1913P. B. Stinson
Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH

March 14 1913
(Month) (Day) (Year)17. I HEREBY CERTIFY, That I attended deceased from
Mar. 8 1913, to Mar. 14 1913that I last saw him alive on Mar. 11 1913
and that death occurred on the date stated above, at 89 M.

The CAUSE OF DEATH* was as follows:

Influenza(Duration) yrs. mos. 8 ds.Contributory
(Secondary)Senility

(Duration) yrs. mos. ds.

(Signed)

E. P. Johnson M. D.
Mar 14 1913 (Address) Oakley Idaho

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place yrs. mos. ds. In the
of death yrs. mos. ds. State yrs. mos. ds.

Where was disease contracted,

If not at place of death?

Former or

usual residence.

19. PLACE OF BURIAL OR REMOVAL DATE OF BURIAL

1913

20. UNDERTAKER

ADDRESS

Harvey SessionsMarion Idaho

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Form V. S. No. 5. 12½ M. 7-24-11

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics
File No. 4743
Registered No. 19

1. PLACE OF DEATH. Registration District 31
County of Cassia Primary Registration District No. 21st
City of Burley (No. , St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Audra Billa Willard

If death occurred in a hospital, institution or camp give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX female 4. COLOR OR RACE white 5. SINGLE, MARRIED, WIDOWED OR DIVORCED. Married
6. DATE OF BIRTH Aug. 22 1890
(Month) (Day) (Year)
7. AGE 23 yrs. 4 mos. 15 ds. IF LESS than 1 day how many hrs. or min?

8. OCCUPATION

(a) Trade, profession or particular kind of work. Housewife
(b) General nature of industry business or establishment in which employed (or employer)

9. BIRTHPLACE

(State or Country) Cassia Co. Ida.

10. NAME OF FATHER

Meritt B. Beecher

11. BIRTHPLACE OF FATHER

(State or Country) Bonanza Co. Utah

12. MAIDEN NAME OF MOTHER

Ms. P. C.

13. BIRTHPLACE OF MOTHER

(State or Country) Navajo Co. Utah

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Art Willard
(Address) Burley, Ida.

15. Filed May 5 1913 P.B. Simons
Local

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

Apr 13 1913
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from April 10 1913, to Apr. 13 1913 that I last saw him alive on Apr. 12 1913 and that death occurred on the date stated above, at 6 A. M.

The CAUSE OF DEATH* was as follows:

Puerperal Septicemia

(Duration) yrs. 5 mos. ds.
Contributory Hypertension Gravidarum
(Secondary)

(Duration) yrs. mos. ds.
(Signed) J. C. Patterson M. D.
4-13 1913 (Address) Burley, Ida.

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place In the
of death yrs. mos. ds. State yrs. mos. ds.
Where was disease contracted,
If not at place of death?
Former or usual residence.

19. PLACE OF BURIAL OR REMOVAL DATE OF BURIAL

Idaho Ida. April 14 1913

20. UNDERTAKER ADDRESS

L. B. Gallagher Burley, Ida.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Form V. S. No. 5. 12½M.7-24-11

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics
File No. 174
Registered No. 21

1. PLACE OF DEATH. Registration District No. 31
County of Cassia Primary Registration District No. 2196
City of _____ (No. _____ St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

David Walker

If death occurred in a hospital, institution or camp give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX Male 4. COLOR OR RACE white 5. SINGLE, MARRIED, WIDOWED OR DIVORCED. Married
(Write the word.)

6. DATE OF BIRTH

Aug. 23 1897
(Month) (Day) (Year)

7. AGE

75 yrs. 5 mos. 16 ds.

IF LESS than 1 day
how many..... hrs. or
..... min?

8. OCCUPATION

(a) Trade, profession or particular kind of work.
(b) General nature of industry business or establishment in which employed (or employer)

Farmer

9. BIRTHPLACE

(State or Country)

North Carolina

10. NAME OF FATHER

11. BIRTHPLACE OF FATHER

(State or Country)

12. MAIDEN NAME OF MOTHER

13. BIRTHPLACE OF MOTHER

(State or Country)

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

(Address)

J. F. Walker
Oakley, Idaho

15.

Filed

April 2 1913

A. B. Stockinger
Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH

February 5 1913
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from May 1909, to Feb. 2 1913
that I last saw him alive on Feb. 2 1913

and that death occurred on the date stated above, at 11:30 A.M.

The CAUSE OF DEATH* was as follows:

Angina Pectoris

(Duration) 2 yrs. 8 mos. — ds.

Contributory (Secondary) Arteriosclerosis from Bronchitis

(Duration) many yrs. — mos. — ds.

(Signed) E. P. McPherson M. D.
Feb. 5 1913 (Address) Oakley, Idaho

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place In the
of death..... yrs..... mos..... ds. State..... yrs..... mos..... ds.

Where was disease contracted,

If not at place of death?

Former or

usual residence.....

19. PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

Oakley, Idaho

Feb. 7 1913

20. UNDERTAKER

ADDRESS

Chas Walker

Oakley

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Form V. S. No. 5 20M.1-16-12

CERTIFICATE OF DEATH

1. PLACE OF DEATH

County of CusterCity of ChallisRegistration District No. 14Primary Registration District No. 2061

(No.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Thelma Nadine BoyState of Idaho
BOARD OF HEALTH
Bureau of Vital StatisticsFile No. 4716Registered No. 48

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX

4. COLOR OR RACE

5. SINGLE, MARRIED, WIDOWED OR DIVORCED.

(Write the word.)

6. DATE OF BIRTH

(Month)

(Day)

(Year)

7. AGE

..... yrs. mos. ds.

IF LESS than 1 day
how many hrs. or
..... mins.?

8. OCCUPATION

- (a) Trade, profession or particular kind of work
(b) General nature of industry business, or establishment in which employed (or employer)

9. BIRTHPLACE

(State or Country)

10. NAME OF FATHER

11. BIRTHPLACE OF FATHER

(State or Country)

12. MAIDEN NAME OF MOTHER

13. BIRTHPLACE OF MOTHER

(State or Country)

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

(Address)

15.

Filed

1913

Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH

(Month)

(Day)

1913

(Year)

17. I HEREBY CERTIFY, That I attended deceased from

4/11/1913, to 4/24/1913,

that I last saw her alive on 4/24/1913,

and that death occurred on the date stated above, at 10:30 P.M.

The CAUSE OF DEATH* was as follows:

Pneumonia

(Duration) yrs. mos. 9 ds.

Contributory
(Secondary)

(Duration) yrs. mos. ds.

(Signed) C. S. Ruffey M. D.4/25/1913 (Address) Challis, Ida

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death yrs. mos. days. In the State yrs. mos. days.

Where was disease contracted if not place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

Family Challis

4/26/1913

20. UNDERTAKER

ADDRESS

FamilyChallis

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Form V. S. No. 5 20M.1-16-12

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH.

Registration District No. 14

County of Custer

Primary Registration District No. 2061

City of Challis

(No.,

File No. 4747

Registered No. 47

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Chas. Turner

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX

Male

4. COLOR OR RACE

White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED.

Single

(Write the word.)

6. DATE OF BIRTH

Do not know

(Month)

(Day)

(Year)

7. AGE

58

yrs.

mos.

ds.

IF LESS than 1 day
how many hrs. or
..... mins.

8. OCCUPATION

(a) Trade, profession or particular kind of work

Miner

(b) General nature of industry business, or establishment in which employed (or employer)

9. BIRTHPLACE

(State or Country)

Sweden

10. NAME OF FATHER

Do not know

11. BIRTHPLACE OF FATHER

(State or Country)

Sweden

12. MAIDEN NAME OF MOTHER

Do not know

13. BIRTHPLACE OF MOTHER

(State or Country)

Sweden

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) C. L. Kirtley

(Address) Challis, Ida.

15.

Filed 4/30

1913

Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH

April

29th., 1913

191

(Month)

(Day)

(Year)

17. I HEREBY CERTIFY, That I attended deceased from

4/15

1913

to 4/27

191

that I last saw him alive on 4/27- 1913

and that death occurred on the date stated above, at M.

The CAUSE OF DEATH* was as follows:

Mitral Regurgitation

Was found dead in bed on above date

(Duration)

yrs.

mos.

ds.

Contributory Alcoholism

(Secondary)

(Duration)

yrs.

mos.

ds.

(Signed) C. L. Kirtley

M. D.

4/27 1913

(Address) Challis, Ida.

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place

of death yrs. mos. days.

In the

State yrs. mos. days.

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

Challis, Ida.

5/1-1913 191

20. UNDERTAKER

ADDRESS

Joe Ebberts

Challis.

MARGIN RESERVED FOR BINDING
WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Form V. S. No. 5 20M.1-16-12

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH.

Registration District No. 14

County of Custer

Primary Registration District No. 2060

File No. 174

City of Clayton

(No. , St.)

Registered No. 49

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Jimmie Smith

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX

Male

4. COLOR OR RACE

White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED.

Single

(Write the word.)

6. DATE OF BIRTH

Do not know

(Month)

(Day)

(Year)

7. AGE

83

yrs.

mos.

ds.

IF LESS than 1 day
how many hrs. or
mins.?

8. OCCUPATION

(a) Trade, profession or particular kind of work

Miner

(b) General nature of industry business, or establishment in which employed (or employer)

9. BIRTHPLACE

(State or Country)

Do not know

10. NAME OF FATHER

Do not know

11. BIRTHPLACE OF FATHER

(State or Country)

" " "

12. MAIDEN NAME OF MOTHER

" " "

13. BIRTHPLACE OF MOTHER

(State or Country)

" " "

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Robert Campbell

(Address) Clayton, Idaho.

15.

Filed 5/5

1913

Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH

4/3 - 1913

(Month)

(Day)

191

(Year)

17. I HEREBY CERTIFY, That I attended deceased from

191, to

191,

that I last saw h. alive on

191,

and that death occurred on the date stated above, at M.

The CAUSE OF DEATH* was as follows:

Had no medical care was found dead in his cabin

(Duration)

yrs.

mos.

ds.

Contributory
(Secondary)

(Duration)

yrs.

mos.

ds.

(Signed)

C. L. Hustley

M. D.

1913 (Address) Clayton, Ida.

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death.

yrs.

mos.

days.

In the State

yrs.

mos.

days.

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

Clayton Ida.

4/4, 1913 191

20. UNDERTAKER

ADDRESS

Friends

Clayton

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Form V. S. No. 5 20M.1-16-12

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH

Registration District No. 14

County of Peach Cr.

Primary Registration District No. 2060

City of Clayton

(No.)

File No. 4749

Registered No. 46

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

Wm Roy Ennet

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX

4. COLOR OR RACE

5. SINGLE, MARRIED, WIDOWED OR DIVORCED.

Male

White

Single (Write the word.)

6. DATE OF BIRTH

Sept.6th1913

(Month)

(Day)

(Year)

7. AGE

7 yrs. 7 mos. 7 ds.

IF LESS than 1 day
how many hrs. or
..... mins.?

8. OCCUPATION

(a) Trade, profession or particular kind of work

(b) General nature of industry business, or establishment in which employed (or employer)

9. BIRTHPLACE

(State or Country)

Challis, Ida.

10. NAME OF FATHER

Chas. A. Ennet

11. BIRTHPLACE OF FATHER

(State or Country)

Idaho.

12. MAIDEN NAME OF MOTHER

Frances Cooper

13. BIRTHPLACE OF MOTHER

(State or Country)

Idaho.

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

Chas. A. Ennet

(Address)

Clayton, Ida.

15.

Filed 5/51913A. B. Kistley

Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH

April131913

(Month)

(Day)

(Year)

17. I HEREBY CERTIFY, That I attended deceased from

1913, to1913,that I last saw him alive on 1913,and that death occurred on the date stated above, at M.

The CAUSE OF DEATH* was as follows:

I did not see this case butjudge from account given byparents that some form of boweltrouble (Duration) yrs. mos. ds.

Contributory

(Secondary)

(Duration)

yrs.

mos.

ds.

(Signed)

C. S. Kistley

M. D.

5/5 1913 (Address) Challis, Ida

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place

of death yrs. mos. days.

In the

State yrs. mos. days.

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

Peach Creek, Custer Co.4/14 1913

20. UNDERTAKER

ADDRESS

FamilyClayton

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Form V. S. No. 5 20M.1-16-12

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. **PLACE OF DEATH.** *Bannock*
County of *Bannock* Registration District No. *19*
City of *McCammon* (No. *Genl Hospital* St.)
Primary Registration District No. *1002*
If death occurs away from usual residence, give facts called for under special information. 2. **FULL NAME** *Cho Berry.*

File No. *47501*
Registered No. *38*
If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. **SEX** *Male* 4. **COLOR OR RACE** *White* 5. **SINGLE, MARRIED, WIDOWED OR DIVORCED.**
(Write the word.)

6. **DATE OF BIRTH**
unknown 1 (Month) (Day) (Year)

7. **AGE** *23 (about)* yrs. mos. ds. IF LESS than 1 day how many hrs. or mins.?

8. **OCCUPATION**
(a) Trade, profession or particular kind of work *Labourer*
(b) General nature of industry, business, or establishment in which employed (or employer)

9. **BIRTHPLACE**
(State or Country) ✓

10. **NAME OF FATHER** ✓

11. **BIRTHPLACE OF FATHER** ✓
(State or Country)

12. **MAIDEN NAME OF MOTHER** ✓

13. **BIRTHPLACE OF MOTHER** ✓
(State or Country)

14. **THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE**

(Informant) *J. E. Cooper*
(Address) *McCammon*

15. Filed *Mar 26* 191*3* *O. Berry*
Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. **DATE OF DEATH**
March 26 191*3*
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from *March 17* 191*3*, to *March 25* 191*3*, that I last saw him alive on *March 25* 191*3*, and that death occurred on the date stated above, at *M.*

The CAUSE OF DEATH* was as follows:
Operation for appendicitis followed by rupture of bowel
(Duration) yrs. mos. ds.

Contributory (Secondary)

(Duration) yrs. mos. ds.

(Signed) *G. H. Cooper* M. D.

Mar 26 1913 (Address) *McCammon*

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. **LENGTH OF RESIDENCE** (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death yrs. mos. *8* days. In the State yrs. mos. days.

Where was disease contracted if not at place of death?

Former or usual residence

19. **PLACE OF BURIAL OR REMOVAL** *Scatello* **DATE OF BURIAL** *April 1* 191*3*

20. **UNDERTAKER** *W. H. Mark* **ADDRESS** *Scatello*

1. PLACE OF DEATH
County of Bannock
City of PocatelloRegistration District No. 100
Primary Registration District No. 100
(No. _____, St.)File No. 4751
Registered No. 40

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Lorin Ray Walker Jr.

If death occurred in a hospital, institution or camp give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX Male 4. COLOR OR RACE White 5. SINGLE, MARRIED, WIDOWED OR DIVORCED. Single
(Write the word.)6. DATE OF BIRTH Feb. 1 1891
(Month) (Day) (Year)7. AGE 22 yrs. 2 mos. 4 ds. IF LESS than 1 day how many hrs. or min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work Labourer

(b) General nature of industry business or establishment in which employed (or employer)

9. BIRTHPLACE

(State or Country) Idaho

10. NAME OF FATHER

Lorin Walker

11. BIRTHPLACE OF FATHER

(State or Country) Utah

12. MAIDEN NAME OF MOTHER

Sarah Howell

13. BIRTHPLACE OF MOTHER

(State or Country) Idaho

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Lorin Walker(Address) Warm River, Idaho

15.

Filed Apr 19 1913Local Registrar O. B. [unclear]

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

April 7 1913
(Month) (Day) (Year)17. I HEREBY CERTIFY, That I attended deceased from April 4 1913 to April 5 1913that I last saw him alive on April 5 1913, and that death occurred on the date stated above, at 3 P. M.

The CAUSE OF DEATH was as follows:

Purulent Peritonitis
Refused operation till
day of death - operated.
(Duration) yrs. mos. 8 ds.Contributory (Secondary) Cholecystitis(Duration) yrs. mos. several ds.(Signed) W. F. Howard M. D. 4/7/1913 (Address) Pocatello

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place Pocatello General Hospital In the
of death. yrs. mos. 1 ds. State. yrs. mos. ds.Where was disease contracted, Residence in Pocatello

If not at place of death?

Former or

usual residence. Warm River, Utah

19. PLACE OF BURIAL OR REMOVAL

Warm River, Idaho shipped April 8 1913

20. UNDERTAKER

W. L. Walker Pocatello

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Form V. S. No. 5 20M.1-16-12

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics
File No. 47521
Registered No. 46

1. PLACE OF DEATH.

Registration District No. 19County of BannockPrimary Registration District No. 1002City of Pocatello

(No. _____ St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

Fiadys Eleanor Green

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX

4. COLOR OR RACE

5. SINGLE, MARRIED, WIDOWED OR DIVORCED.

Female Whitesingle
(Write the word.)

6. DATE OF BIRTH

Jan 23 1913
(Month) (Day) (Year)

7. AGE

X yrs. 2 mos. 26 ds.IF LESS than 1 day
how many hrs. or
..... mins.?

8. OCCUPATION

(a) Trade, profession or

particular kind of work

(b) General nature of industry

business, or establishment in

which employed (or employer)

None

9. BIRTHPLACE

(State or Country)

Idaho

10. NAME OF FATHER

John T. Green

11. BIRTHPLACE OF FATHER

(State or Country)

England

12. MAIDEN NAME OF MOTHER

Della Hunt

13. BIRTHPLACE OF MOTHER

(State or Country)

Wyoming

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

(Address)

J. T. Green
1306 S. 3rd

15.

Filed

4/281913O. J. Green

Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH

April 19 1913
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from

April 18 1913, to April 19 1913,that I last saw her alive on April 19 1913,and that death occurred on the date stated above, at 2:00 P.M.

The CAUSE OF DEATH* was as follows:

Bronch. pneumonia(Duration) yrs. mos. 3 ds.

Contributory

(Secondary)

(Duration) yrs. mos. ds.

(Signed)

A. M. Newton

M. D.

April 1913 (Address) 125 N. 2nd St. Pocatello, Idaho

State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place

of death yrs. mos. days.

In the

State yrs. mos. days.

Where was disease contracted
if not at place of death?Former or
usual residence

19. PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

St. Andrew's April 21 1913

20. UNDERTAKER

ADDRESS

W. A. Walker Pocatello

MARGIN RESERVED FOR BINDING
WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHOTOCOPIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Form V. S. No. 5 20M.1-16-12

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH

Registration District No. 19

County of

Primary Registration District No. 1002

City of

(No. 502, 11. Main St.)

File No. 2 1754

Registered No. 327

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

Emma Louise Ferguson

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX

4. COLOR OR RACE

5. SINGLE, MARRIED, WIDOWED OR DIVORCED

Female

White

Married (Widow)

6. DATE OF BIRTH

Feb. 17 1863

(Month) (Day) (Year)

7. AGE

50 yrs. 2 mos. 12 ds.

IF LESS than 1 day how many hrs. or mins.

8. OCCUPATION

(a) Trade, profession or particular kind of work

Nurse

(b) General nature of industry business, or establishment in which employed (or employer)

9. BIRTHPLACE

(State or Country)

Michigan

10. NAME OF FATHER

August Dohmeyer

11. BIRTHPLACE OF FATHER

(State or Country)

Germany

12. MAIDEN NAME OF MOTHER

Minnie Blum

13. BIRTHPLACE OF MOTHER

(State or Country)

Germany

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

L. C. Grosse

(Address)

Pocatello, Ida.

15.

Filed

Apr 29, 1913 Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

April 29 1913
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from April 10 1913, to April 29 1913, that I last saw her alive on April 29 1913, and that death occurred on the date stated above, at 9 A.M.

The CAUSE OF DEATH* was as follows:

Mild insufficiency

(Duration) 10 yrs. - mos. - ds.

Contributory (Secondary)

Nephritis, Ascites

(Duration) 6 yrs. - mos. - ds.

(Signed)

W. F. Hennrich, D. M. 5/2 1913 (Address) Pocatello, Idaho

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death... yrs. ... mos. ... days. In the State... yrs. ... mos. ... days.

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

Home

1913

20. UNDERTAKER

ADDRESS

W. F. Hennrich Pocatello

Form V. S. No. 5 20M.1-16-12

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH

Registration District No.

County of

Primary Registration District No.

City of

(No. 306, 4. Lincoln St.)

File No.

Registered No. 53

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX

4. COLOR OR RACE

5. SINGLE, MARRIED, WIDOWED OR DIVORCED.

6. DATE OF BIRTH

7. AGE

IF LESS than 1 day
how many hrs. or
mins.?

8. OCCUPATION

(a) Trade, profession or particular kind of work

(b) General nature of industry business, or establishment in which employed (or employer)

9. BIRTHPLACE

(State or Country)

10. NAME OF FATHER

11. BIRTHPLACE OF FATHER

(State or Country)

12. MAIDEN NAME OF MOTHER

13. BIRTHPLACE OF MOTHER

(State or Country)

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

(Address)

15.

Filed

1913

Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH

17. I HEREBY CERTIFY, That I attended deceased from

that I last saw her alive on

and that death occurred on the date stated above, at

The CAUSE OF DEATH* was as follows:

(Duration) yrs. mos. 14 ds.

Contributory (Secondary)

(Duration) yrs. mos. 30 ds.

(Signed) M. D.

19 (Address)

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death yrs. mos. days. In the State yrs. mos. days.

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL DATE OF BURIAL

20. UNDERTAKER ADDRESS

Form V. S. No. 5 20M.1-16-12

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics
File No. 47567
Registered No. 51.

1. PLACE OF DEATH. Bamrock
County of Blaine
City of Pocatello
Registration District No. 19
Primary Registration District No. 1002
(No. 456, So 10 ave St.)
If death occurs away from usual residence, give facts called for under special information. 2. FULL NAME Mattie Corrahey

PERSONAL AND STATISTICAL PARTICULARS

3. SEX Female 4. COLOR OR RACE White 5. SINGLE/MARRIED, WIDOWED OR DIVORCED. Widow
(Married) (Widow) (Divorced)

6. DATE OF BIRTH May 24 1890
(Month) (Day) (Year)

7. AGE 42 yrs. 11 mos. 1 ds. IF LESS than 1 day how many hrs. or mins.

8. OCCUPATION (a) Trade, profession or particular kind of work Nursewife
(b) General nature of industry, business, or establishment in which employed (or employer)

9. BIRTHPLACE North Carolina
(State or Country)

10. NAME OF FATHER J. V. Minshew

11. BIRTHPLACE OF FATHER N. Carolina
(State or Country)

12. MAIDEN NAME OF MOTHER Dolly Chase

13. BIRTHPLACE OF MOTHER N. Carolina
(State or Country)

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE (Informant) J. J. Corrahey
(Address) Pocatello Ida

15. Filed Apr 26 1913 Off Steady
Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH April 25 1913
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from Jan 10 1913, to April 25 1913, that I last saw her alive on April 25 1913, and that death occurred on the date stated above, at 11:20 M.

The CAUSE OF DEATH* was as follows:
Valvular Heart Trouble
Precipitated regurgitation
(Duration) yrs. mos. ds.

Contributory (Secondary) Rheumatism
(Duration) yrs. mos. ds.
(Signed) J. A. Castle M. D.
Apr 26 1913 (Address) Pocatello

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death.....yrs.....mos.....days. In the State.....yrs.....mos.....days.

Where was disease contracted if not at place of death?
Former or usual residence.....

19. PLACE OF BURIAL OR REMOVAL St. Paul's Church DATE OF BURIAL April 27 1913

20. UMBERTAKER H. H. Mallett ADDRESS Pocatello

MARGIN RESERVED FOR BINDING
WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Form V. S. No. 5 20M.1-16-12

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics
File No. 47571
Registered No. 50

1. PLACE OF DEATH.

Registration District No. 19

County of Bannock

Primary Registration District No. 1002

City of Pocatello

(No. 1018, T. Harneon St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

Tracton Verna Olsen

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX

Male

4. COLOR OR RACE

White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED.

Single

6. DATE OF BIRTH

April 19 1912

(Month)

(Day)

(Year)

7. AGE

1 yrs. 4 mos. 4 ds.

IF LESS than 1 day
how many hrs. or
..... mins.?

8. OCCUPATION

(a) Trade, profession or particular kind of work

None

(b) General nature of industry business, or establishment in which employed (or employer)

9. BIRTHPLACE

(State or Country)

Pocatello

10. NAME OF FATHER

Marvin Olsen

11. BIRTHPLACE OF FATHER

(State or Country)

Norway

12. MAIDEN NAME OF MOTHER

William

13. BIRTHPLACE OF MOTHER

(State or Country)

Idaho

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

Marvin Olsen

(Address)

Pocatello

15.

Filed Apr 24 1913

Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH

April 23 1913

(Month)

(Day)

(Year)

17. I HEREBY CERTIFY, That I attended deceased from

April 20 1913

to April 23 1913

that I last saw him alive on April 23 1913

and that death occurred on the date stated above, at 10:30 P.M.

The CAUSE OF DEATH* was as follows: Bilateral Pneumonia

~~Septic pneumonia~~

(Duration)

yrs.

mos.

ds.

Contributory (Secondary)

~~Pneumonia~~

(Duration)

yrs.

mos.

ds.

(Signed)

W. A. Caste

Apr 23 1913 (Address) Pocatello, Idaho

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death yrs. mos. days.

In the State yrs. mos. days.

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL

W. A. Caste

DATE OF BURIAL

April 25 1913

20. UNDERTAKER

W. A. Caste

ADDRESS

Pocatello

MARGIN RESERVED FOR BINDING
WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Form V. S. No. 5 20M.1-16-12

Ray
CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. **PLACE OF DEATH.**

Registration District No.

County of *Bannock*

Primary Registration District No.

City of *Pocatello, Ida*

(No. *658*) *N. Harrison* St.)

If death occurs away from usual residence, give facts called for under special information.

2. **FULL NAME**

Infant N.L. Hartvigsen

File No. *475-1*

Registered No. *49*

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. **SEX**

4. **COLOR OR RACE**

5. **SINGLE, MARRIED, WIDOWED OR DIVORCED.**

Male

White

Single (write the word.)

6. **DATE OF BIRTH**

April 22
Month Day Year

1913
Year

7. **AGE**

— yrs. — mos. — ds.

IF LESS than 1 day
how many *2* hrs. or
..... mins.

8. **OCCUPATION**

(a) Trade, profession or particular kind of work

(b) General nature of industry business, or establishment in which employed (or employer)

None

9. **BIRTHPLACE**

(State or Country)

Pocatello

10. **NAME OF FATHER**

Harold L. Hartvigsen

11. **BIRTHPLACE OF FATHER**

(State or Country)

Utah

12. **MAIDEN NAME OF MOTHER**

Myrtle Harris

13. **BIRTHPLACE OF MOTHER**

(State or Country)

Idaho

14. **THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE**

(Informant)

Harold Hartvigsen

(Address)

658 N. Harrison

15.

Filed

Apr 24

191 *3*

O.P. Steeg
Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. **DATE OF DEATH**

April

23

3
191

(Month)

(Day)

(Year)

17. I HEREBY CERTIFY, That I attended deceased from

Apr 23 191*3*, to *Apr 23* 191*3*.

that I last saw him alive on *Apr 23 about 10⁴⁵* 191*3*.

and that death occurred on the date stated above, at *10⁴⁵* M.

The CAUSE OF DEATH* was as follows:

Asphyxia pallida

(Duration)

yrs.

mos.

ds.

Contributory
(Secondary)

(Duration)

yrs.

mos.

ds.

(Signed)

Apr 24 191*3*

(Address)

Pocatello, Idaho

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. **LENGTH OF RESIDENCE** (For Hospitals, Institutions, Transients or Recent Residents.)

At place

of death.....yrs.....mos.....days.

In the

State.....yrs.....mos.....days.

Where was disease contracted if not at place of death?

Former or usual residence.....

19. **PLACE OF BURIAL OR REMOVAL**

DATE OF BURIAL

At Home

Apr 24 191*3*

20. **UNDERTAKER**

ADDRESS

H. MacKee

Pocatello

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Form V. S. No. 5 20M.1-16-12

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH.

Registration District No. 19

County of Bannock

Primary Registration District No. 1002

City of Pocatello

(No. 313, D. Mann St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME James Hood

File No. 4760

Registered No. 47

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX Male

4. COLOR OR RACE White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED. Married
(Write the word.)

6. DATE OF BIRTH 1889

(Month)

(Day)

(Year)

7. AGE about 47

..... yrs. mos. ds.

IF LESS than 1 day
how many hrs. or
..... mins.

8. OCCUPATION Laborer

(a) Trade, profession or particular kind of work

(b) General nature of industry business, or establishment in which employed (or employer)

9. BIRTHPLACE

(State or Country)

10. NAME OF FATHER

11. BIRTHPLACE OF FATHER

(State or Country)

12. MAIDEN NAME OF MOTHER

13. BIRTHPLACE OF MOTHER

(State or Country)

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) M. M. Macker

(Address) Pocatello Idaho

15.

Filed Apr 24 1913

191

Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH April 20 1913

(Month)

(Day)

(Year)

17. I HEREBY CERTIFY, That I attended deceased from

1913, to 1913,

that I last saw him alive on 1913,

and that death occurred on the date stated above, at 4 M.

The CAUSE OF DEATH* was as follows:

Myocarditis
Coronary Sclerosis

(Duration) yrs. mos. ds.

Contributory (Secondary)

(Duration) yrs. mos. ds.

(Signed) O. B. Steacy, M. D.

Apr 24 1913 (Address) Pocatello, Idaho

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death yrs. mos. days. In the State yrs. mos. days.

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL DATE OF BURIAL

Washington D. C. 1913

20. UNDERTAKER

ADDRESS

M. M. Macker Pocatello

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Form V. S. No. 5 20M.1-16-12

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH
County of *Bannock*
City of *Pocatello*

Registration District No. *19*
Primary Registration District No. *102*
(No. *617*, N. Garfield St.)

File No. *14761*
Registered No. *42*

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME *Emily Service*

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX *Female* 4. COLOR OR RACE *White* 5. SINGLE, MARRIED, WIDOWED OR DIVORCED *Married*
(Write the word)

6. DATE OF BIRTH *Dec 9 1859*
(Month) (Day) (Year)

7. AGE *54* yrs. *4* mos. *4* ds. IF LESS than 1 day how many hrs. or mins?

8. OCCUPATION
(a) Trade, profession or particular kind of work *Housewife*
(b) General nature of industry business, or establishment in which employed (or employer)

9. BIRTHPLACE
(State or Country) *Lansdowne Wis*

10. NAME OF FATHER *David Courtney*

11. BIRTHPLACE OF FATHER
(State or Country) *England*

12. MAIDEN NAME OF MOTHER *Jane Courtney*

13. BIRTHPLACE OF MOTHER
(State or Country) *England*

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) *A. H. Service*
(Address) *Pocatello Ida*

15. Filed *Apr 11* 191 *3* *AP Service*
Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH *April 10 1913*
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from *April 1st 1913* to *April 10 1913*, that I last saw her alive on *April 10 1913*, and that death occurred on the date stated above, at *6 A.M.*

The CAUSE OF DEATH* was as follows:
Primary carcinoma of uterus
Secondary carcinoma of liver
About 2 yrs. mos. ds.
(Duration) *Toxaemia*
Contributory (Secondary)
(Duration) *2* yrs. *2* mos. *2* ds.
(Signed) *W. A. Wright* M. D.
4/10 1913 (Address) *Pocatello, Idaho*

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death. yrs. mos. days. In the State. yrs. mos. days.

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL *Marion Cemetery* DATE OF BURIAL *Apr 27 1913*

20. UNDERTAKER *W. H. Walker* ADDRESS *Pocatello*

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Form V. S. No. 5 20M.1-16-12

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics
File No. 4762
Registered No. 44

1. PLACE OF DEATH.

Registration District No. 19

County of Sanwock

Primary Registration District No. 1002

City of Pocatello

(No. Old yds. 1002 St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

Fred Dieter

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX

Male

4. COLOR OR RACE

White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED.

Single (Write the word.)

6. DATE OF BIRTH

Sept
(Month)

19
(Day)

1848
(Year)

7. AGE

65 yrs. 6 mos. 25 ds.

IF LESS than 1 day
how many hrs. or
..... mins.?

8. OCCUPATION

(a) Trade, profession or particular kind of work
(b) General nature of industry business, or establishment in which employed (or employer)

Laborer

9. BIRTHPLACE

(State or Country)

Praden Germany

10. NAME OF FATHER

11. BIRTHPLACE OF FATHER

(State or Country)

12. MAIDEN NAME OF MOTHER

13. BIRTHPLACE OF MOTHER

(State or Country)

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

(Address)

W. M. Macker
Pocatello

15.

Filed

4-17-

1910

Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

April

14

1913

(Month)

(Day)

(Year)

17. I HEREBY CERTIFY, That I attended deceased from

191 to 191

that I last saw him alive on 191

and that death occurred on the date stated above, at M.

The CAUSE OF DEATH* was as follows:

Accident - struck by
switch engine

(Duration) yrs. mos. ds.

Contributory
(Secondary)

(Duration) yrs. mos. ds.

(Signed)

4-14, 1913 (Address) Pocatello, Idaho

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death yrs. mos. days. In the State yrs. mos. days.

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

St. Lewis cemetery

April 17 1913

20. UNDERTAKER

ADDRESS

W. M. Macker Pocatello

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Form V. S. No. 5 20M.1-16-12

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH

Registration District No.

County of

Primary Registration District No.

City of

(No. *Terrell Rooming House* St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

File No.

Registered No.

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX

4. COLOR OR RACE

5. SINGLE, MARRIED, WIDOWED OR DIVORCED.

6. DATE OF BIRTH

7. AGE

IF LESS than 1 day
how many hrs. or
..... mins.?

8. OCCUPATION

(a) Trade, profession or particular kind of work

(b) General nature of industry business, or establishment in which employed (or employer)

9. BIRTHPLACE

(State or Country)

10. NAME OF FATHER

11. BIRTHPLACE OF FATHER

(State or Country)

12. MAIDEN NAME OF MOTHER

13. BIRTHPLACE OF MOTHER

(State or Country)

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

(Address)

15.

Filed

1913

Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH

(Month)

(Day)

(Year)

17. I HEREBY CERTIFY, That I attended deceased from

Dec. 23 1912 to April 16 1913

that I last saw her alive on April 16 1913

and that death occurred on the date stated above, at 1:30 P.M.

The CAUSE OF DEATH* was as follows:

Carcinoma Cervix

(Duration) One yrs. 6 mos. 5 ds.

Contributory
(Secondary)

Secondary Metastasis

(Duration) 3 yrs. 3 mos. 3 ds.

(Signed)

4/17/13 (Address) Pocatello Idaho

State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place

of death.....yrs.....mos.....days.

In the

State.....yrs.....mos.....days.

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

20. UNDERTAKER

ADDRESS

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Form V. S. No. 5 20M.1-16-12

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH

Registration District No.

County of

Primary Registration District No.

City of

(No. 411, Box 3 Ave. St.)

File No.

Registered No.

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX

4. COLOR OR RACE

5. SINGLE, MARRIED, WIDOWED OR DIVORCED.

6. DATE OF BIRTH

7. AGE

IF LESS than 1 day
how many hrs. or mins.

8. OCCUPATION

- (a) Trade, profession or particular kind of work
(b) General nature of industry, business, or establishment in which employed (or employer)

9. BIRTHPLACE

(State or Country)

10. NAME OF FATHER

11. BIRTHPLACE OF FATHER

(State or Country)

12. MAIDEN NAME OF MOTHER

13. BIRTHPLACE OF MOTHER

(State or Country)

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

(Address)

15.

Filed

1913

Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

17. I HEREBY CERTIFY, That I attended deceased from

that I last saw him alive on

and that death occurred on the date stated above, at

The CAUSE OF DEATH* was as follows:

(Duration) yrs. mos. ds.

Contributory
(Secondary)

(Duration) yrs. mos. ds.

(Signed) M. D.

(Address)

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death. yrs. mos. days. In the State. yrs. mos. days.

Where was disease contracted if not at place of death?

Former or usual residence.

19. PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

20. UNDERTAKER

ADDRESS

WRITE PLAINLY, WITH UNFADING INK--THIS IS A PERMANENT RECORD.
N. B.--Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact state-ment of OCCUPATION is very important. See instructions on back of certificate.

1. PLACE OF DEATH.		Registration District No. <u>11</u>		BOARD OF HEALTH Bureau of Vital Statistics	
County of <u>Barnstable</u>		Primary Registration District No. <u>2046</u>		File No. <u>4765</u>	
City of <u>Mashpee</u>		(No. _____ St.)		Registered No. <u>41</u>	
If death occurs away from usual residence, give facts called for under special information.		2. FULL NAME <u>Henry Howe</u> If death occurred in a hospital, institution or camp give its NAME instead of street and number.			
PERSONAL AND STATISTICAL PARTICULARS			MEDICAL CERTIFICATE OF DEATH.		
3. SEX <u>M</u>	4. COLOR OR RACE <u>W</u>	5. SINGLE, MARRIED, WIDOWED OR DIVORCED. <u>married</u> (Write the word.)			
6. DATE OF BIRTH <u>June 27 1850</u> (Month) (Day) (Year)					
7. AGE <u>63</u> yrs. — mos. — ds.		IF LESS than 1 day how many _____ hrs. or _____ min?			
8. OCCUPATION (a) Trade, profession or particular kind of work. <u>Farmer</u> (b) General nature of industry business or establishment in which employed (or employer)					
9. BIRTHPLACE (State or Country) <u>Hemel Hempstead Eng.</u>					
10. NAME OF FATHER <u>don't know</u>					
11. BIRTHPLACE OF FATHER (State or Country) <u>"</u>					
12. MAIDEN NAME OF MOTHER <u>Elizabeth Balman</u>					
13. BIRTHPLACE OF MOTHER (State or Country) <u>Hemel Hempstead Eng.</u>					
14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE (Informant) <u>Fred Howe</u> (Address) <u>Mashpee, Mass.</u>					
15. Filed <u>Apr 19 1913</u> <u>O. B. Steeley</u> Local Registrar					
16. DATE OF DEATH <u>April 7 1913</u> (Month) (Day) (Year)					
17. I HEREBY CERTIFY, That I attended deceased from <u>April 7 1913</u> , to <u>1913</u> that I last saw him alive on <u>April 7 1913</u> and that death occurred on the date stated above, at <u>9:30 M.</u> The CAUSE OF DEATH* was as follows: <u>Acute myocarditis</u>					
(Duration) <u>few minutes</u> yrs. mos. ds.					
Contributory (Secondary) _____					
(Duration) <u>10 B. Steeley</u> yrs. mos. ds.					
(Signed) <u>O. B. Steeley</u> M. D. <u>April 8 1913</u> (Address) <u>per George J. Smith, Barnstable</u>					
*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.					
18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.) At place _____ In the _____ of death _____ yrs. mos. ds. State _____ yrs. mos. ds. Where was disease contracted, _____ If not at place of death? _____ Former or _____ usual residence _____					
19. PLACE OF BURIAL OR REMOVAL <u>Ogden St</u> DATE OF BURIAL <u>1913</u>					
20. UNDERTAKER <u>Roy Russell Pocatello</u> ADDRESS _____					

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Form V. S. No. 5 20M.1-16-12

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH

Registration District No. 19

County of Blaine

Primary Registration District No. 1002

City of Pocatello

(No. 345, St. 9 Ave. St.)

File No. 4766

Registered No. 39

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX

4. COLOR OR RACE

5. SINGLE, MARRIED, WIDOWED OR DIVORCED.

6. DATE OF BIRTH

7. AGE

IF LESS than 1 day
how many hrs. or
..... mins.?

8. OCCUPATION

- (a) Trade, profession or particular kind of work
(b) General nature of industry business, or establishment in which employed (or employer)

9. BIRTHPLACE

(State or Country)

10. NAME OF FATHER

11. BIRTHPLACE OF FATHER

(State or Country)

12. MAIDEN NAME OF MOTHER

13. BIRTHPLACE OF MOTHER

(State or Country)

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

(Address)

15.

Filed

1913

Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

17. I HEREBY CERTIFY, That I attended deceased from

that I last saw him alive on

and that death occurred on the date stated above, at

The CAUSE OF DEATH* was as follows

Contributory
(Secondary)

(Signed)

(Address)

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death yrs mos days. In the State yrs mos days.

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

20. UNDERTAKER

ADDRESS

Form V. S. No. 5 20M.1-16-12

CERTIFICATE OF DEATH

 State of Idaho
 BOARD OF HEALTH
 Bureau of Vital Statistics

1. PLACE OF DEATH.

Registration District No. 18County of FranklinPrimary Registration District No. 2119City of Burton

(No. _____)

(St. _____)

File No. 476Registered No. 40

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Geoffrey Barworth

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX Male4. COLOR OR RACE White5. SINGLE, MARRIED, WIDOWED OR DIVORCED. Single

(Write the word.)

6. DATE OF BIRTH Oct 18 1906

(Month)

(Day)

(Year)

7. AGE 7 yrs. 5 mos. 9 ds.
 IF LESS than 1 day
 how many hrs. or
 mins.?

8. OCCUPATION

(a) Trade, profession or particular kind of work

(b) General nature of industry business, or establishment in which employed (or employer)

9. BIRTHPLACE

(State or Country) Burton Ida10. NAME OF FATHER Robert Barworth11. BIRTHPLACE OF FATHER Idaho

(State or Country)

12. MAIDEN NAME OF MOTHER Barstow13. BIRTHPLACE OF MOTHER Burton Ida

(State or Country)

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Robert Barworth(Address) Burton Idaho

15.

Filed Apr 1 19131913D. C. Gray Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH March 27 1913

(Month)

(Day)

(Year)

17. I HEREBY CERTIFY, That I attended deceased from March 25 1913 to March 27 1913that I last saw him alive on March 27 1913and that death occurred on the date stated above, at 8 P. M.

The CAUSE OF DEATH* was as follows:

Measles(Duration) 1 yrs. 10 mos. 10 ds.Contributory Broncho pneumonia (Secondary)(Duration) 1 yrs. 7 mos. 7 ds.(Signed) G. W. States M. D.March 1913 (Address) Burton Ida

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death yrs. mos. days. In the State yrs. mos. days.

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL Burton IdaDATE OF BURIAL Mar 30 191320. UNDERTAKER J. J. HansenADDRESS Burton Ida

Form V. S. No. 5 20M.1-16-12

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH.

Registration District No. 18County of FranklinPrimary Registration District No. 2119City of Bozeman

(No. _____)

(St. _____)

File No. 4768Registered No. 37

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

Joseph Victor Beck

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX

Male

4. COLOR OR RACE

White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED.

(Write the word.)

6. DATE OF BIRTH

Dec191912

(Month)

(Day)

(Year)

7. AGE

2 yrs.28 mos.28 ds.IF LESS than 1 day
how many hrs. or
..... mins.?

8. OCCUPATION

(a) Trade, profession or

particular kind of work

(b) General nature of industry

business, or establishment in

which employed (or employer)

9. BIRTHPLACE

(State or Country)

Bozeman

10. NAME OF FATHER

Eugene Beck

11. BIRTHPLACE OF FATHER

(State or Country)

Idaho

12. MAIDEN NAME OF MOTHER

Hali

13. BIRTHPLACE OF MOTHER

(State or Country)

Fairview Ida

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

Eugene Beck

(Address)

Bozeman Idaho

15.

Filed

Mar 151913G. E. Ray

Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH

March 10

(Month)

(Day)

1913

(Year)

17. I HEREBY CERTIFY, That I attended deceased from

Feb 25 1913, to Feb 26 1913,that I last saw him alive on Feb 26 1913,and that death occurred on the date stated above, at 7 A. M.

The CAUSE OF DEATH* was as follows:

Whooping Cough -(Duration) ✓ yrs. ✓ mos. 30 ds.

Contributory (Secondary)

Branch pneumonia(Duration) ✓ yrs. ✓ mos. 36 hrs ds.

(Signed)

E. W. Stiles M. D.Mar 15 1913 (Address) Bozeman Ida

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death yrs. mos. days. In the State yrs. mos. days.

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL DATE OF BURIAL

Fairview Ida 3/17 1913

20. UNDERTAKER

ADDRESS

A. J. Hansen BozemanIda

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Form V. S. No. 5 20M.1-16-12

CERTIFICATE OF DEATH

State of Idaho
BUREAU OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH.

Registration District No. 18

County of Franklin

Primary Registration District No. 2119

City of Preston

(No. _____)

(St. _____)

File No. 4769

Registered No. 39

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME James L. Luther

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX Male

4. COLOR OR RACE White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED. Single
(Write the word.)

6. DATE OF BIRTH Mar 27 1913
(Month) (Day) (Year)

7. AGE 27
yrs. mos. ds.

IF LESS than 1 day
how many hrs. or
mins.?

8. OCCUPATION

(a) Trade, profession or particular kind of work
(b) General business, profession, business, or establishment in which employed (or employee)

9. BIRTHPLACE

(State or Country) Preston, Ida

10. NAME OF FATHER James L. Luther

11. BIRTHPLACE OF FATHER

(State or Country) Idaho

12. MAIDEN NAME OF MOTHER McEugene

13. BIRTHPLACE OF MOTHER

(State or Country) Idaho

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) James L. Luther

(Address) Preston

15.

Filed Apr 1 1913

G. B. Emery
Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH Mar 27 1913
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from 8/27 1913, to 8/27 1913,

that I last saw him alive on Mar 27 1913, and that death occurred on the date stated above, at 6 A.M.

The CAUSE OF DEATH* was as follows:

Babe was born through difficult labor. I breathing established - artificially and in 2 hours heart respiration stopped.
(Duration) yrs. mos. ds. 2 hours

Contributory (Secondary)

(Duration) yrs. mos. ds.

(Signed) Allen R. Gatto M. D.
27 1913 (Address) Physician, Preston, Idaho

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death. yrs. mos. days. In the State. yrs. mos. days.

Where was disease contracted if not at place of death?

Former or usual residence.

19. PLACE OF BURIAL OR REMOVAL Preston, Ida

DATE OF BURIAL Mar 28 1913

20. UNDERTAKER Dr. Hansen

ADDRESS Preston, Ida

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Form V. S. No. 5 20M.1-16-12

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH.

Registration District No. 18

County of Oneida

Primary Registration District No. 7060

City of Malad

(No. _____, St.)

If death occurs after from usual residence, give facts called for under special information.

2. FULL NAME Amos Jones Sr.File No. 4770Registered No. 46

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX

Male

4. COLOR OR RACE

White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED.

Married

6. DATE OF BIRTH

Dec191887

(Month)

(Day)

(Year)

7. AGE

75

yrs.

3

mos.

4

ds.

IF LESS than 1 day
how many hrs. or
..... mins.?

8. OCCUPATION

(a) Trade, profession or particular kind of work

Mason

(b) General nature of industry business, or establishment in which employed (or employer)

Brick Mason

9. BIRTHPLACE

(State or Country)

Wales

10. NAME OF FATHER

Richard P. Jones

11. BIRTHPLACE OF FATHER

(State or Country)

Wales

12. MAIDEN NAME OF MOTHER

Louise Edwards

13. BIRTHPLACE OF MOTHER

(State or Country)

Wales

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

A. W. Jones

(Address)

Malad, Idaho

15.

Filed

3-25

191

3J. C. Roy

Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH

March

(Month)

23

(Day)

1913

(Year)

17. I HEREBY CERTIFY, That I attended deceased from

March 20

191

3

to

March 20

191

3

that I last saw him alive on

March 20

191

3and that death occurred on the date stated above, at 2:45 PM.

The CAUSE OF DEATH* was as follows:

General debility

(Duration)

yrs.

mos.

ds.

Contributory
(Secondary)Chronic lead poisoning

(Duration)

yrs.

mos.

ds.

(Signed)

O. C. Roy

M. D.

March 20 1913 (Address) Malad, Idaho

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place

of death.....yrs.....mos.....days.

In the

State.....yrs.....mos.....days.

Where was disease contracted
if not at place of death?Former or
usual residence.....

19. PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

Malad, IdaMar. 26 1913

20. UNDERTAKER

ADDRESS

H. E. JohnsonMalad, Ida

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. PHYSICIANS SHOULD STATE CAUSE OF DEATH IN PLAIN TERMS, SO THAT IT MAY BE PROPERLY CLASSIFIED. EXACT STATEMENT OF OCCUPATION IS VERY IMPORTANT. SEE INSTRUCTIONS ON BACK OF CERTIFICATE.

Form V. S. No. 5 20M.1-16-12

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH.

County of Oneida
City of Samaroa

Registration District No. 18

Primary Registration District No. 7069

(No. _____ St.)

File No. 47715

Registered No. 45

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME William B Morse

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX Male 4. COLOR OR RACE White 5. SINGLE, MARRIED, WIDOWED OR DIVORCED. Married (Write the word.)

6. DATE OF BIRTH

March 4 1848
(Month) (Day) (Year)

7. AGE

65 yrs. 16 mos. 16 ds.

IF LESS than 1 day
how many hrs. or
..... mins.?

8. OCCUPATION

(a) Trade, profession or particular kind of work Farmer
(b) General nature of industry, business, or establishment in which employed (or employer)

9. BIRTHPLACE

(State or Country) Wales

10. NAME OF FATHER

John Morse

11. BIRTHPLACE OF FATHER

(State or Country) Wales

12. MAIDEN NAME OF MOTHER

Bennett

13. BIRTHPLACE OF MOTHER

(State or Country) Wales

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Arthur Marshall

(Address) Samaroa, Ida

15.

Filed 3-22 1913 W.C. Ray
Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH

March 20 1913
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from

Feb 27 1913 to March 20 1913

that I last saw him alive on March 20 1913

and that death occurred on the date stated above, at 741 A.M.

The CAUSE OF DEATH* was as follows:

Auto intubation
abscess of liver.

(Duration) yrs. mos. ds.

Contributory

(Secondary)

(Duration) yrs. mos. ds.

(Signed) W.C. Ray M.D.

3-22-1913 (Address) Malad City, Ida

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death yrs. mos. days. In the State yrs. mos. days.

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL

Samaroa, Ida March 24 1913

20. UNDERTAKER

W.S. Johnson Malad, Ida

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSI-
CIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact state-
ment of OCCUPATION is very important. See instructions on back of certificate.

Form V. S. No. 5 20M.1-16-12

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics
File No. 4773

1. PLACE OF DEATH.

Registration District No. 18

County of Orinda

Primary Registration District No. 2069

City of Malad

(No. St.)

Registered No. 14

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

Rose Johana Palmer

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX

4. COLOR OR RACE

5. SINGLE, MARRIED, WID-
OWED OR DIVORCED.

Female White

Single (Write the word.)

6. DATE OF BIRTH

Nov (Month)

5 (Day)

1913 (Year)

7. AGE

4 yrs. 10 mos. 10 ds.

IF LESS than 1 day
how many hrs. or
..... mins.?

8. OCCUPATION

(a) Trade, profession or
particular kind of work
(b) General nature of industry
business, or establishment in
which employed (or employer)

None

9. BIRTHPLACE

(State or Country)

Malad Idaho

10. NAME OF
FATHER

James H. Palmer

11. BIRTHPLACE
OF FATHER

(State or Country)

Brigham City, Utah

12. MAIDEN NAME
OF MOTHER

Elizabeth Anderson

13. BIRTHPLACE
OF MOTHER

(State or Country)

Brigham, Utah

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

J. H. Palmer

(Address)

Malad Idaho

15.

Filed

3-15 1913

3 W. C. Ray

Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

Mar (Month)

14 (Day)

1913 (Year)

17. I HEREBY CERTIFY, That I attended deceased from

March 13 1913 to March 14 1913,

that I last saw her alive on March 14 1913

and that death occurred on the date stated above, at.....M.

The CAUSE OF DEATH* was as follows:

La Grippe

(Duration) yrs. mos. ds.

Contributory

(Secondary)

(Duration) yrs. mos. ds.

(Signed)

W. C. Ray

M. D.

3-15 1913 (Address) Malad Idaho

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL OR HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death yrs. mos. days. In the State yrs. mos. days.

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

Malad Idaho

Mar. 17 1913

20. UNDERTAKER

ADDRESS

W. S. Johnson

Malad Idaho

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Form V. S. No. 5 20M.1-16-12

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH.

Registration District No. 18

County of Conida

Primary Registration District No. 2069

City of St. John

(No. _____ St.)

File No. 4773

Registered No. 43

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Barclay James

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX

4. COLOR OR RACE

5. SINGLE, MARRIED, WIDOWED OR DIVORCED.

Male

White

Single (Write the word.)

6. DATE OF BIRTH

Sept.
(Month)

7
(Day)

1911
(Year)

7. AGE

1 yrs. 7 mos. 7 ds.

IF LESS than 1 day
how many hrs. or
..... mins.?

8. OCCUPATION

(a) Trade, profession or particular kind of work
(b) General nature of industry, business, or establishment in which employed (or employer)

None

9. BIRTHPLACE

(State or Country)

St. John, Idaho

10. NAME OF FATHER

Wainal James

11. BIRTHPLACE OF FATHER

(State or Country)

St. John, Ida

12. MAIDEN NAME OF MOTHER

Laura Hansen

13. BIRTHPLACE OF MOTHER

(State or Country)

Gentil Valley, Ida

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

(Address)

James
St. John, Idaho

15.

Filed

3-12

1913

D. C. Ray

Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH

Mar.
(Month)

14
(Day)

1913
(Year)

17. I HEREBY CERTIFY, That I attended deceased from

March 9 1913 to March 14 1913,

that I last saw him alive on March 14 1913,

and that death occurred on the date stated above, at 3 P.M.

The CAUSE OF DEATH* was as follows:

La Grippe - Measles
Broncho pneumonia

(Duration) yrs. mos. ds.

Contributory

(Secondary)

(Duration) yrs. mos. ds.

(Signed)

D. C. Ray M. D.

3-15-1913 (Address) Malad Ida

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place

of death yrs. mos. days.

In the

State yrs. mos. days.

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

St. John, Ida.

Mar. 16 1913

20. UNDERTAKER

ADDRESS

W. S. Johnson

Malad Ida

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Form V. S. No. 5 20M.1-16-12

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH

Registration District No. 18

County of Oneida

Primary Registration District No. 2069

City of Malad

(No.)

(St.)

Registered No. 4774

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

Samuel Hill

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX

4. COLOR OR RACE

5. SINGLE, MARRIED, WIDOWED OR DIVORCED.

Male

White

Single (Write the word.)

6. DATE OF BIRTH

Feb (Month)

19 (Day)

1913 (Year)

7. AGE

18 yrs. mos. ds.

IF LESS than 1 day
how many hrs. or
 mins.?

8. OCCUPATION

(a) Trade, profession or particular kind of work

None

(b) General nature of industry, business, or establishment in which employed (or employer)

9. BIRTHPLACE

(State or Country)

Saint John Ida

10. NAME OF FATHER

William Hill

11. BIRTHPLACE OF FATHER

(State or Country)

Saint John Ida

12. MAIDEN NAME OF MOTHER

Phoebe Jones

13. BIRTHPLACE OF MOTHER

(State or Country)

Saint John Ida

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) William Hill

(Address) St John R F Dr Ida

15.

Filed 3-10

191 3

D C Ray

Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

March (Month)

9 (Day)

1913 (Year)

17. I HEREBY CERTIFY, That I attended deceased from

March 8 1913, to March 9 1913

that I last saw him alive on March 8 1913

and that death occurred on the date stated above, at 7 A.M.

The CAUSE OF DEATH* was as follows:

Pneumonia

(Duration) yrs. mos. ds.

Contributory

(Secondary)

(Duration) yrs. mos. ds.

(Signed)

J F Alton M. D. 3-10 1913 (Address) Malad Ida

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death

 yrs. mos. days.

In the State

 yrs. mos. days.

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

Saint John Ida

Mar 11 1913

20. UNDERTAKER

ADDRESS

W S Johnson

Malad Ida

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Form V. S. No. 5 20M.1-16-12

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH.

Registration District No. 18

County of Oneida

Primary Registration District No. 2069

City of Malad

(No. _____ St.)

File No. 4775

Registered No. 17

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

Jessie Richard Wredge

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX

4. COLOR OR RACE

5. SINGLE, MARRIED, WIDOWED OR DIVORCED.

Male White

Married (the word.)

6. DATE OF BIRTH

Jan

14

1898

(Month)

(Day)

(Year)

7. AGE

85 yrs. 1 mos. 28 ds.

IF LESS than 1 day
how many _____ hrs. or
_____ mins.?

8. OCCUPATION

(a) Trade, profession or particular kind of work
(b) General nature of industry business, or establishment in which employed (or employer)

Farmer

9. BIRTHPLACE

(State or Country) England

10. NAME OF FATHER

Richard Dredge

11. BIRTHPLACE OF FATHER

(State or Country) England

12. MAIDEN NAME OF MOTHER

Sarah Sharp

13. BIRTHPLACE OF MOTHER

(State or Country) England

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

J. H. Dredge
Malad, Ida

(Address)

15.

Filed

3-14

1913

J. H. Dredge

Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH

March

11

1913

(Month)

(Day)

(Year)

17. I HEREBY CERTIFY, That I attended deceased from

Dec 21 1912, to March 7 1913

that I last saw him alive on March 7 1913

and that death occurred on the date stated above, at 12 M.

The CAUSE OF DEATH* was as follows:

La Grippe

(Duration) _____ yrs. _____ mos. _____ ds.

Contributory (Secondary)

Great Debility

(Duration) _____ yrs. _____ mos. _____ ds.

(Signed)

D. C. Ray

M. D.

3-15-1913 (Address) Malad City, Ida

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death _____ yrs. _____ mos. _____ days. In the State _____ yrs. _____ mos. _____ days.

Where was disease contracted if not at place of death?

Former or usual residence.

19. PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

Malad Ida

Mar. 14 1913

20. UNDERTAKER

ADDRESS

W. S. Johnson

Malad Ida

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Form V. S. No. 5 20M.1-16-12

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics
File No. 4776
Registered No. 38

PLACE OF DEATH
County of Franklin
City of Glendale

Registration District No. 18
Primary Registration District No. 2119
(No. , St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

James Addison Wagstaff

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX male 4. COLOR OR RACE White 5. SINGLE, MARRIED, WIDOWED OR DIVORCED. Single (Write the word.)

6. DATE OF BIRTH

June 24 1898
(Month) (Day) (Year)

7. AGE

14 yrs. 8 mos. 19 ds.

IF LESS than 1 day
how many hrs. or mins.?

8. OCCUPATION

(a) Trade, profession or particular kind of work Farmer
(b) General nature of industry business, or establishment in which employed (or employer)

9. BIRTHPLACE

(State or Country) Glendale Ida

10. NAME OF FATHER

Wm A Wagstaff

11. BIRTHPLACE OF FATHER

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

1. PLACE OF DEATH.		Registration District No. <u>9</u>		BOARD OF HEALTH Bureau of Vital Statistics	
County of <u>Tremont</u>		Primary Registration District No. <u>2037</u>		File No. <u>4777</u>	
City of <u>Clawson</u>		(No. <u> </u> , St.)		Registered No. <u>43</u>	
If death occurs away from usual residence, give facts called for under special information.					
2. FULL NAME <u>Sarah E. Heunie</u>					
PERSONAL AND STATISTICAL PARTICULARS					
3. SEX <u>Female</u>	4. COLOR OR RACE <u>W</u>	5. SINGLE, MARRIED, WIDOWED OR DIVORCED. <u>married</u> (Write the word.)			
6. DATE OF BIRTH <u>Apr 9 1895</u> (Month) (Day) (Year)					
7. AGE <u>37</u> yrs. <u>9</u> mos. <u>18</u> ds. IF LESS than 1 day how many <u> </u> hrs. or <u> </u> min?					
8. OCCUPATION (a) Trade, profession or particular kind of work. <u>Housewife</u> (b) General nature of industry business or establishment in which employed (or employer)					
9. BIRTHPLACE <u>Utah</u> (State or Country)					
10. NAME OF FATHER <u>Joseph Hovey</u>					
11. BIRTHPLACE OF FATHER <u>Not known</u> (State or Country)					
12. MAIDEN NAME OF MOTHER <u>Mary Huke</u>					
13. BIRTHPLACE OF MOTHER <u>England</u> (State or Country)					
14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE (Informant) <u>John A. Heunie</u> (Address) <u>Clawson</u>					
15. <u>Apr 10 1913</u> <u>Ray H. Foster</u> Filed Local Registrar					
MEDICAL CERTIFICATE OF DEATH.					
16. DATE OF DEATH <u>Jan 27 1913</u> (Month) (Day) (Year)					
17. I HEREBY CERTIFY, That I attended deceased from <u>Jan 25 1913</u> to <u>Jan 27 1913</u> that I last saw him alive on <u>Jan 27 1913</u> and that death occurred on the date stated above, at <u>3 A. M.</u> The CAUSE OF DEATH* was as follows: <u>Shock from difficult labor during confinement</u> (Duration) <u> </u> yrs. <u> </u> mos. <u>3</u> ds.					
Contributory (Secondary) <u> </u> (Duration) <u> </u> yrs. <u> </u> mos. <u> </u> ds. (Signed) <u>Ora D. Keith</u> M. D. <u>Jan 29 1913</u> (Address) <u>Driggs, Ida.</u>					
*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.					
18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.) At place of death <u> </u> yrs. <u> </u> mos. <u> </u> ds. State <u> </u> yrs. <u> </u> mos. <u> </u> ds. Where was disease contracted, If not at place of death? <u> </u> Former or usual residence <u> </u>					
19. PLACE OF BURIAL OR REMOVAL <u>Clawson</u> DATE OF BURIAL <u>Jan 29 1913</u>					
20. UNDERTAKER <u>C. Cherrington Driggs</u> ADDRESS <u> </u>					

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Form V. S. No. 5 20M.1-16-12

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics
File No. 4718
Registered No. 141

1. PLACE OF DEATH

Registration District No. 2

County of Ada

Primary Registration District No. 1004

City of Boise

(No. 1715 No. 16th St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

Joel Jesse Doolittle

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX

4. COLOR OR RACE

5. SINGLE, MARRIED, WIDOWED OR DIVORCED
(Write the word.)

Male

White American

married

6. DATE OF BIRTH

Dec

1

1826

(Month)

(Day)

(Year)

7. AGE

86 yrs. 4 mos. 14 ds.

IF LESS than 1 day
how many hrs. or
..... mins.?

8. OCCUPATION

(a) Trade, profession or particular kind of work

Musician

(b) General nature of industry business, or establishment in which employed (or employer)

9. BIRTHPLACE

(State or Country)

Rochester N.Y.

10. NAME OF FATHER

Joel D. Doolittle

11. BIRTHPLACE OF FATHER

(State or Country)

Hartford Conn.

12. MAIDEN NAME OF MOTHER

Debra Hilcox

13. BIRTHPLACE OF MOTHER

(State or Country)

N.Y.

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

S. J. Doolittle

(Address)

91309 1415 St

15.

Filed

4 - 16 1913

G. S. M. Council

Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

April

15

1913

(Month)

(Day)

(Year)

17. I HEREBY CERTIFY, That I attended deceased from

April 10th 1913, to April 15th 1913

that I last saw him alive on April 10th 1913

and that death occurred on the date stated above, at 10 P.M.

The CAUSE OF DEATH* was as follows:

Senility with Senile Dementia - death softening of brain

(Duration) yrs. 9 mos. ds.

Contributory (Secondary)

(Duration) yrs. mos. ds.

(Signed)

John B. O'Connell D. April 16 1913 (Address) Boise Idaho

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death yrs. mos. days. In the State yrs. mos. days.

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

Morris Hill Cemetery

Apr. 17 1913

20. UNDERTAKER

ADDRESS

Fry Summers &

Boise Ida.

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Form V. S. No. 5 20M.1-16-12

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH.

Registration District No. 2

County of Ada

Primary Registration District No. 1004

City of Boise

(No. 526, So. 13 St.)

File No. 4779

Registered No. 89

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Anna Milove

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX F

4. COLOR OR RACE W

5. SINGLE, MARRIED, WIDOWED OR DIVORCED. Single
(Write the word.)

6. DATE OF BIRTH

March 24 1913
(Month) (Day) (Year)

7. AGE

5 yrs. 5 mos. 5 ds.

IF LESS than 1 day
how many ... hrs. or
... mins.?

8. OCCUPATION

- (a) Trade, profession or particular kind of work ✓
(b) General nature of industry business, or establishment in which employed (or employer)

9. BIRTHPLACE

(State or Country) Idaho

10. NAME OF FATHER

Morris Milove

11. BIRTHPLACE OF FATHER

(State or Country) Russia

12. MAIDEN NAME OF MOTHER

Bertha Sergo

13. BIRTHPLACE OF MOTHER

(State or Country) Russia

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOW

(Informant) Mrs. Morris Milove

(Address) 526 So 13 St. Boise

15.

Filed 3-29 1913 6:57 PM

Local

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH

March 29 1913
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from March 24 1913, to March 29 1913, that I last saw her alive on March 28 1913, and that death occurred on the date stated above, at 49 M.

The CAUSE OF DEATH* was as follows:

Pneumonia (7 months)

(Duration) 5 yrs. 5 mos. 5 ds.

Contributory (Secondary)

(Duration) 5 yrs. 5 mos. 5 ds.

(Signed)

W. J. T. M. D.

March 29, 1913 (Address) Boise, Ida

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death ... yrs. ... mos. ... days. In the State ... yrs. ... mos. ... days.

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL

Beth Israel Cem

DATE OF BURIAL

3-30 1913

20. ~~CORRECTOR~~

ADDRESS

Morris Milove

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Form V. S. No. 5 20M.1-16-12

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH.

Registration District No. 2

County of Ada

Primary Registration District No. 1004

File No. 4780

City of Boise

(No. 1317 State Idaho St.)

Registered No. 93

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Charles W. King

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX

4. COLOR OR RACE

5. SINGLE, MARRIED, WIDOWED OR DIVORCED.

Male White American

Married
(Write the word.)

6. DATE OF BIRTH

Sept. 3 1850
(Month) (Day) (Year)

7. AGE

62 yrs. 6 mos. 2 ds.

IF LESS than 1 day
how many hrs. or
..... mins.?

8. OCCUPATION

(a) Trade, profession or particular kind of work

(b) General nature of industry business, or establishment in which employed (or employer)

Civil Engineer

9. BIRTHPLACE

(State or Country)

Pennsylvania

10. NAME OF FATHER

Joseph B. King

11. BIRTHPLACE OF FATHER

(State or Country)

Penn

12. MAIDEN NAME OF MOTHER

Mary B. King

13. BIRTHPLACE OF MOTHER

(State or Country)

Penn

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

Mrs. F. P. King

(Address)

1317 State

15.

Filed 4 - 1 1913

68 mcmuel

Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

April 1 1913
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from

1913, to 1913,

that I last saw h..... alive on 1913,

and that death occurred on the date stated above, at..... M.

The CAUSE OF DEATH* was as follows:

Cerebral Hemorrhage

(Duration) yrs. mos. ds.

Contributory (Secondary)

Arterio Sclerosis

(Duration) yrs. mos. ds.

(Signed)

J. B. Springer M. D.

19 (Address)

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death.....yrs.....mos.....days. In the State.....yrs.....mos.....days.

Where was disease contracted if not at place of death?.....

Former or usual residence.....

19. PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

Morris Hill Court

Apr 2 1913

20. UNDERTAKER

ADDRESS

Try & Summer House

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Form V. S. No. 5 20M.1-16-12

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH

Registration District No. 2

County of Ada

Primary Registration District No. 1004

City of Boise

(No. 1119, Jefferson St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

Gayle Genevieve Stevenson

File No. 4781

Registered No. 90

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX

Female

4. COLOR OR RACE

White
American

5. SINGLE, MARRIED, WIDOWED OR DIVORCED.

Single
(Write the word.)

6. DATE OF BIRTH

Mar 18 1895
(Month) (Day) (Year)

7. AGE

18 yrs. 1 mos. 3 ds.

IF LESS than 1 day
how many hrs. or mins.?

8. OCCUPATION

(a) Trade, profession or particular kind of work
(b) General nature of industry, business, or establishment in which employed (or employer)

Student of High School

9. BIRTHPLACE

(State or Country)

Kansas

10. NAME OF FATHER

Joseph R. Stevenson

11. BIRTHPLACE OF FATHER

(State or Country)

Iowa

12. MAIDEN NAME OF MOTHER

Ruth M Broughs

13. BIRTHPLACE OF MOTHER

(State or Country)

Iowa

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Mrs R. M. Stevenson

(Address) 1119 Jefferson St

15.

Filed 7 - 14 1913

W. S. M. Corneil
Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH

April 13 1913
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from

April 1 1913 to April 13 1913

that I last saw h.s. alive on April 13 1913

and that death occurred on the date stated above, at 7 a.m.

The CAUSE OF DEATH* was as follows:

Peritonitis

(Duration) yrs. mos. ds.

Contributory appendicitis
(Secondary)

(Duration) yrs. mos. ds.

(Signed) J. Springer M. D.

April 13 1913 (Address) Boise, Ida.

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death yrs. mos. days. In the State yrs. mos. days.

Where was disease contracted if not at place of death?

Former or usual residence.

19. PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

Morris Hill Cemetery Apr 14 1913

20. UNDERTAKER

ADDRESS

J. Springer Boise

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Form V. S. No. 5 20M.1-1-52

DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH

Registration District No.

County of

Primary Registration District No.

City of

(No. 1202 N. 13th St.) St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

File No.

Registered No.

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX

4. COLOR OR RACE

5. SINGLE, MARRIED, WIDOWED OR DIVORCED.

6. DATE OF BIRTH

7. AGE

IF LESS than 1 day
how many hrs. or
mins.?

8. OCCUPATION

(a) Trade, profession or particular kind of work

(b) General nature of industry business, or establishment in which employed (or employer)

9. BIRTHPLACE

(State or Country)

10. NAME OF FATHER

11. BIRTHPLACE OF FATHER

(State or Country)

12. MAIDEN NAME OF MOTHER

13. BIRTHPLACE OF MOTHER

(State or Country)

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

(Address)

15.

Filed

1913

Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH

17. I HEREBY CERTIFY, That I attended deceased from

that I last saw him alive on

and that death occurred on the date stated above, at M.

The CAUSE OF DEATH* was as follows:

Contributory
(Second)

(Duration) yrs. mos. ds.

(Signed) M. D.

(Address)

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death yrs. mos. days. In the State yrs. mos. days.

Where was disease contracted if not at place of death?

Former or usual residence.

19. PLACE OF BURIAL OR REMOVAL DATE OF BURIAL

20. UNDERTAKER ADDRESS

Form V. S. No. 5 20M.1-16-12

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics
4783

1. PLACE OF DEATH.

Registration District No. 2
County of Ada
Primary Registration District No. 1004
City of Basis
(No. 410, St.)

File No. 4783
Registered No. 98

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

Mary Emaline Paul

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX female 4. COLOR OR RACE White 5. SINGLE, MARRIED, WIDOWED OR DIVORCED. single
(Write the word.)

6. DATE OF BIRTH

March 18 1893
(Month) (Day) (Year)

7. AGE

23 yrs. 1 mo. 5 ds.

IF LESS than 1 day
how many hrs.
.....mins.

8. OCCUPATION

(a) Trade, profession or particular kind of work House keeping
(b) General nature of industry business, or establishment in which employed (or employer)

9. BIRTHPLACE

(State or Country) Linker Creek Ida.

10. NAME OF FATHER

Joseph Paul

11. BIRTHPLACE OF FATHER

(State or Country) Cornwall Eng.

12. MAIDEN NAME OF MOTHER

Mary Emaline Paater

13. BIRTHPLACE OF MOTHER

(State or Country) Morgan County W. Va.

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Missie Paul
(Address) Murphy, Ida.

15.

Filed 4-16 1913

L. S. McCune
Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH

April 14 1913
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from April 13 1913, to April 14 1913, that I last saw her alive on April 13 1913, and that death occurred on the date stated above, at 9 A.M.

The CAUSE OF DEATH* was as follows:

Urbane Poisoning

(Duration) yrs. mos. 2 ds.

Contributory (Secondary)

(Duration) yrs. mos. ds.

(Signed) Chas. B. Ballard M. D.

4/16 1913 (Address) 201-4 McCarty Bldg.

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death. yrs. mos. 2 days. In the State. yrs. mos. days.

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL DATE OF BURIAL

Morris Hill Cemetery 4/16 1913

20. UNDERTAKER

ADDRESS

Schreiber & Widener Boise

Form V. S. No. 5 20M.1-16-12

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH.

Registration District No. 2

County of Ada

Primary Registration District No. 1004

City of Boise(No. 1201, 71 16 St.)File No. 4781Registered No. 113

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

Lelia Olive Chesney

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX

Female

4. COLOR OR RACE

White American

5. SINGLE, MARRIED, WIDOWED OR DIVORCED.

Single
(Write the word.)

6. DATE OF BIRTH

January 6 1883
(Month) (Day) (Year)

7. AGE

30 yrs. 3 mos. 20 ds.IF LESS than 1 day
how many hrs. or
..... mins.?

8. OCCUPATION

(a) Trade, profession or particular kind of work

Sales Lady in

(b) General nature of industry business, or establishment in which employed (or employer)

Department Stores

9. BIRTHPLACE

(State or Country)

Maryland

10. NAME OF FATHER

Irrel Chesney

11. BIRTHPLACE OF FATHER

(State or Country)

Maryland

12. MAIDEN NAME OF MOTHER

Lelia Marshall

13. BIRTHPLACE OF MOTHER

(State or Country)

Maryland

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

(Address)

Mrs. Geo. W. Scharf

15.

Filed

1201 16 St
4-27 1913C. M. McGee Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

April 26 1913
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from

April 1 1913, to April 26 1913that I last saw her alive on April 26 1913and that death occurred on the date stated above, at 5 P.M.

The CAUSE OF DEATH* was as follows:

Pulmonary tuberculosis

(Duration) yrs. mos. ds.

Contributory
(Secondary)

(Duration) yrs. mos. ds.

(Signed)

Ralph Sals M. D.

4/27/13

(Address)

Boise

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place

of death yrs. mos. days.

In the

State yrs. mos. days.

Where was disease contracted
if not at place of death?

Former or

usual residence

19. PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

Masonic CemeteryApr. 27 1913

20. UNDERTAKER

ADDRESS

Joy & SummersBoise Id

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Form V. S. No. 5 20M.1-16-12

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH.

Registration District No. 2County of AdaPrimary Registration District No. 1004City of Boise(No. 147, South 7th St.)File No. 4785Registered No. 99

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME James Carey

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX

Male

4. COLOR OR RACE

White5. SINGLE, MARRIED, WIDOWED OR DIVORCED.
not obtainable
(Write the word.)

6. DATE OF BIRTH

Not obtainable

(Month)

(Day)

(Year)

7. AGE

About 27 Years

.....yrs.mos.ds.

IF LESS than 1 day
how manyhrs. or
.....mins.?

8. OCCUPATION

(a) Trade, profession or particular kind of work

Not obtainable

(b) General nature of industry business, or establishment in which employed (or employer)

9. BIRTHPLACE

(State or Country)

Not obtainable

10. NAME OF FATHER

"

"

11. BIRTHPLACE OF FATHER

(State or Country)

"

"

12. MAIDEN NAME OF MOTHER

"

"

13. BIRTHPLACE OF MOTHER

(State or Country)

"

"

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Adolph Schreiber(Address) Boise

15.

Filed 4/161913C. S. McCune
Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

April 9th1913

(Month)

(Day)

(Year)

17. I HEREBY CERTIFY, That I ~~attended~~ deceased ~~from~~
dead April 9th 1913
that I last saw him alive on 1913and that death occurred on the date stated above, at 10 A.M.

The CAUSE OF DEATH* was as follows:

about
gun shot wound inflicted by himself suicidal intent

(Duration)yrs.mos.ds.

Contributory

(Secondary)

(Duration)yrs.mos.ds.

(Signed) Adolph Schreiber19..... (Address) Boise Ada County

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of deathyrs.mos.days. In the Stateyrs.mos.days.

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

Monroe Hill Cemetery April 16 1913

20. UNDERTAKER

ADDRESS

Schreiber & Widenfaden Boise

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Form V. S. No. 5 20M.1-16-12

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH.

Registration District No. 2County of AdaPrimary Registration District No. 1004City of Boise(No. 18x Hill Rd. Davidson St.)File No. 4788Registered No. 150

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Mary Jane Davidson

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX

F

4. COLOR OR RACE

W.

5. SINGLE, MARRIED, WIDOWED OR DIVORCED.

Widow
(Write the word.)

6. DATE OF BIRTH

July 13th 1842
(Month) (Day) (Year)

7. AGE

70 yrs. 9 mos. 2 ds.IF LESS than 1 day
how many hrs. or
..... mins.?

8. OCCUPATION

(a) Trade, profession or particular kind of work

retired Housekeeper

(b) General nature of industry, business, or establishment in which employed (or employer)

9. BIRTHPLACE

(State or Country)

Idaho

10. NAME OF FATHER

not obtainable

11. BIRTHPLACE OF FATHER

(State or Country)

not obtainable

12. MAIDEN NAME OF MOTHER

not obtainable

13. BIRTHPLACE OF MOTHER

(State or Country)

not obtainable

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

Floyd White

(Address)

Collister St

15.

Filed

5/161913C. S. McConnell

Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH

April 15th 1913
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from

Dec 4 1913 to April 15 1913
that I last saw her alive on April 15 1913and that death occurred on the date stated above, at 9 P.M.

The CAUSE OF DEATH* was as follows:

Carcinoma of stomach(Duration) 4 yrs. 0 mos. 0 ds.Contributory Exophthalmic Goiter
(Secondary)(Duration) 2 yrs. 0 mos. 0 ds.(Signed) W. H. Hallman M. D.19. (Address) Boise, Idaho

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death yrs. mos. days. In the State yrs. mos. days.

Where was disease contracted if not at place of death?

Former or usual residence Boise, Idaho

19. PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

Harris Hill Cemetery4/17 1913

20. UNDERTAKER

ADDRESS

Schreiber & SidenfadenBoise, Idaho

Form V. S. No. 5 20M.1-16-12

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH.

Registration District No. 2County of AdaPrimary Registration District No. 1004City of Boise(No. 1106, North 22 St.)File No. 4787Registered No. 103

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Mary A. Van Slyke

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX Female4. COLOR OR RACE White5. SINGLE, MARRIED, WIDOWED OR DIVORCED.
Widowed
(Write the word.)6. DATE OF BIRTH Jan 10 1894

(Month)

(Day)

(Year)

7. AGE 89 yrs. 3 mos. 7 ds.IF LESS than 1 day
how many hrs. or
..... mins.?

8. OCCUPATION

(a) Trade, profession or particular kind of work
(b) General nature of industry, business, or establishment in which employed (or employer)Retired

9. BIRTHPLACE

(State or Country)

Conn.10. NAME OF FATHER Jacob Wincker11. BIRTHPLACE OF FATHER American

(State or Country)

12. MAIDEN NAME OF MOTHER Not obtainable13. BIRTHPLACE OF MOTHER Conn.

(State or Country)

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) C. E. Van Slyke(Address) Boise

15.

Filed 4 - 18 1913C. S. McCune
Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH April 17 1913

(Month)

(Day)

(Year)

17. I HEREBY CERTIFY, That I attended deceased from dead 101 to now 1913that I last saw him alive on April 17 1913
and that death occurred on the date stated above, at 10 M.

The CAUSE OF DEATH* was as follows:

Appoplexy no doctor
like attendance

(Duration) yrs. mos. ds.

Contributory
(Secondary)

(Duration) yrs. mos. ds.

(Signed) Adolph Schreiber19. (Address) Boise, Conn.

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death yrs. mos. days. In the State yrs. mos. days.

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL DATE OF BURIAL

Morris Hill Cemetery 4/19 1913

20. UNDERTAKER

ADDRESS

Schreiber & Schindler Boise

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Form V. S. No. 5 20M.1-16-12

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH.

Registration District No. 2County of AdaPrimary Registration District No. 1004City of Boise(No. 625 1/2 Main St.)File No. 4789Registered No. 105

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

Frank Calahan

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX

Male

4. COLOR OR RACE

White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED.

(Write the word.)

6. DATE OF BIRTH

Not obtainable

(Month)

(Day)

(Year)

7. AGE

About 48 Years

yrs. mos. ds.

IF LESS than 1 day
how many hrs. or
mins.?

8. OCCUPATION

(a) Trade, profession or particular kind of work

Signer Painter

(b) General nature of industry, business, or establishment in which employed (or employer)

9. BIRTHPLACE

(State or Country)

Not obtainable

10. NAME OF FATHER

""

11. BIRTHPLACE OF FATHER

(State or Country)

""

12. MAIDEN NAME OF MOTHER

""

13. BIRTHPLACE OF MOTHER

(State or Country)

""

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

John Diehl

(Address)

Boise

15.

Filed 4-19 1913C. S. McOmney

Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH

April171913

(Month)

(Day)

(Year)

17. I HEREBY CERTIFY, That I attended deceased from

191saw191that I last saw him alive on dead 191and that death occurred on the date stated above, at 2 P. M.

The CAUSE OF DEATH* was as follows:

AlcoholismFound dead in
Boat.

(Duration)

yrs.

mos.

ds.

Contributory

(Secondary)

(Duration)

yrs.

mos.

ds.

(Signed)

A. Schreiber, M.D.

19

(Address)

Boise

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place

of death.....yrs.....mos.....days.

In the

State.....yrs.....mos.....days.

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

Morris Hill Cemetery4/19 1913

20. UNDERTAKER

ADDRESS

Schreiber & Vidin
Boise

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Form V. S. No. 5 20M.1-16-12

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH.

Registration District No. 2

County of Ada

Primary Registration District No. 1004

City of Boise

(No. 410, State St.)

File No. 4789

Registered No. 106

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

James Farrell

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX

M.

4. COLOR OR RACE

White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED.

(Write the word.)

6. DATE OF BIRTH

1 (Month) 1 (Day) 1913 (Year)

7. AGE

48 yrs. mos. ds.

IF LESS than 1 day
how many hrs. or mins.?

8. OCCUPATION

(a) Trade, profession or particular kind of work

Laborer

(b) General nature of industry, business, or establishment in which employed (or employer)

9. BIRTHPLACE

(State or Country)

Ireland Wis.

10. NAME OF FATHER

Roderick Farrell

11. BIRTHPLACE OF FATHER

(State or Country)

Ireland

12. MAIDEN NAME OF MOTHER

Mary Ryan

13. BIRTHPLACE OF MOTHER

(State or Country)

Ireland

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

John Farrell

(Address)

East Claire, Wis.

15.

Filed 4 21 1913

C. S. McCune

Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

April 16 1913
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from

April 14 1913, to April 16 1913,

that I last saw him alive on April 16 1913

and that death occurred on the date stated above, at 3 P. M.

The CAUSE OF DEATH* was as follows:

Pneumonia

(Duration) yrs. mos. 5 ds.

Contributory (Secondary)

Asthma

(Duration) yrs. mos. ds.

(Signed)

R. E. Shurtz

M. D.

19. (Address)

Boise

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death yrs. mos. 3 days. In the State yrs. mos. days.

Where was disease contracted if not at place of death?

Boise

Former or usual residence

Flag Rooming House Boise

19. PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

East Claire Wis.

4/24 1913

20. UNDERTAKER

ADDRESS

Shurtz & Hidenfader

Boise

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Form V. S. No. 5 20M.1-16-12

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH.

Registration District No. 2County of AdaPrimary Registration District No. 1004City of Boise(No. 420, Residence St.)File No. 4200Registered No. 108

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

Rozilla M. Prescott

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX

Female

4. COLOR OR RACE

White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED.

Widow
(Write the word.)

6. DATE OF BIRTH

May 1891
(Month)9th
(Day)1891
(Year)

7. AGE

81 yrs. 11 mos. 13 ds.IF LESS than 1 day
how many hrs. or
..... mins.?

8. OCCUPATION

(a) Trade, profession or particular kind of work

Retired

(b) General nature of industry business, or establishment in which employed (or employer)

9. BIRTHPLACE

(State or Country)

Franklin N.H.

10. NAME OF FATHER

Daniel H. Haley

11. BIRTHPLACE OF FATHER

(State or Country)

Not obtainable

12. MAIDEN NAME OF MOTHER

Nancy Morrison

13. BIRTHPLACE OF MOTHER

(State or Country)

Not obtainable

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

C. W. Lynde

(Address)

Nampa Idaho

15.

Filed 4 - 24 1913C. S. McConnell

Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH

April241913

(Month)

(Day)

(Year)

17. I HEREBY CERTIFY, That I attended deceased from

191...

to

191...that I last saw h. alive on 191...and that death occurred on the date stated above, at 5 A.M.

The CAUSE OF DEATH* was as follows:

Senility
was dead before
arrived.

(Duration)

yrs.

mos.

ds.

Contributory
(Secondary)

(Duration)

yrs.

mos.

ds.

(Signed)

Ralph Fagall M. D.

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place

of death yrs. mos. days.

In the

State yrs. mos. days.

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

Wampa Cemetery4/26 1913

20. UNDERTAKER

ADDRESS

Schirmer & Vidensfeldt Boise Id.

Form V. S. No. 5 20M.1-16-12

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH.

Registration District No. 2

County of

Ada

Primary Registration District No. 1004

City of

Boise

(No. 1217, Bannock St.)

File No. 4791

Registered No. 109

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

Willie Chapman

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX

Male

4. COLOR OR RACE

white American

5. SINGLE, MARRIED, WIDOWED OR DIVORCED.

Single
(Write the word.)

6. DATE OF BIRTH

May

30

1908

(Month)

(Day)

(Year)

7. AGE

4 yrs. 10 mos. 25 ds.

IF LESS than 1 day
how many hrs. or
mins.?

8. OCCUPATION

(a) Trade, profession or particular kind of work

(none) Child

(b) General nature of industry business, or establishment in which employed (or employer)

9. BIRTHPLACE

(State or Country)

Montana

10. NAME OF FATHER

Sr. W. Chapman

11. BIRTHPLACE OF FATHER

(State or Country)

Mo.

12. MAIDEN NAME OF MOTHER

not obtainable

13. BIRTHPLACE OF MOTHER

(State or Country)

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

E. B. Chapman

(Address)

429 2010 St

15.

Filed

4

-26

1913

G. M. Connel

Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH

April

25th

1913

(Month)

(Day)

(Year)

17. I HEREBY CERTIFY, That I attended deceased from

dead

1913

seen

1913

that I last saw him alive on April 25th 1913

and that death occurred on the date stated above, at 4:30 P.M.

The CAUSE OF DEATH* was as follows:

Accident, they burnt
to death near
1217 Bannock St Boise

(Duration)

yrs.

mos.

ds.

Contributory
(Secondary)

(Duration)

yrs.

mos.

ds.

(Signed) A. Schreiber Coroner M. D.

19

(Address)

Boise

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place

of death

yrs.

mos.

days

In the

State

yrs.

mos.

days

Where was disease contracted if not at place of death?

Former or

usual residence

216 W. 13 St.

19. PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

Morris Hill Cem

April 27 1913

20. UNDERTAKER

ADDRESS,

Fry & Summers Co

Boise

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Form V. S. No. 5 20M.1-16-12

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH

Registration District No. 2

County of Ada

Primary Registration District No. 1004

City of Boise

(No. 1217, Ramon St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

Herman Emanuel Schultz

File No. 4792

Registered No. 110

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX

Male

4. COLOR OR RACE

White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED.

(Write the word.)

6. DATE OF BIRTH

February 6 1909
(Month) (Day) (Year)

7. AGE

4 yrs. 2 mos. 19 ds.

IF LESS than 1 day
how many hrs. or mins?

8. OCCUPATION

(a) Trade, profession or particular kind of work

None

(b) General nature of industry, business, or establishment in which employed (or employer)

None

9. BIRTHPLACE

(State or Country)

Canyon Co. Idaho

10. NAME OF FATHER

William F. Schultz

11. BIRTHPLACE OF FATHER

(State or Country)

Wisconsin

12. MAIDEN NAME OF MOTHER

Maudie A. Peterson

13. BIRTHPLACE OF MOTHER

(State or Country)

Iowa

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

M. Peterson

(Address)

921 7th City

15.

Filed

4-26

1913

Ed. W. Bruce

Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

April 25 1913
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased ~~from~~ ^{since} ~~dead~~ ^{dead} ~~101~~ ¹⁰¹ ~~to~~ ^{to} ~~April 25~~ ^{April 25} 1913, that I last saw him alive on ~~101~~ ¹⁰¹ ~~to~~ ^{to} ~~April 25~~ ^{April 25} 1913, and that death occurred on the date stated above, at 4:30 P.M.

The CAUSE OF DEATH* was as follows:

Accidental burn to death near of 1217 Ramon St.

(Duration) yrs. mos. ds.

Contributory (Secondary)

(Duration) yrs. mos. ds.

(Signed)

Adolph Schreyer M.D.

19 (Address) Boise corner

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death... yrs. mos. days. In the State... yrs. mos. days.

Where was disease contracted if not at place of death?

Former or usual residence... 1311 Jefferson St.

19. PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

Moore Hill Cemetery

4/26 1913

20. UNDERTAKER

ADDRESS

Schreyer & Sidenfaden Boise

Form V. S. No. 5 20M.1-16-12

CERTIFICATE OF DEATH

State of Idaho
DEPARTMENT OF HEALTH
BUREAU OF VITAL STATISTICS

1. PLACE OF DEATH.

Registration District No. 2County of AdaPrimary Registration District No. 1004City of Boise(No. 1217, Bannock St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Earl William Schultz

Death occurred in a hospital, institution or camp, give its NAME and of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX

4. COLOR OR RACE

5. SINGLE, MARRIED, WIDOWED OR DIVORCED.

MaleWhite

(Write the word.)

6. DATE OF BIRTH

July 24 1907
(Month) (Day) (Year)

7. AGE

5 yrs. 9 mos. 1 ds.IF LESS than 1 day
how many hrs. or
..... mins.?

8. OCCUPATION

(a) Trade, profession or particular kind of work

none

(b) General nature of industry business, or establishment in which employed (or employer)

9. BIRTHPLACE

(State or Country)

Idaho, Canyon Co.

10. NAME OF FATHER

William F. Schultz

11. BIRTHPLACE OF FATHER

(State or Country)

Wisconsin

12. MAIDEN NAME OF MOTHER

Mrs. A. Peterson

13. BIRTHPLACE OF MOTHER

(State or Country)

Iowa

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

J. R. Peterson

(Address)

721 Fort City

15.

Filed

4-16

191

Ed M. Connel

Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

April 25 1913
(Month) (Day) (Year)17. I HEREBY CERTIFY, That I attended deceased from
dead 1913, to April 25 1913,
that I last saw alive on 1913,
and that death occurred on the date stated above, at 4:30 M.

The CAUSE OF DEATH* was as follows:

Accidental burn to
death in rear of
1217 Bannock St
(Duration) yrs. mos. ds.Contributory
(Secondary)

(Duration) yrs. mos. ds.

(Signed) Adolph Schreiber M.D.19..... (Address) Boise

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death yrs. mos. days. In the State yrs. mos. days.

Where was disease contracted if not at place of death?

Former or usual residence 1311 Jefferson St

19. PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

Wain Hill Cemetery4/26 1913

20. UNDERTAKER

ADDRESS

Schreiber & SidenfadenBoise

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Form V. S. No. 5 20M.1-16-12

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH.

Registration District No. 9

County of Fremont

Primary Registration District No. 2040

City of Meridian

(No. , St.)

File No. 4795

Registered No. 70

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Zala Hall

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX M

4. COLOR OR RACE W

5. SINGLE, MARRIED, WIDOWED OR DIVORCED?
Married
(Write the word.)

6. DATE OF BIRTH

Sept. 1 1880
(Month) (Day) (Year)

7. AGE

37 yrs. 8 mos. ds.

IF LESS than 1 day
how many hrs. or
 mins.?

8. OCCUPATION

(a) Trade, profession or particular kind of work
(b) General nature of industry, business, or establishment in which employed (or employer)

Housewife

9. BIRTHPLACE

(State or Country)

Utah

10. NAME OF FATHER

Walter Christensen

11. BIRTHPLACE OF FATHER

(State or Country)

Utah

12. MAIDEN NAME OF MOTHER

Alice Day

13. BIRTHPLACE OF MOTHER

(State or Country)

Santa Fe, New Mex.

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Cramer Hall

(Address) Meridian - Idaho

15.

Filed May 15 1913 Ray H. H. M.
Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH

May 15 1913
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from Mar 19 1913, to May 15 1913

that I last saw her alive on May 8 1913

and that death occurred on the date stated above, at 11 A. M.

The CAUSE OF DEATH* was as follows:

Labor Pneumonia

(Duration) yrs. mos. ds.

Contributory (Secondary) Phlebitis
Pleural Effusion

(Duration) yrs. mos. ds.

(Signed) J. E. Milton M. D.
May 19 1913 (Address) Meridian - Idaho

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death yrs. mos. days. In the State yrs. mos. days.

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL DATE OF BURIAL

Little Butte Cemetery May 17 1913

20. UNDERTAKER ADDRESS

M. T. Peck & Sons Reidy, Idaho

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Form V. S. No. 5 20M.1-16-12

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH. Registration District No. 9
County of Bernheim Primary Registration District No. 2040
City of Roberts (No. _____ St.)

File No. 1795

Registered No. 64

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Edna David

PERSONAL AND STATISTICAL PARTICULARS

3. SEX 7. 4. COLOR OR RACE W 5. SINGLE, MARRIED, WIDOWED OR DIVORCED. child
(Write the word.)

6. DATE OF BIRTH Feb. 9 1913
(Month) (Day) (Year)

7. AGE 1 yrs. 2 mos. 9 ds. IF LESS than 1 day how many _____ hrs. or _____ mins.?

8. OCCUPATION
(a) Trade, profession or particular kind of work child
(b) General nature of industry business, or establishment in which employed (or employer)

9. BIRTHPLACE Idaho
(State or Country)

10. NAME OF FATHER P. F. David

11. BIRTHPLACE OF FATHER Germany
(State or Country)

12. MAIDEN NAME OF MOTHER Emma Wornike

13. BIRTHPLACE OF MOTHER Iowa
(State or Country)

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) P. F. David

(Address) Roberts

15. Filed May 10 1913 Ray St. Fisher Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH Apr. 18 1913
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from Aug 16 1912, to Apr 18 1913 that I last saw him alive on Apr 18 1913 and that death occurred on the date stated above, at 3 A.M.

The CAUSE OF DEATH* was as follows:

Enteritis and pneumonia

(Duration) _____ yrs. _____ mos. _____ ds.

Contributory (Secondary) Obstruction of the bowels

(Duration) _____ yrs. _____ mos. _____ ds.

(Signed) Thos. McCamp M. D.

Apr 19 1913 (Address) Idaho Falls - Ida.

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death _____ yrs. _____ mos. _____ days. In the State _____ yrs. _____ mos. _____ days.

Where was disease contracted if not at place of death? _____

Former or usual residence _____

19. PLACE OF BURIAL OR REMOVAL Roberts - Ida. DATE OF BURIAL Apr 20 1913

20. UNDERTAKER E. E. Duwoody ADDRESS Idaho Falls - Ida.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Form V. S. No. 5 20M.1-16-12

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH. Registration District No. 9
County of Tremont Primary Registration District No. 2040
City of Rigby (No. _____, St.)

File No. 1182
Registered No. 1182

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

Irma Tall

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX M 4. COLOR OR RACE W 5. SINGLE, MARRIED, WIDOWED OR DIVORCED, Infant
(Write the word.)

6. DATE OF BIRTH

Mar 1st, 1913
(Month) (Day) (Year)

7. AGE

10 weeks IF LESS than 1 day
how many hrs. or
..... mins.?

8. OCCUPATION

(a) Trade, profession or particular kind of work
(b) General nature of industry business, or establishment in which employed (or employer)

Infant

9. BIRTHPLACE

(State or Country)

Idaho

10. NAME OF FATHER

Wm A Tall

11. BIRTHPLACE OF FATHER

(State or Country)

Utah

12. MAIDEN NAME OF MOTHER

Belle Kinghorn

13. BIRTHPLACE OF MOTHER

(State or Country)

Utah

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

W. A. Tall

(Address)

Rigby Idaho

15.

Filed

May 10 1913

Ray H. Fisher
Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH

May 10 1913
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from May 9th 1913, to May 10 1913, that I last saw her alive on May 10 1913, and that death occurred on the date stated above, at 4 P. M.

The CAUSE OF DEATH* was as follows:

Capillary Bronchitis

(Duration) yrs. mos. ds.

Contributory
(Secondary)

(Duration) yrs. mos. 3 ds.

(Signed) H. A. Anderson M. D.

May 1913 (Address) Rigby, Ida

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death yrs. mos. days. In the State yrs. mos. days.

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL

Rigby

DATE OF BURIAL

May 12 1913

20. UNDERTAKER

M. S. Beck & Sons

ADDRESS

Rigby

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Form V. S. No. 5 20M.1-16-12

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH.

Registration District No.

County of

Primary Registration District No.

City of

(No.

St.)

File No.

Registered No.

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX

4. COLOR OR RACE

5. SINGLE, MARRIED, WID-
OWED OR DIVORCED

6. DATE OF BIRTH

7. AGE

IF LESS than 1 day
how many hrs. or
mins.?

8. OCCUPATION

(a) Trade, profession or
particular kind of work
(b) General nature of industry
business, or establishment in
which employed (or employer)

9. BIRTHPLACE

(State or Country)

10. NAME OF
FATHER11. BIRTHPLACE
OF FATHER

(State or Country)

12. MAIDEN NAME
OF MOTHER13. BIRTHPLACE
OF MOTHER

(State or Country)

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

(Address)

15.

Filed

1913

Ray N. Fisher
Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH

17. I HEREBY CERTIFY, That I attended deceased from

Apr 10 1913, to Apr 12 1913
that I last saw him alive on Apr 10 1913

and that death occurred on the date stated above, at 5 A.M.

The CAUSE OF DEATH* was as follows:

(Duration) yrs. mos. 14 ds.

Contributory
(Secondary)

(Duration) yrs. mos. 4 ds.

(Signed)

Apr 12 1913 (Address) Idaho Falls

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place
of death.....yrs.....mos.....days.In the
State.....yrs.....mos.....days.Where was disease contracted
if not at place of death?Former or
usual residence.

19. PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

Grant Idaho Apr 13 1913

20. UNDERTAKER

ADDRESS

G. H. Hunt Idaho Falls

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Form V. S. No. 5 20M.1-16-12

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH.

Registration District No. 7County of FremontPrimary Registration District No. 2040City of Reghy

(No. _____, _____ St.)

File No. 4804Registered No. 56

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

Francis L. Clegg

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX

m

4. COLOR OR RACE

w

5. SINGLE, MARRIED, WIDOWED OR DIVORCED.

Child
(Write the word.)

6. DATE OF BIRTH

Nov 23 1912
(Month) (Day) (Year)

7. AGE

5 yrs. 21 mos. ds.

IF LESS than 1 day
how many hrs. or
..... mins.?

8. OCCUPATION

(a) Trade, profession or particular kind of work
(b) General nature of industry business, or establishment in which employed (or employer)

Child

9. BIRTHPLACE

(State or Country)

Idaho

10. NAME OF FATHER

Lyman Clegg

11. BIRTHPLACE OF FATHER

(State or Country)

Utah

12. MAIDEN NAME OF MOTHER

Sylvia Campbell

13. BIRTHPLACE OF MOTHER

(State or Country)

Utah

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

A. H. Campbell

(Address)

Reghy, Idaho

15.

Filed

May 10 1913Ray H. Fisher
Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH

Apr 12 1913
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from

Apr 1st 1913, to Apr 11 1913

that I last saw him alive on Apr 11 1913

and that death occurred on the date stated above, at 5 P. M.

The CAUSE OF DEATH* was as follows:

Broncho-Pneumonia

(Duration) yrs. mos. 10 ds.

Contributory
(Secondary)

(Duration) yrs. mos. ds.

(Signed) Ray H. Fisher M. D.

Apr 13 1913 (Address) Reghy, Idaho

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death yrs. mos. days. In the State yrs. mos. days.

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL

Milo

DATE OF BURIAL

Apr 14 1913

20. UNDERTAKER

M. J. Peck & Sons

ADDRESS

Reghy

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

1. PLACE OF DEATH. Registration District No. 9
County of Fremont Primary Registration District No. 2037
City of Driggs (No. _____, St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME George Alvin Wallace

File No. 1801
Registered No. 8

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX M 4. COLOR OR RACE W 5. SINGLE, MARRIED, WIDOWED OR DIVORCED. Single
(Write the word.)

6. DATE OF BIRTH April 27 1908
(Month) (Day) (Year)

7. AGE 4 yrs. 11 mos. 16 ds. IF LESS than 1 day how many _____ hrs. or _____ mins.?

8. OCCUPATION Child
(a) Trade, profession or particular kind of work
(b) General nature of industry business, or establishment in which employed (or employer)

9. BIRTHPLACE Idaho
(State or Country)

10. NAME OF FATHER Howard Wallace

11. BIRTHPLACE OF FATHER Utah
(State or Country)

12. MAIDEN NAME OF MOTHER Marquette Little

13. BIRTHPLACE OF MOTHER Utah
(State or Country)

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) M. S. Wallace

(Address) Driggs

15. Filed May 10 1913 Ray H. Fisher
Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH April 13 1913
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from Apr 6 1913 to Apr 13 1913
that I last saw him alive on Apr 13 1913
and that death occurred on the date stated above, at 4²⁰ P.

The CAUSE OF DEATH* was as follows:

Mitral incompetency

(Duration) _____ yrs. _____ mos. _____ ds.

Contributory (Secondary) _____

(Duration) _____ yrs. _____ mos. _____ ds.

(Signed) Ora D. Keith M. D.

Apr 19 1913 (Address) Driggs

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death _____ yrs. _____ mos. _____ days. In the State _____ yrs. _____ mos. _____ days.

Where was disease contracted if not at place of death? _____

Former or usual residence _____

19. PLACE OF BURIAL OR REMOVAL Driggs DATE OF BURIAL Apr 15 1913

20. UNDERTAKER C. Cherrington ADDRESS Driggs

Form V. S. No. 5 20M.1-16-12

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH.

Registration District No. 9

County of Fremont

Primary Registration District No. 2038

City of Chester

(No. , St.)

File No. 1902

Registered No. 63

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

Frederick Ewaldt

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS.

3. SEX

4. COLOR OR RACE

5. SINGLE, MARRIED, WIDOWED OR DIVORCED.

m

w

(Write the word.) Single

6. DATE OF BIRTH

Apr 29 1913
(Month) (Day) (Year)

7. AGE

63 yrs. 4 mos. 3 ds.

IF LESS than 1 day
how many hrs. or
..... mins.?

8. OCCUPATION

(a) Trade, profession or particular kind of work
(b) General nature of industry business, or establishment in which employed (or employer)

Shoemaker

9. BIRTHPLACE

(State or Country)

Germany

10. NAME OF FATHER.

Don't know

11. BIRTHPLACE OF FATHER

(State or Country)

"

12. MAIDEN NAME OF MOTHER

"

13. BIRTHPLACE OF MOTHER

(State or Country)

"

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

(Address)

John M. Halchauer
Chester - Ida.

15.

Filed

May 10 1913 Ray J. Fisher, M.D.
Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH

Apr 29 1913
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from Nov 1913, to Dec 1913,

that I last saw him alive on Apr 28 1913,

and that death occurred on the date stated above, at 3 A.M.

The CAUSE OF DEATH* was as follows:

Nephritis

(Duration) yrs. mos. ds.

Contributory
(Secondary)

(Duration) yrs. mos. ds.

(Signed) W. B. Bursch M. D.

Apr 30 1913 (Address) St. Anthony's Ida.

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death yrs. mos. days. In the State yrs. mos. days.

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

Chester May 12 1913

20. UNDERTAKER

ADDRESS

None (Friends) Chester Ida.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Form V. S. No. 5 20M.1-16-12

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH. Registration District No. 9
County of Thurmont Primary Registration District No. 2038
City of St Anthony (No. _____, St.)

File No. 1903
Registered No. 60

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Herald R. Higby

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX M 4. COLOR OR RACE W 5. SINGLE, MARRIED, WIDOWED OR DIVORCED Single
(Write the word.)

6. DATE OF BIRTH May 9 1911
(Month) (Day) (Year)

7. AGE 1 yrs. 10 mos. 20 ds. IF LESS than 1 day how many hrs. or mins.

8. OCCUPATION
(a) Trade, profession or particular kind of work Child
(b) General nature of industry business, or establishment in which employed (or employer) _____

9. BIRTHPLACE Idaho
(State or Country)

10. NAME OF FATHER Samuel Higby

11. BIRTHPLACE OF FATHER Utah
(State or Country)

12. MAIDEN NAME OF MOTHER Phoebe Bagley

13. BIRTHPLACE OF MOTHER Utah
(State or Country)

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Dr Morefield
(Address) St Anthony

15. Filed May 10 1913 Ray H. Fisher
Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH Mar 29 1913
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from Mar 16 1913 to Mar 29 1913, that I last saw him alive on Mar 29 1913, and that death occurred on the date stated above, at 1 P. M.

The CAUSE OF DEATH* was as follows:
Broncho pneumonia

(Duration) yrs. mos. ds.
Contributory.....
(Secondary)

(Duration) yrs. mos. ds.
(Signed) A. Morefield M. D.
Mar 30 1913 (Address) St Anthony

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death yrs. mos. days. In the State yrs. mos. days.

Where was disease contracted if not at place of death? _____

Former or usual residence _____

19. PLACE OF BURIAL OR REMOVAL Wilford DATE OF BURIAL Mar 31 1913

20. UNDERTAKER Friends ADDRESS St Anthony

Form V. S. No. 5 20M.1-16-12

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH.

Registration District No. 9County of FremontPrimary Registration District No. 2038City of St Anthony (No. _____ St.)File No. 4501Registered No. 59

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

George David Black

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX

M

4. COLOR OR RACE

W

5. SINGLE, MARRIED, WIDOWED OR DIVORCED.

Married
(Write the word.)

6. DATE OF BIRTH

Feb 18 1 841
(Month) (Day) (Year)

7. AGE

72 yrs. 1 mos. 19 ds.IF LESS than 1 day
how many hrs. or
..... mins.?

8. OCCUPATION

(a) Trade, profession or particular kind of work

Farmer

(b) General nature of industry business, or establishment in which employed (or employer)

9. BIRTHPLACE

(State or Country)

Mississippi

10. NAME OF FATHER

George Black

11. BIRTHPLACE OF FATHER

(State or Country)

Mississippi

12. MAIDEN NAME OF MOTHER

Mary Mc Cree

13. BIRTHPLACE OF MOTHER

(State or Country)

Miss.

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

Dr A Morefield

(Address)

St Anthony

15.

Filed

May 10 1913 Ray H. Fisher

Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH

Apr 7 1913
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from

Apr 3 1913, to Apr 7 1913that I last saw him alive on Apr 7 1913and that death occurred on the date stated above, at 1 M.

The CAUSE OF DEATH* was as follows:

Injury to spine
(Accidental)

(Duration) yrs. mos. ds.

Contributory Semility, Arterio Sclerosis
(Secondary)

(Duration) yrs. mos. ds.

(Signed) A Morefield M. D.Apr 19 (Address) St Anthony

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death yrs. mos. days. In the State yrs. mos. days.

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL

Wilford

DATE OF BURIAL

Apr 9 1913

20. UNDERTAKER

Friedrichs

ADDRESS

St Anthony

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Form V. S. No. 5 20M.1-16-12

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH.

Registration District No. 9County of BenewahPrimary Registration District No. 2039File No. 4806City of Benton

(No. _____ St.)

Registered No. 69

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

Christian H. Jensen

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX

M.

4. COLOR OR RACE

W.5. SINGLE, MARRIED, WID-
OWED OR DIVORCED.married
(Write the word.)

6. DATE OF BIRTH

Apr. 17 1835
(Month) (Day) (Year)

7. AGE

77 yrs. 11 mos. 23 ds.IF LESS than 1 day
how many hrs. or
..... mins.?

8. OCCUPATION

(a) Trade, profession or
particular kind of work(b) General nature of industry
business, or establishment in
which employed (or employer)Farmer

9. BIRTHPLACE

(State or Country)

Denmark10. NAME OF
FATHERHans Jensen11. BIRTHPLACE
OF FATHER

(State or Country)

Denmark12. MAIDEN NAME
OF MOTHERMary Nelson13. BIRTHPLACE
OF MOTHER

(State or Country)

Denmark

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

Joseph Jensen

(Address)

Salt Lake City Utah

15.

Filed

May 10 1913 Ray H. Fisher
Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH

Mar 28 1913
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from

191 to 191that I last saw him alive on 191and that death occurred on the date stated above, at M.

The CAUSE OF DEATH* was as follows:

Pneumonia
No attendance by physician
(Duration) yrs. mos. ds.Contributory
(Secondary)

(Duration) yrs. mos. ds.

(Signed) J. G. Espe M. D.Mar 19 1913 (Address) Reynolds Ida

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death yrs. mos. days. In the State yrs. mos. days.

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

BentonApr 1 1913

20. UNDERTAKER

ADDRESS

John Phillips Reynolds Ida

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Form V. S. No. 5 20M.1-16-12

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH.

Registration District No. 9

County of

Primary Registration District No. 2039

City of

(No. , St.)

File No. 4807

Registered No. 68

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

Mortha Beck

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX

7

4. COLOR OR RACE

W

5. SINGLE, MARRIED, WIDOWED OR DIVORCED.

Babe
(Write the word.)

6. DATE OF BIRTH

May 6

(Month)

(Day)

1912 (Year)

7. AGE

1 yrs. 1 mos. 1 ds.

IF LESS than 1 day
how many hrs. or mins.?

8. OCCUPATION

(a) Trade, profession or particular kind of work

(b) General nature of industry, business, or establishment in which employed (or employer)

Babe

9. BIRTHPLACE

(State or Country)

Idaho

10. NAME OF FATHER

Alma E. Beck

11. BIRTHPLACE OF FATHER

(State or Country)

Utah

12. MAIDEN NAME OF MOTHER

Mary McNeil

13. BIRTHPLACE OF MOTHER

(State or Country)

Idaho

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

Alma E. Beck

(Address)

Hubbard - Ida.

15.

Filed

May 10 1913 Ray H. Fish Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH

Apr 7

(Month)

(Day)

1913 (Year)

17. I HEREBY CERTIFY, That I attended deceased from

Mar 3 1913, to Apr 7 1913

that I last saw him alive on Apr 7 1913

and that death occurred on the date stated above, at 6 P.M.

The CAUSE OF DEATH* was as follows:

Pertussis

(Duration) yrs. mos. ds.

Contributory
(Secondary)

(Duration) yrs. mos. ds.

(Signed)

Apr 1913 (Address) Reibung

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death yrs. mos. days. In the State yrs. mos. days.

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL

Hubbard

DATE OF BURIAL

Apr 9 1913

20. UNDERTAKER

John Phillips

ADDRESS

Reibung

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Form V. S. No. 5 20M.1-16-12

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH.

Registration District No. 9

County of Jerome

Primary Registration District No. 2039

City of Reynolds

(No. _____)

St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME _____

File No. 1809

Registered No. 66

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX 7

4. COLOR OR RACE W

5. SINGLE, MARRIED, WIDOWED OR DIVORCED. married
(Write the word.)

6. DATE OF BIRTH May 5 1867
(Month) (Day) (Year)

7. AGE 45 yrs. 11 mos. 4 ds.

IF LESS than 1 day
how many _____ hrs. or
_____ mins.?

8. OCCUPATION

(a) Trade, profession or particular kind of work

(b) General nature of industry, business, or establishment in which employed (or employer)

Housewife

9. BIRTHPLACE

(State or Country)

Idaho

10. NAME OF FATHER

Jacob Christensen

11. BIRTHPLACE OF FATHER

(State or Country)

Dunsmuir

12. MAIDEN NAME OF MOTHER

Mary T. Meyer

13. BIRTHPLACE OF MOTHER

(State or Country)

Dunsmuir

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

John W. Long
Reynolds

(Address)

15.

Filed May 10 1913

Ray H. Phillips
Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH Apr 14 1913
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from Feb 26 1913 to Apr 12 1913

that I last saw h. E alive on Apr 12 1913

and that death occurred on the date stated above, at 7:30 M.

The CAUSE OF DEATH* was as follows:

Myocardial degeneration
unknown

(Duration) _____ yrs. _____ mos. _____ ds.

Contributory

(Secondary)

Pregnancy - threatened abortion

(Duration) _____ yrs. _____ mos. _____ ds.

(Signed)

W. A. Crisman M. D.

Apr 14 1913 (Address) Reynolds - Ida

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place

of death _____ yrs. _____ mos. _____ days.

In the

State _____ yrs. _____ mos. _____ days.

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

Ingomar City - Ida

Apr 15 1913

20. UNDERTAKER

ADDRESS

John Phillips

Reynolds

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Form V. S. No. 5 20M.1-16-12

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH.

Registration District No. 9County of IdahoPrimary Registration District No. 2039City of Teton

(No. _____, _____ St.)

File No. 4810Registered No. 65

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

Anna Hazel Richmond

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX

F

4. COLOR OR RACE

W

5. SINGLE, MARRIED, WIDOWED OR DIVORCED.

Married
(Write the word.)

6. DATE OF BIRTH

May 1 1913
(Month) (Day) (Year)

7. AGE

22 yrs. 1 mos. 9 ds.IF LESS than 1 day
how many _____ hrs. or
_____ mins.?

8. OCCUPATION

- (a) Trade, profession or particular kind of work
(b) General nature of industry, business, or establishment in which employed (or employer)

Housewife

9. BIRTHPLACE

(State or Country)

Utah

10. NAME OF FATHER

Mr. H. Hill

11. BIRTHPLACE OF FATHER

(State or Country)

Utah

12. MAIDEN NAME OF MOTHER

C. S. Johnson

13. BIRTHPLACE OF MOTHER

(State or Country)

Utah

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

J. H. Richmond

(Address)

Teton - Idaho

15.

Filed Mar 10 1913Ray M. Fisher, M.D.
Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH

May 3 1913
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from Apr. 30 1913 to May 1 1913, that I last saw him alive on May 1 1913, and that death occurred on the date stated above, at 3:20 M.

The CAUSE OF DEATH* was as follows:

Pronounced Vomiting(Duration) yrs. 6 mos. ds.

Contributory (Secondary)

Pregnancy

(Duration) yrs. mos. ds.

(Signed)

J. R. Shupe M. D.
May 4 1913 (Address) Lugor City, Ida.

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death _____ yrs. _____ mos. _____ days. In the State _____ yrs. _____ mos. _____ days.

Where was disease contracted if not at place of death?

Former or usual residence _____

19. PLACE OF BURIAL OR REMOVAL

Teton - Ida.

DATE OF BURIAL

5-5 1913

20. UNDERTAKER

J. R. Young

ADDRESS

Rexburg, Ida.

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Form V. S. No. 5 20M.1-16-12

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH.
County of Franklin
City of Franklin

Registration District No. 18
Primary Registration District No. 219
(No. _____, St.)

File No. 4811
Registered No. 404

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME John P. Agamas

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX Male 4. COLOR OR RACE White 5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.)

6. DATE OF BIRTH June 27 1911
(Month) (Day) (Year)

7. AGE 1 yrs. 8 mos. 10 ds.
IF LESS than 1 day how many _____ hrs. or _____ min.

8. OCCUPATION
(a) Trade, profession or particular kind of work
(b) General nature of industry, business, or establishment in which employed (or employer)

9. BIRTHPLACE Franklin
(State or Country)

10. NAME OF FATHER Burt Agamas

11. BIRTHPLACE OF FATHER Idaho
(State or Country)

12. MAIDEN NAME OF MOTHER Berry

13. BIRTHPLACE OF MOTHER Logan Mont
(State or Country)

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) John Berry
(Address) Chelant Idaho

15. Filed Apr 19 1913
G. B. Emery
Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH Mar. 10 1913
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from Feb. 25 1913, to Mar 10 1913, that I last saw him alive on Mar. 8 1913, and that death occurred on the date stated above, at 4 A.M.

The CAUSE OF DEATH* was as follows:
Bronchitis Pneumonia & Diphtheria

(Duration) 1 mos. 10 ds.
Contributory Lagrip
(Secondary)

(Duration) 12 mos. 10 ds.
(Signed) Alvin R. Butler M. D.
3/11 1913 (Address) Preston

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death _____ yrs. _____ mos. _____ days. In the State _____ yrs. _____ mos. _____ days.

Where was disease contracted if not at place of death?

Former or usual residence _____

19. PLACE OF BURIAL OR REMOVAL Franklin Ida DATE OF BURIAL May 12 1913

20. UNDERTAKER P. J. Hansen ADDRESS Preston Ida

MARGIN RESERVED FOR BINDING
WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Form V. S. No. 5 20M.1-16-12

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH.

Registration District No. 18

County of Franklin

Primary Registration District No. 2119

City of Preston

(No. _____ St.)

File No. 18174

Registered No. _____
If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME John Herman Holden

PERSONAL AND STATISTICAL PARTICULARS

3. SEX

Male

4. COLOR OR RACE

White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED.

(Write the word.)

6. DATE OF BIRTH

March

11

1912

(Month)

(Day)

(Year)

7. AGE

one yrs. 25 mos. 25 ds.

IF LESS than 1 day
how many hrs. or
..... mins.?

8. OCCUPATION

(a) Trade, profession or particular kind of work

(b) General nature of industry business, or establishment in which employed (or employer)

9. BIRTHPLACE

(State or Country)

Mapleton Idaho

10. NAME OF FATHER

Enos Holden

11. BIRTHPLACE OF FATHER

(State or Country)

Whitney Idaho

12. MAIDEN NAME OF MOTHER

Jina Buckley

13. BIRTHPLACE OF MOTHER

(State or Country)

Franklin Idaho

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

Margaret Oliverson

(Address)

Preston

15.

Filed

Apr 11 1913

G. C. Gray

Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH

Apr

5

1913

(Month)

(Day)

(Year)

17. I HEREBY CERTIFY, That I attended deceased from

Apr 1 1913, to Apr 5 1913

that I last saw him alive on Apr 5 1913

and that death occurred on the date stated above, at 9:30 P. M.

The CAUSE OF DEATH* was as follows:

Bronch. Pneumonia

(Duration) ✓ yrs. ✓ mos. 7 ds.

Contributory (Secondary)

Measles

(Duration) ✓ yrs. ✓ mos. 7 ds.

(Signed)

G. W. State M. D.

4/6 1913 (Address) Preston Ida

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death yrs. mos. days. In the State yrs. mos. days.

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

Franklin Ida

Apr 7 1913

20. UNDERTAKER

ADDRESS

P. J. Hansen

Preston Ida

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Form V. S. No. 5 20M.1-16-12

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH.

Registration District No. 18County of FranklinPrimary Registration District No. 2119City of Camp 113 U. S. Prison No. _____ St.)File No. 4813Registered No. 49

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

Walter Stetson

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX

4. COLOR OR RACE

5. SINGLE, MARRIED, WIDOWED OR DIVORCED.

Male White

(Write the word.)

6. DATE OF BIRTH

Nov 29 1900
(Month) (Day) (Year)

7. AGE

12 yrs. 10 mos. _____ ds.IF LESS than 1 day
how many _____ hrs. or
_____ mins.

8. OCCUPATION

(a) Trade, profession or particular kind of work

(b) General nature of industry business, or establishment in which employed (or employer)

Clark

9. BIRTHPLACE

(State or Country)

Idaho B.C.

10. NAME OF FATHER

Robert Stetson

11. BIRTHPLACE OF FATHER

(State or Country)

Idaho

12. MAIDEN NAME OF MOTHER

Boyd

13. BIRTHPLACE OF MOTHER

(State or Country)

Idaho B.C.

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

Preston Idaho

(Address)

Robt Stetson

15.

Filed

Apr 12 1913 G. E. Emery
May 7 1913 D. C. Ray

Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

April 10 1913
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from

Apr 7 1913, to April 10 1913,that I last saw him alive on April 10 1913,and that death occurred on the date stated above, at 7 A.M.

The CAUSE OF DEATH* was as follows:

meningitis(Duration) _____ yrs. _____ mos. 3 ds.

Contributory

(Secondary)

(Duration) _____ yrs. _____ mos. _____ ds.

(Signed)

H. C. C. Canfield M. D.
4/10 1913 (Address) Briston Idaho

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place

of death _____ yrs. _____ mos. _____ days.

In the

State _____ yrs. _____ mos. _____ days.

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

Preston Ida Apr 11 1913

20. UNDERTAKER

ADDRESS

G. J. Danner Briston Ida

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Form V. S. No. 5 20M.1-16-12

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH.

Registration District No. 18

County of Franklin

Primary Registration District No. 2119

City of Boise

(No. _____, St.)

File No. 4811

Registered No. 160

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME William Edgar Martin

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX

Male

4. COLOR OR RACE

White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED.

(Write the word.)

6. DATE OF BIRTH

Nov 16 1906
(Month) (Day) (Year)

7. AGE

6 yrs. 4 mos. _____ ds.

IF LESS than 1 day
how many _____ hrs. or
_____ mins.?

8. OCCUPATION

(a) Trade, profession or particular kind of work

(b) General nature of industry, business, or establishment in which employed (or employer)

9. BIRTHPLACE

(State or Country)

Boise

10. NAME OF FATHER

Edgar M Martin

11. BIRTHPLACE OF FATHER

(State or Country)

Boise Idaho

12. MAIDEN NAME OF MOTHER

Stephens

13. BIRTHPLACE OF MOTHER

(State or Country)

Idaho

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

William S Martin

(Address)

Boise

15.

Filed

Apr 15 1913 W. S. Martin
Mar 7 1913 W. S. Martin
Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

April 13 1913
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from

Mar 15 1913, to Apr 13 1913,

that I last saw him alive on Apr 12 1913,

and that death occurred on the date stated above, at 4 1/2 M.

The CAUSE OF DEATH* was as follows:

Cerebro - Spinal Meningitis

(Duration) ✓ yrs. ✓ mos. 30 ds.

Contributory (Secondary)

Following measles

(Duration) _____ yrs. _____ mos. _____ ds.

(Signed)

Apr 12 1913 (Address) Boise Idaho

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death _____ yrs. _____ mos. _____ days. In the State _____ yrs. _____ mos. _____ days.

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

Boise Idaho Apr 15 1913

20. UNDERTAKER

ADDRESS

J. J. Hansen Boise Idaho

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Form V. S. No. 5 20M.1-16-12

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH.

Registration District No. 18

County of Franklin

Primary Registration District No. 2119

City of Burton

(No. _____ St.)

File No. 1815

Registered No. 6

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME William B Merrill

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX

4. COLOR OR RACE

5. SINGLE, MARRIED, WIDOWED OR DIVORCED.

Male

White

(Write the word.)

6. DATE OF BIRTH

July 27 1902
(Month) (Day) (Year)

7. AGE

1 yrs. 3 mos. 0 ds.

IF LESS than 1 day
how many _____ hrs. or
_____ mins.

8. OCCUPATION

(a) Trade, profession or particular kind of work
(b) General nature of industry, business, or establishment in which employed (or employer)

9. BIRTHPLACE

(State or Country)

Burton

10. NAME OF FATHER

Adelbert C Merrill

11. BIRTHPLACE OF FATHER

(State or Country)

Idaho

12. MAIDEN NAME OF MOTHER

Baird

13. BIRTHPLACE OF MOTHER

(State or Country)

Idaho

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

Adelbert C. Merrill

(Address)

Burton Idaho

15.

Filed

Apr 17 1913

May

Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH

Apr 15 1913
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from

Apr 14 1913, to Apr 15 1913,

that I last saw him alive on Apr 15 1913.

and that death occurred on the date stated above, at 10 AM.

The CAUSE OF DEATH* was as follows:

Swampy Cough Complicated with Bronchitis and bowel trouble

(Duration) 3 yrs. 3 mos. 0 ds.

Contributory Mumps and Pneumonia
(Secondary)

(Duration) _____ yrs. _____ mos. _____ ds.

(Signed) Alfred C. Merrill M. D.

4/16/13 (Address) Burton

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death _____ yrs. _____ mos. _____ days. In the State _____ yrs. _____ mos. _____ days.

Where was disease contracted if not at place of death?

Former or usual residence _____

19. PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

Burton Idaho Apr 16 1913

20. UNDERTAKER

ADDRESS

C. J. Hansen Burton Idaho

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Form V. S. No. 5 20M.1-16-12

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH

Registration District No. 18

County of Franklin

Primary Registration District No. 219

City of Minh Creek

(No. , St.)

File No. 4817

Registered No. 3

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Viola E. Baypus

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX

4. COLOR OR RACE

5. SINGLE, MARRIED, WIDOWED OR DIVORCED.

Female

White

(Write the word.)

6. DATE OF BIRTH

June

3

1911

(Month)

(Day)

(Year)

7. AGE

1 yrs. 10 mos. ds.

IF LESS than 1 day
how many hrs. or
 mins.?

8. OCCUPATION

(a) Trade, profession or particular kind of work

(b) General nature of industry business, or establishment in which employed (or employer)

9. BIRTHPLACE

(State or Country)

Minh Creek

10. NAME OF FATHER

Fred Baypus

11. BIRTHPLACE OF FATHER

(State or Country)

Livingstonland

12. MAIDEN NAME OF MOTHER

Christiansen

13. BIRTHPLACE OF MOTHER

(State or Country)

Minh Creek Utah

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

(Address)

O. B. Christiansen
Minh Creek

15.

Filed Apr 21 1913

O. B. Christiansen
Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

Apr

18

1913

(Month)

(Day)

(Year)

17. I HEREBY CERTIFY, That I attended deceased from

Apr 15 1913, to Apr 18 1913,

that I last saw h alive on Apr 15 1913,

and that death occurred on the date stated h at M.

The CAUSE OF DEATH* was as follows:

Rheumatism
Endocarditis

(Duration) yrs. mos. 12 ds.

Contributory
(Secondary)

(Duration) yrs. mos. ds.

(Signed)

Allen C. Kelly M. D.

4/18/13

(Address) Prescott

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death yrs. mos. days. In the State yrs. mos. days.

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

Minh Creek Idaho Apr 20 1913

20. UNDERTAKER

ADDRESS

O. B. Christiansen Prescott

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Form V. S. No. 5 20M.1-16-12

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH.

Registration District No. 18

County of Franklin

Primary Registration District No. 2119

City of Preston

(No. _____) (St. _____)

File No. 4818

Registered No. 384

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

Donald A. Watson

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX

4. COLOR OR RACE

5. SINGLE, MARRIED, WIDOWED OR DIVORCED.

Male White

(Write the word.)

6. DATE OF BIRTH

Mar 20 1912
(Month) (Day) (Year)

7. AGE

1 yrs. 2 mos. _____ ds.

IF LESS than 1 day
how many _____ hrs. or
_____ mins.?

8. OCCUPATION

- (a) Trade, profession or particular kind of work
(b) General nature of industry, business, or establishment in which employed (or employer)

9. BIRTHPLACE

(State or Country)

10. NAME OF FATHER

11. BIRTHPLACE OF FATHER

(State or Country)

12. MAIDEN NAME OF MOTHER

13. BIRTHPLACE OF MOTHER

(State or Country)

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

(Address)

Alfred R. Watson
Preston

15.

Filed

Apr 26 1913
May 7 1913
Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

Apr. 25 1913
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from

from Apr. 17 1913, to Apr. 25 1913,
that I last saw him alive on Apr. 22 1913,
and that death occurred on the date stated above, at P.A.M.

The CAUSE OF DEATH* was as follows:

Broncho Pneumonia

..... (Duration) yrs. mos. 8 ds.

Contributory
(Secondary)

..... (Duration) yrs. mos. ds.

(Signed) G. T. Parkinson M. D.

Apr 25 1913 (Address) Preston, Ida.

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death yrs. mos. days. In the State yrs. mos. days.

Where was disease contracted if not at place of death?

Former or usual residence.

19. PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

Preston, Ida Apr. 26 1913

20. UNDERTAKER

ADDRESS

C. J. Hansen Preston

Form V. S. No. 5 20M.1-16-12

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH

Registration District No. 18

County of Franklin

Primary Registration District No. 2119

City of Whitney

(No. , St.)

File No. 4819

Registered No. 55

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

Margaret H. Dunkley

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX

4. COLOR OR RACE

5. SINGLE, MARRIED, WIDOWED OR DIVORCED

Female

White

(Write the word.)

6. DATE OF BIRTH

May

29

1851

(Month)

(Day)

(Year)

7. AGE

61 yrs. 11 mos. ds.

IF LESS than 1 day
how many hrs. or
..... mins.?

8. OCCUPATION

(a) Trade, profession or particular kind of work

(b) General nature of industry business, or establishment in which employed (or employer)

Hansen Whips

9. BIRTHPLACE

(State or Country)

Scotland

10. NAME OF FATHER

George Wright

11. BIRTHPLACE OF FATHER

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. N. B.—Every item of information should be carefully supplied. AGE should be state EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

1. PLACE OF DEATH Registration District No. 2012
 County of Adams Primary Registration District No. 2012
 City of Garrock (No. , St.)
 Bureau of Vital Statistics
 File No. 1521
 Registered No. 28
 If death occurs away from usual residence, give facts called for under special information. 2. FULL NAME Baby Rinehart
 If death occurred in a hospital, institution or camp give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX Male 4. COLOR OR RACE white 5. SINGLE, MARRIED, WIDOWED OR DIVORCED. Single
 (Write the word.)

6. DATE OF BIRTH April 14, 1913
 (Month) (Day) (Year)

7. AGE yrs. mos. ds. IF LESS than 1 day how many hrs. or min.?

8. OCCUPATION
 (a) Trade, profession, or particular kind of work Nurse
 (b) General nature of industry business, or establishment in which employed (or employer)

9. BIRTHPLACE Idaho
 (State or Country)

10. NAME OF FATHER Olin Rinehart

11. BIRTHPLACE OF FATHER Idaho
 (State or Country)

12. MAIDEN NAME OF MOTHER Berice Larson

13. BIRTHPLACE OF MOTHER Utah
 (State or Country)

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
 (Informant) D. I. Martin
 (Address) Council Idaho

15. Filed 4-15-1913 Frank E. Brown
 Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH April 14, 1913
 (Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from April 14, 1913, to April 14, 1913
 that I last saw her alive on April 14, 1913,
 and that death occurred on the date stated above, at 12 M.
 The CAUSE OF DEATH* was as follows:
 Prematurity
 (Duration) yrs. mos. ds.
 Contributory (Secondary)
 (Duration) yrs. mos. ds.
 (Signed) D. I. Martin M. D.
 4, 15 1913 (Address) Council Idaho

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
 At place In the
 of death yrs. mos. ds. State yrs. mos. ds.
 Where was Disease contracted,
 If not at place of death?
 Former or usual residence.

19. PLACE OF BURIAL OR REMOVAL Council DATE OF BURIAL 4-16-1913

20. UNDERTAKER Ross Young ADDRESS Council

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
 N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Form V. S. No. 5 20M.1-16-12

CERTIFICATE OF DEATH

 State of Idaho
 BOARD OF HEALTH
 Bureau of Vital Statistics

1. PLACE OF DEATH.

Registration District No. 4County of AdamsPrimary Registration District No. 2012City of Samarak

(No. _____, St.)

File No. 1582Registered No. 29

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

Carl O Nelson

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX

Male

4. COLOR OR RACE

White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED.

Single
(Write the word.)

6. DATE OF BIRTH

June
(Month)16
(Day)1883
(Year)

7. AGE

29 yrs. 10 mos. 3 ds.
 IF LESS than 1 day
 how many hrs. or
 mins.?

8. OCCUPATION

(a) Trade, profession or particular kind of work

Timberman
Boatman
Deporter

(b) General nature of industry business, or establishment in which employed (or employer)

9. BIRTHPLACE

(State or Country)

Iowa

10. NAME OF FATHER

Erich. Nelson

11. BIRTHPLACE OF FATHER

(State or Country)

Norway

12. MAIDEN NAME OF MOTHER

13. BIRTHPLACE OF MOTHER

(State or Country)

Norway

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

Swen E. Nelson

(Address)

Argyle, Wis.

15.

Filed

Apr 261913Frank E. Brown

Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH

Apr
(Month)19
(Day)1913
(Year)

17. I HEREBY CERTIFY, That I attended deceased from

1913, to1913,that I last saw h. _____ alive on _____ 1913,

and that death occurred on the date stated above, at _____ M.

The CAUSE OF DEATH* was as follows:

Striking

(Duration) _____ yrs. _____ mos. _____ ds.

Contributory
(Secondary)

(Duration) _____ yrs. _____ mos. _____ ds.

(Signed)

Frank E. Brown M. D.

19. (Address)

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death

..... yrs. mos. days.

In the State

..... yrs. mos. days.

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

Council IdahoApr. 25 1913

20. UNDERTAKER

ADDRESS

Robt YoungCouncil

Form V. S. No. 5 20M.1-16-12

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH.

Registration District No. 4County of AdairPrimary Registration District No. 2011City of Council

(No. _____, _____ St.)

File No. 4823Registered No. 30

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Abraham Hinkle

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX

Male

4. COLOR OR RACE

White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED.

Single
(Write the word.)

6. DATE OF BIRTH

June
(Month)18
(Day)1867
(Year)

7. AGE

45 yrs. 10 mos. 11 ds.

IF LESS than 1 day
how many hrs. or
..... mins.?

8. OCCUPATION

(a) Trade, profession or particular kind of work
(b) General nature of industry business, or establishment in which employed (or employer)

Farmer

9. BIRTHPLACE

(State or Country)

South Car

10. NAME OF FATHER

Elijah Hinkle

11. BIRTHPLACE OF FATHER

(State or Country)

South Car

12. MAIDEN NAME OF MOTHER

May Stewart

13. BIRTHPLACE OF MOTHER

(State or Country)

South Car

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

Jake Hinkle

(Address)

Council Idaho

15.

Filed

4-301913Frank E. Birm

Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH

April291913

(Month)

(Day)

(Year)

17. I HEREBY CERTIFY, That I attended deceased from

April 28 - 1913 to April 28, 1913that I last saw him alive on April 28 1913and that death occurred on the date stated above, at 6 A.M.

The CAUSE OF DEATH* was as follows:

Uremia due tochronic nephritis

(Duration)

yrs.

mos.

7 ds.Contributory
(Secondary)Insanity

(Duration)

yrs.

mos.

ds.

(Signed)

D. I. Martin M. D.4-29-13 (Address) Council Idaho

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death

..... yrs. mos. days.

In the State

..... yrs. mos. days.

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

Idaho4-30 1913

20. UNDERTAKER

ADDRESS

R.H. YoungCouncil

Form V. S. No. 5 20M.1-16-12

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH.

Registration District No. 4

County of Adams

Primary Registration District No. 20

City of Trinidad

(No. _____, _____ St.)

File No. 1821

Registered No. 31

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Jane Camp

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX

Fr

4. COLOR OR RACE

Wht.

5. SINGLE, MARRIED, WIDOWED OR DIVORCED.

Married
(Write the word.)

6. DATE OF BIRTH

Jan 13 1852
(Month) (Day) (Year)

7. AGE

61 yrs. 3 mos. 17 ds.

IF LESS than 1 day
how many _____ hrs. or
_____ mins.

8. OCCUPATION

(a) Trade, profession or particular kind of work

House Wife

(b) General nature of industry business, or establishment in which employed (or employer)

9. BIRTHPLACE

(State or Country)

Iowa

10. NAME OF FATHER

David Fife

11. BIRTHPLACE OF FATHER

(State or Country)

Ohio

12. MAIDEN NAME OF MOTHER

Smith

13. BIRTHPLACE OF MOTHER

(State or Country)

Iowa

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

W. H. Camp

(Address)

Council Bluffs

15.

Filed

5-10

191

Frank E. Brown

Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH

April 30 1913
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from

June 25 1912, to April 30 1913,

that I last saw her alive on April 20 1913,

and that death occurred on the date stated above, at 2 A.M.

The CAUSE OF DEATH* was as follows:

Chronic myocarditis
Fibroid uterus

(Duration) 20 yrs. _____ mos. _____ ds.

Contributory
(Secondary)

(Duration) _____ yrs. _____ mos. _____ ds.

(Signed)

D. Z. Martin

M. D.

April 1913 (Address) Council Bluffs

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death _____ yrs. _____ mos. _____ days. In the State _____ yrs. _____ mos. _____ days.

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL

Council Bluffs

DATE OF BURIAL

May 1 1913

20. UNDERTAKER

Robt Young

ADDRESS

Council

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

1. PLACE OF DEATH. County of <u>Adams</u> City of <u>Indian Valley</u>		Registration District No. Primary Registration District No. (No., St.)		Bureau of Vital Statistics File No. Registered No.	
If death occurs away from usual residence, give facts called for under special information.					
2. FULL NAME <u>Reges Mannier</u>					
PERSONAL AND STATISTICAL PARTICULARS					
3. SEX <u>Male</u>	4. COLOR OR RACE <u>Mexican</u>	5. SINGLE, MARRIED, WIDOWED OR DIVORCED. <u>Single</u> (Write the word.)			
6. DATE OF BIRTH <u>Unknown</u> (Month) (Day) (Year)					
7. AGE <u>45</u> yrs. mos. ds. IF LESS than 1 day how many hrs. or min?					
8. OCCUPATION (a) Trade, profession or particular kind of work. <u>Shepherd</u> (b) General nature of industry business or establishment in which employed (or employer)					
9. BIRTHPLACE (State or Country) <u>New Mexico</u>					
10. NAME OF FATHER <u>Unknown</u>					
11. BIRTHPLACE OF FATHER (State or Country)					
12. MAIDEN NAME OF MOTHER					
13. BIRTHPLACE OF MOTHER (State or Country)					
14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE (Informant) <u>Walter L. Savoy</u> (Address) <u>Cambidge, Ida.</u>					
15. <u>Frank E. Brown</u> <u>C. E. Schindz</u> Local Registrar					
16. DATE OF DEATH <u>April 25</u> 191 <u>3</u> (Month) (Day) (Year)					
17. I HEREBY CERTIFY, That I attended deceased from <u>April 20</u> 191 <u>3</u> , to <u>April 25</u> 191 <u>3</u> that I last saw him alive on <u>April 20</u> 191 <u>3</u> and that death occurred on the date stated above, at <u>8 9 M.</u> The CAUSE OF DEATH* was as follows: <u>Spotted Fever</u>					
..... (Duration) yrs. mos. <u>10</u> ds. Contributory (Secondary) (Duration) yrs. mos. ds. (Signed) <u>C. E. Schindz</u> M. D. <u>Apr 26</u> 191 <u>3</u> (Address) <u>Cambidge</u>					
*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.					
18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.) At place In the of death yrs. mos. ds. State yrs. mos. ds. Where was disease contracted, If not at place of death? Former or usual residence.					
19. PLACE OF BURIAL OR REMOVAL DATE OF BURIAL <u>Indian Valley</u> <u>April 26</u> 191 <u>3</u>					
20. UNDERTAKER ADDRESS <u>Gas Hudelson</u> <u>Cambidge, Ida.</u>					
Filed <u>April 26</u> 191 <u>3</u>					

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Form V. S. No. 5. 12½ M. 7-24-11

CERTIFICATE OF DEATH

1. PLACE OF DEATH. Registration District No. 2118
 County of Butterfield Primary Registration District No. 2118
 City of Brant Mission (No. _____, _____ St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME William Joseph

State of Idaho
 BOARD OF HEALTH
 Bureau of Vital Statistics
 File No. 1825
 Registered No. 279

If death occurred in a hospital, institution or camp give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX Male 4. COLOR OR RACE Indian 5. SINGLE, MARRIED, WIDOWED OR DIVORCED. Single
 (Write the word.)

6. DATE OF BIRTH about 1894
 (Month) (Day) (Year)

7. AGE 19 yrs. — mos. — ds. IF LESS than 1 day how many hrs. or min?

8. OCCUPATION
 (a) Trade, profession or particular kind of work. School boy
 (b) General nature of industry business or establishment in which employed (or employer)

9. BIRTHPLACE
 (State or Country) Calville Reservation

10. NAME OF FATHER Louis Joseph

11. BIRTHPLACE OF FATHER
 (State or Country) Calville Reserva.

12. MAIDEN NAME OF MOTHER Mrs. Thomas

13. BIRTHPLACE OF MOTHER
 (State or Country) Calville

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
 (Informant) Father Eugene
 (Address) Brant, Ida.

15. May 10, 13 L. D. Drewings
 Filed Apr 22 1913 Geo. D. Hughes
Sub-Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH Apr 21 1913
 (Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from Sept 1912, to Apr 21 1913
 that I last saw him alive on Apr 15 1913
 and that death occurred on the date stated above, at 10 P. M.
 The CAUSE OF DEATH* was as follows:

Pulmonary Tuberculosis

(Duration) — yrs. 6 mos. — ds.
 Contributory None
 (Secondary)

(Duration) — yrs. — mos. — ds.
 (Signed) J. R. Leppard M. D.
Apr 22 1913. (Address) Brant, Ida.

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place In the
 of death yrs. mos. ds. State yrs. mos. ds.
 Where was disease contracted,
 If not at place of death?
 Former or
 usual residence

19. PLACE OF BURIAL OR REMOVAL Brant Mission DATE OF BURIAL Apr 23 1913
 20. UNDERTAKER None ADDRESS

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Form V. S. No. 5. 12½ M. 7-24-11

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics
File No. 152
Registered No. 278

1. PLACE OF DEATH. Registration District No. 2118
County of Bonner Primary Registration District No. 2118
City of Deerfoot-Mission (No. _____, St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Sam Abraham

If death occurred in a hospital, institution or camp give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX Male 4. COLOR OR RACE Indian 5. SINGLE, MARRIED, WIDOWED OR DIVORCED. Single
(Write the word.)

6. DATE OF BIRTH Sept 1901
(Month) (Day) (Year)

7. AGE 17 yrs. 0 mos. 0 ds.
IF LESS than 1 day how many 0 hrs. or 0 min?

8. OCCUPATION
(a) Trade, profession or particular kind of work. None
(b) General nature of industry business or establishment in which employed (or employer)

9. BIRTHPLACE
(State or Country) Idaho

10. NAME OF FATHER Leo Abraham

11. BIRTHPLACE OF FATHER
(State or Country) Reservation

12. MAIDEN NAME OF MOTHER Mary Davis

13. BIRTHPLACE OF MOTHER
(State or Country) Reservation

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Leo Abraham
(Address) Deerfoot, Ida

15. May 10 1913
Filed May 8 1913
D. D. Greenman
Lib. J. Greenman
Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH April 5 1913
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from 191 to 191

that I last saw him alive on 191

and that death occurred on the date stated above, at M.

The CAUSE OF DEATH* was as follows:

No physician.
Consumption

(Duration) 1 yrs. 0 mos. 0 ds.

Contributory (Secondary)

(Duration) 0 yrs. 0 mos. 0 ds.

(Signed) M. D.

19 (Address)

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place In the
of death 0 yrs. 0 mos. 0 ds. State 0 yrs. 0 mos. 0 ds.
Where was disease contracted,
If not at place of death?
Former or
usual residence.

19. PLACE OF BURIAL OR REMOVAL DATE OF BURIAL

Deerfoot Mission Apr. 9 1913

20. UNDERTAKER ADDRESS

None

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Form V. S. No. 5. 12½ M. 7-24-11

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics
File No. _____
Registered No. 280

1. PLACE OF DEATH. Registration District No. 2118
County of Boston Primary Registration District No. 2118
City of Drum Mission (No. _____, St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Mary L. Mitchell

If death occurred in a hospital, institution or camp give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX Female 4. COLOR OR RACE Indian 5. SINGLE, MARRIED, WIDOWED OR DIVORCED. Single
(Write the word.)

6. DATE OF BIRTH Oct 18 1897
(Month) (Day) (Year)

7. AGE 16 yrs. 4 mos. 9 ds. IF LESS than 1 day how many hrs. or min?

8. OCCUPATION
(a) Trade, profession or particular kind of work. Nurse
(b) General nature of industry business or establishment in which employed (or employer)

9. BIRTHPLACE
(State or Country) Reservation

10. NAME OF FATHER Louis Mitchell

11. BIRTHPLACE OF FATHER
(State or Country) Old Mission

12. MAIDEN NAME OF MOTHER Mary Magdaline Louis

13. BIRTHPLACE OF MOTHER
(State or Country) Reservation

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Louis Mitchell
(Address) Drum, Ida

15. May 10, 13 S. D. Green
April 29, 1913 Geo. J. Hughes
Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH Apr 27 1913
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from March 30 1913, to Apr 20 1913
that I last saw her alive on Apr 20 1913
and that death occurred on the date stated above, at 1 P. M.
The CAUSE OF DEATH* was as follows:
Acute Mitral Regurgitation

(Duration) yrs. 3 mos. ds.
Contributory (Secondary)
(Duration) yrs. mos. ds.
(Signed) J. R. Ballard M. D.
Apr 29 1913 (Address) Drum, Ida

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place In the
of death yrs. mos. ds. State yrs. mos. ds.
Where was disease contracted,
If not at place of death?
Former or
usual residence.....

19. PLACE OF BURIAL OR REMOVAL Drum Mission DATE OF BURIAL Apr 29 1913
20. UNDERTAKER None ADDRESS

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Form V. S. No. 5. 12½ M. 7-24-11

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics
File No. 4829
Registered No. 265

1. PLACE OF DEATH. Registration District No. 14
County of Kootenai Primary Registration District No. 1003
City of Coeur d'Alene (No. _____ St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

John J. Nevens.

If death occurred in a hospital, institution or camp give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX 4. COLOR OR RACE 5. SINGLE, MARRIED, WIDOWED OR DIVORCED.

Male White Single
(Write the word.)

6. DATE OF BIRTH

_____. (Month) _____. (Day) _____. (Year)

7. AGE

38 yrs. _____. mos. _____. ds.

IF LESS than 1 day
how many _____ hrs. or
_____ min?

8. OCCUPATION

(a) Trade, profession or particular kind of work.
(b) General nature of industry business or establishment in which employed (or employer)

Bar tender

9. BIRTHPLACE

(State or Country)

Mo.

10. NAME OF FATHER

Nevens

11. BIRTHPLACE OF FATHER

(State or Country)

Ireland

12. MAIDEN NAME OF MOTHER

13. BIRTHPLACE OF MOTHER

(State or Country)

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

John J. Nevens
(Address) 414 Sprague and
Spokane Wash

15.

Filed

5/10 1913

J. D. Newman
Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH

April 1st 1913
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from

March 23 1913, to March 31 1913

that I last saw him alive on March 31 1913

and that death occurred on the date stated above, at 3:25 A. M.

The CAUSE OF DEATH* was as follows:

Delirium potatorum

_____. (Duration) _____. yrs. _____. mos. _____. ds.

Contributory Chronic Alcoholism
(Secondary)

_____. (Duration) _____. yrs. _____. mos. _____. ds.

(Signed) W. H. Halden M. D.

Apr. 4 1913 (Address) Coeur d'Alene

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place _____ In the _____
of death _____ yrs. _____. mos. _____. ds. State _____ yrs. _____. mos. _____. ds.

Where was disease contracted,

If not at place of death?

Former or

usual residence

19. PLACE OF BURIAL OR REMOVAL DATE OF BURIAL

St Louis Missouri 1913

20. UNDERTAKER

ADDRESS

Cassedy & Nelson Coeur d'Alene

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Form V. S. No. 5 20M.1-16-12

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH.

Registration District No. 12County of IdahoPrimary Registration District No. 1003City of Manzanilla

(No. _____, St.)

File No. 1581Registered No. 266

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Roy M. Adey

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX

male

4. COLOR OR RACE

white

5. SINGLE, MARRIED, WIDOWED OR DIVORCED.

single
(Write the word.)

6. DATE OF BIRTH

7/10 2 1911
(Month) (Day) (Year)

7. AGE

1 yrs. 6 mos. ds.IF LESS than 1 day
how many _____ hrs. or
_____ mins.?

8. OCCUPATION

(a) Trade, profession or particular kind of work

(b) General nature of industry business, or establishment in which employed (or employer)

9. BIRTHPLACE

(State or Country)

Idaho

10. NAME OF FATHER

Henry Adey

11. BIRTHPLACE OF FATHER

(State or Country)

Missouri

12. MAIDEN NAME OF MOTHER

Edna Henry

13. BIRTHPLACE OF MOTHER

(State or Country)

Missouri

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Edna

(Address) _____

15.

Filed 8/101913L. A. Adams
Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH

4 21 1913
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from

191, to 191,that I last saw h. alive on 191,and that death occurred on the date stated above, at M.

The CAUSE OF DEATH* was as follows:

Whooping Cough (?)(Duration) 3 yrs. 2 mos. ds.Contributory worms.
(Secondary)(Duration) 3 yrs. 2 mos. ds.(Signed) [Signature] M. D.4/3 1913 (Address) C. D. C.

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death. 3 yrs. 2 mos. ds. In the State. 3 yrs. 2 mos. ds.

Where was disease contracted if not at place of death? _____

Former or usual residence. _____

19. PLACE OF BURIAL OR REMOVAL

Trust

DATE OF BURIAL

Apr 21 1913

20. UNDERTAKER

[Signature]

ADDRESS

C. D. C.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
 N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Form V. S. No. 5 20M.1-16-12

CERTIFICATE OF DEATH

 State of Idaho
 BUREAU OF HEALTH
 Bureau of Vital Statistics

1. PLACE OF DEATH.

Registration District No. 12County of KootenaiPrimary Registration District No. 10 & 3City of Conrad

(No. _____, St.)

File No. 1531Registered No. 267

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

Eliza Pond

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX

Female

4. COLOR OR RACE

White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED.

Widow
(Write the word.)

6. DATE OF BIRTH

1835

(Month)

(Day)

(Year)

7. AGE

78 yrs.

mos.

ds.

 IF LESS than 1 day
 how many _____ hrs. or
 _____ mins.?

8. OCCUPATION

(a) Trade, profession or particular kind of work

(b) General nature of industry, business, or establishment in which employed (or employer)

9. BIRTHPLACE

(State or Country)

England

10. NAME OF FATHER

11. BIRTHPLACE OF FATHER

(State or Country)

12. MAIDEN NAME OF MOTHER

13. BIRTHPLACE OF MOTHER

(State or Country)

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

(Address)

J. A. Spaulding903 Sherman St

15.

Filed

15/101913

Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH

April81913

(Month)

(Day)

(Year)

17. I HEREBY CERTIFY, That I attended deceased from

April 24 1913, to April 8 1913.that I last saw him alive on April 8 1913.and that death occurred on the date stated above, at 7 A. M.

The CAUSE OF DEATH* was as follows:

Nephritis (Chronic Interstitial)

(Duration)

yrs.

mos.

ds.

Contributory (Secondary)

Chronic Bronchitis

(Duration)

yrs.

mos.

ds.

(Signed)

4/8 1913 (Address) J. O. Dwyer M. D.
Conrad Idaho

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death _____ yrs. _____ mos. _____ days.

In the State _____ yrs. _____ mos. _____ days.

Where was disease contracted if not at place of death? _____

Former or usual residence _____

19. PLACE OF BURIAL OR REMOVAL

Funeral home

DATE OF BURIAL

April 9 1913

20. UNDERTAKER

J. J. Dwyer

ADDRESS

Conrad

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Form V. S. No. 5 20M.1-16-12

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH.

Registration District No. 1County of ButtePrimary Registration District No. 2057City of Butte(No. 1)

St.)

File No. 4832Registered No. 268

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Leslie A. Berry

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX M4. COLOR OR RACE W5. SINGLE, MARRIED, WIDOWED OR DIVORCED. Married
(Write the word.)6. DATE OF BIRTH Jan 14 1840
(Month) (Day) (Year)7. AGE 73 yrs. 2 mos. 27 ds.

IF LESS than 1 day
how many hrs. or
..... mins.?

8. OCCUPATION

(a) Trade, profession or particular kind of work Farmer

(b) General nature of industry, business, or establishment in which employed (or employer)

9. BIRTHPLACE

(State or Country) Conn.10. NAME OF FATHER Leslie Berry

11. BIRTHPLACE OF FATHER

(State or Country)

12. MAIDEN NAME OF MOTHER Curtis

13. BIRTHPLACE OF MOTHER

(State or Country)

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Leslie Berry(Address) Leslie Berry

15.

Filed 5/10 19131913

Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH April 10 1913
(Month) (Day) (Year)17. I HEREBY CERTIFY, That I attended deceased from 191 to 191that I last saw him alive on Apr 10 1913and that death occurred on the date stated above, at 12 PM.

The CAUSE OF DEATH* was as follows:

Mitral Stenosis with
Attending Dropsy

(Duration) 4 yrs. 0 mos. 0 ds.

Contributory

(Secondary)

(Duration) 4 yrs. 0 mos. 0 ds.(Signed) D. H. Druryan M. D.4/12 1913 (Address) Butte, Idaho

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death yrs. mos. days. In the State yrs. mos. days.

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL ButteDATE OF BURIAL 4/13 191320. UNDERTAKER RobertsonADDRESS Butte

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Form V. S. No. 5 20M.1-16-12

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH.

Registration District No. 12County of LatahPrimary Registration District No. 1003City of Laurens(No. Suburban St.)File No. 4832Registered No. 2464

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

Ernest Blumberg

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX

male

4. COLOR OR RACE

white

5. SINGLE, MARRIED, WIDOWED OR DIVORCED.

single
(Write the word.)

6. DATE OF BIRTH

191311 (Month) 21 (Day) (Year)

7. AGE

1 yrs. 21 mos. 21 ds.IF LESS than 1 day
how many hrs. or
mins.

8. OCCUPATION

(a) Trade, profession or particular kind of work

(b) General nature of industry business, or establishment in which employed (or employer)

9. BIRTHPLACE

(State or Country)

Laurens Idaho

10. NAME OF FATHER

Ernest Blumberg

11. BIRTHPLACE OF FATHER

(State or Country)

Mich

12. MAIDEN NAME OF MOTHER

Ruby Frank

13. BIRTHPLACE OF MOTHER

(State or Country)

Mich

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

Ernest

(Address)

Laurens Idaho

15.

Filed

5/101913Ernest Blumberg

Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH

April121913

(Month)

(Day)

(Year)

17. I HEREBY CERTIFY, That I attended deceased from

Apr. 111913, to111913that I last saw him alive on Apr 11 1913and that death occurred on the date stated above, at 49 M.

The CAUSE OF DEATH* was as follows:

Pneumonia(Duration) 2 yrs. 2 mos. 2 ds.Contributory
(Secondary)(Duration) 2 yrs. 2 mos. 2 ds.

(Signed)

4/12/13

(Address)

Ernest Blumberg, Idaho

M. D.

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place

of death.

yrs.

mos.

days.

In the

State.

yrs.

mos.

days.

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL

Laurens Idaho

DATE OF BURIAL

Apr 13 1913

20. UNDERTAKER

Ernest Blumberg

ADDRESS

C. W. A.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Form V. S. No. 5. (2-14-11)

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics
File No. **4834**
Registered No. **270**

1. PLACE OF DEATH. Registration District No. **112**
County of **Kootenai** Primary Registration District No. **2051**
City of **Pathtown** (No. _____, St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

William Wesley Cisco

If death occurred in a hospital, institution or camp give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX **male** 4. COLOR OR RACE **white** 5. SINGLE, MARRIED, WIDOWED OR DIVORCED. **married**
(Write the word.)

6. DATE OF BIRTH **Feb. 15, 1893**
(Month) (Day) (Year)

7. AGE **80** yrs. **2** mos. **-** ds. IF LESS than 1 day
how many hrs. or
..... min?

8. OCCUPATION

- (a) Trade, profession or particular kind of work
(b) General nature of industry business or establishment in which employed (or employer)

farmer

9. BIRTHPLACE
(State or Country)

Id.

10. NAME OF FATHER

11. BIRTHPLACE OF FATHER
(State or Country)

12. MAIDEN NAME OF MOTHER

13. BIRTHPLACE OF MOTHER
(State or Country)

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) **Engene Cisco**
(Address) **Garwood - Ida.**

15.

Filed **7/16** 191**3** **L. J. Schuman**
Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH

April 15, 1913
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from **Apr. 5, 1913**, to **Apr. 15, 1913**
that I last saw him alive on **Apr. 12, 1913**
and that death occurred on the date stated above, at **12** M.
The CAUSE OF DEATH* was as follows:

Hemiplegia due to Cerebral Hemorrhage

(Duration) yrs. mos. **3** ds.
Contributory **Acute Bronchitis**
(Secondary) **& old age**
(Duration) yrs. mos. **16** ds.
(Signed) **Frank M. D.**
4/15, 1913 (Address) **Pathtown, Ida.**

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place yrs. mos. ds. In the
of death yrs. mos. ds. State yrs. mos. ds.
Where was disease contracted,
If not at place of death?
Former or
usual residence.

19. PLACE OF BURIAL OR REMOVAL DATE OF BURIAL

Pathtown **4/16 1913**

20. UNDERTAKER ADDRESS

Rabo & Son **Pathtown**

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Form V. S. No. 5. 1214 M. 7-24-11

CERTIFICATE OF DEATH

State of Idaho

BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH.
County of Boolemai
City of Coeur D'Alene

Registration District No. 12
Primary Registration District No. 1053
(No. _____, _____ St.)

File No. 1933
Registered No. 271

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

Infant Cooper

If death occurred in a hospital, institution or camp give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX Male 4. COLOR OR RACE White 5. SINGLE, MARRIED, WIDOWED OR DIVORCED.
(Write the word.)

6. DATE OF BIRTH Apr 16 1913
(Month) (Day) (Year)

7. AGE _____ yrs. _____ mos. _____ ds. IF LESS than 1 day
how many _____ hrs. or _____ min?

8. OCCUPATION

(a) Trade, profession or particular kind of work. ✓
(b) General nature of industry business or establishment in which employed (or employer)

9. BIRTHPLACE
(State or Country)

Coeur D'Alene

10. NAME OF FATHER Frank Cooper

11. BIRTHPLACE OF FATHER
(State or Country) Oregon

12. MAIDEN NAME OF MOTHER Dora Libbie

13. BIRTHPLACE OF MOTHER
(State or Country) Canada

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Frank Cooper
(Address) _____

15. Filed 570 1913 S. H. Greenman
Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH April 16 1913
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from ✓ 1913, to ✓ 1913

that I last saw him alive on April 15 1913
and that death occurred on the date stated above, at 9⁴⁵ M.

The CAUSE OF DEATH* was as follows:

Premature Birth

(Duration) _____ yrs. _____ mos. _____ ds.

Contributory
(Secondary)

(Duration) ✓ yrs. ✓ mos. ✓ ds.

(Signed) W. H. Hoeden M. D.
April 16 1913 (Address) Coeur D'Alene

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place _____ In the _____
of death _____ yrs. _____ mos. _____ ds. State _____ yrs. _____ mos. _____ ds.
Where was disease contracted,
If not at place of death?
Former or
usual residence _____

19. PLACE OF BURIAL OR REMOVAL Forest Corn DATE OF BURIAL Apr 16 1913

20. UNDERTAKER Carsedy & Nelson ADDRESS Coeur D'Alene

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Form V. S. No. 5. 12½ M. 7-24-11

CERTIFICATE OF DEATH

1. PLACE OF DEATH.
County of *Bozeman*
City of *Corvus D'Alene*

Registration District No. *12*
Primary Registration District No. *1003*
(No. _____ St.)

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics
File No. *48351*
Registered No. *372*

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME *Sarah A. McClelland*

If death occurred in a hospital, institution or camp give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX *Female* 4. COLOR OR RACE *White* 5. SINGLE, MARRIED, WIDOWED OR DIVORCED. *Married*
(Write the word.)

6. DATE OF BIRTH *March 11 1899*
(Month) (Day) (Year)

7. AGE *74* yrs. *1* mos. *6* ds. IF LESS than 1 day how many _____ hrs. or _____ min?

8. OCCUPATION
(a) Trade, profession or particular kind of work. *House wife*
(b) General nature of industry business or establishment in which employed (or employer)

9. BIRTHPLACE
(State or Country) *Ohio*

10. NAME OF FATHER *James White*

11. BIRTHPLACE OF FATHER
(State or Country) *Penn.*

12. MAIDEN NAME OF MOTHER *Elizabeth Willison*

13. BIRTHPLACE OF MOTHER
(State or Country) *Penn*

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) *J. B. McClelland*
(Address) *634 + Elm st. Corvus D'Alene*

15. Filed *5/10* 191*3* *J. B. McClelland*
Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH *April 17* 191*3*
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from *April 16* 191*3*, to *April 17* 191*3*
that I last saw her alive on *April 16* 191*3*
and that death occurred on the date stated above, at *8 A. M.*
The CAUSE OF DEATH* was as follows:

Heart disease

(Duration) *8* yrs. *—* mos. *—* ds.

Contributory (Secondary)

(Duration) *—* yrs. *—* mos. *—* ds.

(Signed) *W. H. Holden* M. D.
April 17 191*3* (Address) *Corvus D'Alene, Ida*

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place _____ In the _____
of death _____ yrs. _____ mos. _____ ds. State _____ yrs. _____ mos. _____ ds.
Where was disease contracted,
If not at place of death? _____
Former or
usual residence _____

19. PLACE OF BURIAL OR REMOVAL *Forest Cem.* DATE OF BURIAL *Apr. 19* 191*3*

20. UNDERTAKER *Cassidy & Nelson* ADDRESS *Corvus D'Alene*

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Form V. S. No. 5. 12½ M. 7-24-11

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics
File No. 153
Registered No. 273

1. PLACE OF DEATH. Registration District No. 12
County of Booleman Primary Registration District No. 1003
City of Booleman (No. _____, St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

George E. Snyder

If death occurred in a hospital, institution or camp give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX 4. COLOR OR RACE 5. SINGLE, MARRIED, WIDOWED OR DIVORCED.

Male White Single
(Write the word.)

6. DATE OF BIRTH

Feb 11 1843
(Month) (Day) (Year)

7. AGE

68 yrs. 3 mos. 6 ds.

IF LESS than 1 day
how many _____ hrs. or
_____ min?

8. OCCUPATION

(a) Trade, profession or particular kind of work
(b) General nature of industry business or establishment in which employed (or employer)

Retired

9. BIRTHPLACE

(State or Country)

New York

10. NAME OF FATHER

Frederick Snyder

11. BIRTHPLACE OF FATHER

(State or Country)

New York

12. MAIDEN NAME OF MOTHER

J. Helmer

13. BIRTHPLACE OF MOTHER

(State or Country)

New York

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

(Address)

A. G. Fisher
Concord Avenue

15.

Filed

5/10 1913

J. H. Newman
Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH

April 17 1913
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from

191____, to 191____

that I last saw him alive on 191____

and that death occurred on the date stated above, at ____ M.

The CAUSE OF DEATH* was as follows:

Apoplexy

(Duration) ____ yrs. ____ mos. ____ ds.

Contributory
(Secondary)

(Duration) ____ yrs. ____ mos. ____ ds.

(Signed) J. H. Fisher M. D.

19 (Address) C. S. A.

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place In the
of death ____ yrs. ____ mos. ____ ds. State ____ yrs. ____ mos. ____ ds.

Where was disease contracted,

If not at place of death? _____

Former or

usual residence. _____

19. PLACE OF BURIAL OR REMOVAL DATE OF BURIAL

Forest Cem. Apr 18 1913

20. UNDERTAKER ADDRESS

Chas. E. & Son Boone D. Helmer

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Form V. S. No. 5. 12½M.7-24-11

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics
File No. 183
Registered No. 274

1. PLACE OF DEATH.

Registration District No. 14County of KootenaiPrimary Registration District No. 2017City of Rathdrum

(No. _____, _____ St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

Mary Frances Chandler

If death occurred in a hospital, institution or camp give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX

female

4. COLOR OR RACE

white

5. SINGLE, MARRIED, WIDOWED OR DIVORCED.

single
(Write the word.)

6. DATE OF BIRTH

Apr. 20. 1913
(Month) (Day) (Year)

7. AGE

1 yrs. 1 mos. 1 ds.

IF LESS than 1 day
how many 16 hrs. or
min?

8. OCCUPATION

(a) Trade, profession or particular kind of work.
(b) General nature of industry business or establishment in which employed (or employer)

None

9. BIRTHPLACE

(State or Country)

Rathdrum Ida.

10. NAME OF FATHER

Charles Chandler

11. BIRTHPLACE OF FATHER

(State or Country)

Minn.

12. MAIDEN NAME OF MOTHER

Julia Burrows

13. BIRTHPLACE OF MOTHER

(State or Country)

Wash.

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

Chas. Chandler

(Address)

Rathdrum Ida.

15.

Filed

Apr. 20. 1913 W. H. Brennan
Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH

Apr. 20. 1913
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from

Apr. 20. 1913, to Apr. 20. 1913that I last saw her alive on Apr. 20. 1913and that death occurred on the date stated above, at 11:25 M.

The CAUSE OF DEATH* was as follows:

Premature Birth(Duration) _____ yrs. _____ mos. 16 ds.

Contributory (Secondary)

(Duration) _____ yrs. _____ mos. _____ ds.

(Signed)

Frank H. M. D.4/21. 1913 (Address) Rathdrum

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place _____ In the _____

of death _____ yrs. _____ mos. _____ ds. State _____ yrs. _____ mos. _____ ds.

Where was disease contracted, _____

If not at place of death? _____

Former or usual residence _____

19. PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

Rathdrum 4/21. 1913

20. UNDERTAKER

ADDRESS

W. H. Brennan Rathdrum

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Form V. S. No. 5. 12½ M. 7-24-11

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics
File No. 1835
Registered No. 275

1. PLACE OF DEATH. Registration District No. 12
County of Bozeman Primary Registration District No. 1003
City of Cour D'Alene (No. _____, St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Edwin G. Cross

If death occurred in a hospital, institution or camp give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX Male 4. COLOR OR RACE White 5. SINGLE, MARRIED, WIDOWED OR DIVORCED. Married
(Write the word.)

6. DATE OF BIRTH Jan 1 1836
(Month) (Day) (Year)

7. AGE 77 yrs. 3 mos. 13 ds. IF LESS than 1 day
how many _____ hrs. or _____ min?

8. OCCUPATION

(a) Trade, profession or particular kind of work. Retired
(b) General nature of industry business or establishment in which employed (or employer) _____

9. BIRTHPLACE
(State or Country) New York

10. NAME OF FATHER Levy Cross

11. BIRTHPLACE OF FATHER
(State or Country) New York

12. MAIDEN NAME OF MOTHER Katherine Flint

13. BIRTHPLACE OF MOTHER
(State or Country) New York

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) E. M. Cross
(Address) 727-13 St.

15. Filed 5/10 1913 D. M. Muman
Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH April 18 1913
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from _____ 191____, to _____ 191____
that I last saw h_____ alive on _____ 191____

and that death occurred on the date stated above, at _____ M.

The CAUSE OF DEATH* was as follows:

Ulceration Stomach
Inaction

(Duration) _____ yrs. _____ mos. _____ ds.
Contributory Age
(Secondary)

(Duration) _____ yrs. _____ mos. _____ ds.
(Signed) D. M. Muman M. D.
4/14 1913 (Address) Rushmore

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place _____ In the _____
of death _____ yrs. _____ mos. _____ ds. State _____ yrs. _____ mos. _____ ds.
Where was disease contracted, _____
If not at place of death? _____
Former or _____
usual residence _____

19. PLACE OF BURIAL OR REMOVAL Forest Cem. DATE OF BURIAL Apr 15 1913
20. UNDERTAKER Cassedy & Nelson ADDRESS Cour D'Alene

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Form V. S. No. 5 20M.1-16-12

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH Registration District No. 12
County of Boone Primary Registration District No. 2057
City of Boone (No. 3 St.)

File No. 4840
Registered No. 276

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Margherite Battler

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX Female 4. COLOR OR RACE White 5. SINGLE, MARRIED, WIDOWED OR DIVORCED. Widowed

6. DATE OF BIRTH 76 years 6 months 1 day
(Month) (Day) (Year)

7. AGE 76 yrs. 6 mos. 14 ds. IF LESS than 1 day how many hrs. or mins.?

8. OCCUPATION

(a) Trade, profession or particular kind of work
(b) General nature of industry business, or establishment in which employed (or employer)

9. BIRTHPLACE

(State or Country) Tenn

10. NAME OF FATHER

11. BIRTHPLACE OF FATHER

(State or Country)

12. MAIDEN NAME OF MOTHER

13. BIRTHPLACE OF MOTHER

(State or Country)

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Mrs. Phillips

(Address) Boone, Tenn

15.

Filed 5/10 1912 Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH April 28th 1913
(Month) (Day) (Year)

I HEREBY CERTIFY, That I attended deceased from Apr. 23 1913, to Apr. 28 1913, that I last saw her alive on Apr. 27 1913, and that death occurred on the date stated above, at 4 P.M.

The CAUSE OF DEATH* was as follows:

Acute Capillary Bronchitis

(Duration) yrs. mos. 5 ds.
Contributory Old age
(Secondary)

(Duration) yrs. mos. ds.
(Signed) Frank H. Hays M. D.
4/28 1913 (Address) Boone, Tenn

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death yrs. mos. days. In the State yrs. mos. days.

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL DATE OF BURIAL

Boone, Tenn Apr. 29 1913
20. UNDERTAKER C. E. B. Co. ADDRESS Boone, Tenn

Form V. S. No. 5 20M.1-16-12

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH

Registration District No. 12County of JeffersonPrimary Registration District No. 2057City of Prater

(No. _____, _____ St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME _____

File No. 4841Registered No. 277

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX

4. COLOR OR RACE

5. SINGLE, MARRIED, WIDOWED OR DIVORCED.

(Write the word.)

6. DATE OF BIRTH

Apr 28 13
(Month) (Day) (Year)

7. AGE

_____ yrs. _____ mos. _____ ds.

IF LESS than 1 day
how many _____ hrs. or
_____ mins.?

8. OCCUPATION

(a) Trade, profession or particular kind of work

(b) General nature of industry, business, or establishment in which employed (or employer)

9. BIRTHPLACE

(State or Country)

10. NAME OF FATHER

11. BIRTHPLACE OF FATHER

(State or Country)

12. MAIDEN NAME OF MOTHER

13. BIRTHPLACE OF MOTHER

(State or Country)

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

(Address)

15.

Filed

1913

Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

Apr 28 1913
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from

Apr 28 1913 to Apr 28 1913that I last saw him alive on Apr 28 1913and that death occurred on the date stated above, at 7 P.M.

The CAUSE OF DEATH* was as follows:

Lack of developmentScars

(Duration) _____ yrs. _____ mos. _____ ds.

Contributory Birth

(Secondary)

(Duration) _____ yrs. _____ mos. _____ ds.

(Signed) J. D. Dwyer M. D.28/29 1913 (Address) Prater

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death _____ yrs. _____ mos. _____ days. In the State _____ yrs. _____ mos. _____ days.

Where was disease contracted if not at place of death?

Former or usual residence _____

19. PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

Prater 2/28 1913

20. UNDERTAKER

ADDRESS

Glady Prater

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Form V. S. No. 5. 12½ M. 7-24-11

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics
File No. 4842
Registered No. 25

1. PLACE OF DEATH. Registration District No. 11
County of Bannock Primary Registration District No. 2047
City of McCammon (No. _____ St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Caroline Glodde

If death occurred in a hospital, institution or camp give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX Female 4. COLOR OR RACE White 5. SINGLE, MARRIED, WIDOWED OR DIVORCED. Widowed
(Write the word.)

6. DATE OF BIRTH 2-7-1855
(Month) (Day) (Year)

7. AGE 57 yrs. 4 mos. 1 ds. IF LESS than 1 day how many _____ hrs. or _____ min?

8. OCCUPATION
(a) Trade, profession or particular kind of work. Housewife
(b) General nature of industry business or establishment in which employed (or employer) no occupation

9. BIRTHPLACE
(State or Country) Germany

10. NAME OF FATHER Martin Gust

11. BIRTHPLACE OF FATHER
(State or Country) Germany

12. MAIDEN NAME OF MOTHER Dora Brown

13. BIRTHPLACE OF MOTHER
(State or Country) Germany

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) W. H. Cooper
(Address) McCammon, Idaho

15. Filed May 19 1913 Elis. Karles
Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH 1-27-1913
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from _____ 1911, to _____ 1913
that I last saw her alive on Jan-19 1913
and that death occurred on the date stated above, at 4 P.M.
The CAUSE OF DEATH* was as follows:

Acute obstruction of Bowel

(Duration) _____ yrs. _____ mos. 13 ds.
Contributory (Secondary) _____
(Duration) _____ yrs. _____ mos. _____ ds.

(Signed) W. H. Cooper M. D.
Apr 19 1913 (Address) McCammon, Idaho

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place _____ In the _____
of death _____ yrs. _____ mos. _____ ds. State _____ yrs. _____ mos. _____ ds.
Where was disease contracted, _____
If not at place of death? _____
Former or _____
usual residence. _____

19. PLACE OF BURIAL OR REMOVAL DATE OF BURIAL

McCammon Jan 27 1913

20. UNDERTAKER ADDRESS

B. J. Deary Deary

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Form V. S. No. 5. 12½ M. 7-24-11

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics
File No. 4843
Registered No. 26

1. PLACE OF DEATH. Registration District No. 11
County of Bannock Primary Registration District No. 2047
City of McCall (No. _____ St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

Glenne Thorne

If death occurred in a hospital, institution or camp give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX Male 4. COLOR OR RACE White 5. SINGLE, MARRIED, WIDOWED OR DIVORCED. Single
(Write the word.)

6. DATE OF BIRTH Sept - 23 - 1891
(Month) (Day) (Year)

7. AGE 13 - yrs. 5 - mos. 22 - ds. IF LESS than 1 day how many hrs. or min?

8. OCCUPATION (a) Trade, profession or particular kind of work. (Child)
(b) General nature of industry business or establishment in which employed (or employer)

9. BIRTHPLACE (State or Country) Rockland, Ida.

10. NAME OF FATHER Isaac Thorne

11. BIRTHPLACE OF FATHER (State or Country) Mt. Pelier

12. MAIDEN NAME OF MOTHER Davis

13. BIRTHPLACE OF MOTHER (State or Country) Idaho

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE (Informant) Mrs Isaac Thorne
(Address) Empire, Ida.

15. Filed May 10, 1913 Elis. Barker
Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH 3 - 15 - 1913
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from 3/14 - 1913, to 3/15 - 1913 that I last saw h. in alive on 3/15 - 1913 and that death occurred on the date stated above, at 6:40 M.

The CAUSE OF DEATH* was as follows:

Brill's Pneumonia

(Duration) yrs. mos. 6 - ds.

Contributory (Secondary) (Duration) yrs. mos. ds.

(Signed) Dr. C. E. ... M. D. April 10 1913 (Address) McCall, Idaho

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death yrs. mos. ds. In the State yrs. mos. ds.
Where was disease contracted, If not at place of death?
Former or usual residence.

19. PLACE OF BURIAL OR REMOVAL DATE OF BURIAL Rockland, Ida. Mar. 6, 1913

20. UNDER ADDRESS W. H. Barker Rockland, Ida.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Form V. S. No. 5. 12½M. 7-24-11

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics
File No. 4844
Registered No. 4

1. PLACE OF DEATH. Registration District No. 11
County of Blaine Primary Registration District No. 2047
City of McCall (No. , St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

Isaac Thorn

If death occurred in a hospital, institution or camp give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX 4. COLOR OR RACE 5. SINGLE, MARRIED, WIDOWED OR DIVORCED.

Male - White Single (Write the word.)

6. DATE OF BIRTH

Oct - 30 1904
(Month) (Day) (Year)

7. AGE

8 yrs. 4 mos. 19 ds.

IF LESS than 1 day
how many hrs. or
..... min?

8. OCCUPATION

- (a) Trade, profession or particular kind of work.
(b) General nature of industry business or establishment in which employed (or employer)

Child =

9. BIRTHPLACE

(State or Country)

Pocatello - Ida.

10. NAME OF FATHER

Isaac Thorn

11. BIRTHPLACE OF FATHER

(State or Country)

Montpelier Idaho

12. MAIDEN NAME OF MOTHER

Alice Davis

13. BIRTHPLACE OF MOTHER

(State or Country)

Idaho

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Mrs Isaac Thorn
(Address) Carey, Idaho

15.

Filed May 10, 1913 Ellis Kasper
Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH

3 - 19 - 1913
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from

8-16-1913, to 3-19-1913

that I last saw him alive on 3-19-1913

and that death occurred on the date stated above, at 10:25 A.M.

The CAUSE OF DEATH* was as follows:

Bronchopneumonia

(Duration) yrs. mos. 3 ds.

Contributory

(Secondary)

Child (Duration) yrs. mos. ds.

(Signed) J. H. Carpenter M. D.

19 (Address) McCall Idaho

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place In the
of death yrs. mos. ds. State yrs. mos. ds.

Where was disease contracted,

If not at place of death?

Former or

usual residence.

19. PLACE OF BURIAL OR REMOVAL DATE OF BURIAL

Pocatello Ida. Mar 23 1913

20. UNDERTAKER

ADDRESS

W. W. Walker Penella

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Form V. S. No. 5. 12½ M. 7-24-11

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics
File No. 4845

1. PLACE OF DEATH. Registration District No. 11
County of Bonanza Primary Registration District No. 2047
City of McCall (No. , St.)

Registered No. 28

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

If death occurred in a hospital, institution or camp give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX 4. COLOR OR RACE 5. SINGLE, MARRIED, WIDOWED OR DIVORCED.

Female White Child (Write the word.)

6. DATE OF BIRTH May 19 1913
(Month) (Day) (Year)

7. AGE 6 yrs. 9 mos. 23 ds. IF LESS than 1 day how many hrs. or min?

8. OCCUPATION

- (a) Trade, profession or particular kind of work.
(b) General nature of industry, business or establishment in which employed (or employer)

(Child)

9. BIRTHPLACE Rockland Ide
(State or Country)

10. NAME OF FATHER Isaac Thorne

11. BIRTHPLACE OF FATHER Missoula Ide
(State or Country)

12. MAIDEN NAME OF MOTHER Davis

13. BIRTHPLACE OF MOTHER Wash
(State or Country)

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Mrs. Isaac Thorne
(Address) McCall

15. Filed May 10, 1913 Ellis Kay Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH 3-17-1913
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from 3/14-1913 to 3/17-1913 that I last saw him alive on 3/17-1913 and that death occurred on the date stated above, at P.M.

The CAUSE OF DEATH* was as follows:

Brain Pneumonia

(Duration) yrs. mos. 3 ds.

Contributory (Secondary)

(Duration) yrs. mos. ds.

(Signed) McCall D.
Apr 14, 1913 (Address)

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place In the
of death yrs. mos. ds. State yrs. mos. ds.
Where was disease contracted,
If not at place of death?
Former or
usual residence.

19. PLACE OF BURIAL OR REMOVAL DATE OF BURIAL

Rexford Wash 29, 1913

20. UNDERTAKER ADDRESS

W. W. Backer Samuels

Form V. S. No. 5 20M.1-16-12

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics
File No. 4846
Registered No. 22

1. PLACE OF DEATH.

Registration District No. 11

County of Bannock

Primary Registration District No. 2046

City of Village of Hooley

(No. _____, _____ St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

Not Named

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX

m

4. COLOR OR RACE

w

5. SINGLE, MARRIED, WIDOWED OR DIVORCED.

single
(Write the word.)

6. DATE OF BIRTH

Feb

24

1913

(Month)

(Day)

(Year)

7. AGE

1 yrs. 8 mos. 8 ds.

IF LESS than 1 day
how many _____ hrs. or
_____ mins.?

8. OCCUPATION

- (a) Trade, profession or particular kind of work
(b) General nature of industry business, or establishment in which employed (or employer)

9. BIRTHPLACE

(State or Country) Idaho

10. NAME OF FATHER

Chas. Sessions

11. BIRTHPLACE OF FATHER

(State or Country) Utah

12. MAIDEN NAME OF MOTHER

Walter Sessions Coffin

13. BIRTHPLACE OF MOTHER

(State or Country) Idaho

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Mrs. Chas. Sessions

(Address) Hooley, Idaho

15.

Filed May 10, 1913 Alvin Carey
Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH

April 2

1913

(Month)

(Day)

(Year)

17. I HEREBY CERTIFY, That I attended deceased from

April 1, 1913, to April 3, 1913,

that I last saw him alive on April 2, 1913

and that death occurred on the date stated above, at 3 A. M.

The CAUSE OF DEATH* was as follows:

Broncho pneumonia

(Duration) _____ yrs. _____ mos. 4 ds.

Contributory malnutrition
(Secondary)

(Duration) _____ yrs. one mos. _____ ds.

(Signed) Casper W. M. D.

Apr. 29/13 (Address) Hooley

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death _____ yrs. _____ mos. _____ days. In the State _____ yrs. _____ mos. _____ days.

Where was disease contracted if not at place of death?

Former or usual residence _____

19. PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

Hooley

April 4, 1913

20. UNDERTAKER

ADDRESS

C. E. Layton

Hooley

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Form V. S. No. 5 20M.1-16-12

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics
File No. 4847

1. PLACE OF DEATH.

Registration District No. 11

County of _____

Primary Registration District No. 2046

City of _____

(No. _____, St.)

Registered No. 30

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Lula May Crashe

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX

Female

4. COLOR OR RACE

White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED.

(Write the word.)

6. DATE OF BIRTH

Jan (Month)

4 (Day)

1898 (Year)

7. AGE

15 yrs. 5 mos. 9 ds.

IF LESS than 1 day how many 2 hrs. or 10 mins.?

8. OCCUPATION

(a) Trade, profession or particular kind of work

Home

(b) General nature of industry business, or establishment in which employed (or employer)

9. BIRTHPLACE

(State or Country)

Barnack

10. NAME OF FATHER

William E Crashe

11. BIRTHPLACE OF FATHER

(State or Country)

Barnack

12. MAIDEN NAME OF MOTHER

Effie D Fisher

13. BIRTHPLACE OF MOTHER

(State or Country)

Davis state

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

(Address) Water Hatch Oxford Idaho

15.

Filed

May 10 1933 Earl Ray

Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

May (Month)

14 (Day)

1913 (Year)

17. I HEREBY CERTIFY, That I attended deceased from May 11 1913, to May 14 1913, that I last saw her alive on May 14 1913, and that death occurred on the date stated above, at 3:10 P.M.

The CAUSE OF DEATH* was as follows:

Cerebral Sclerosis

(Duration) _____ yrs. _____ mos. _____ ds.

Contributory (Secondary)

(Duration) _____ yrs. _____ mos. _____ ds.

(Signed) J. C. North M. D.

May 9 1913 (Address) Signet, Ark

State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death 15 yrs. 9 mos. 10 days. In the State 15 yrs. 9 mos. 10 days.

Where was disease contracted if not at place of death?

Former or usual residence

Oxford

19. PLACE OF BURIAL OR REMOVAL DATE OF BURIAL

Oxford

May 16 1913

20. UNDERTAKER

B. J. Lewis

ADDRESS

Oxford

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Form V. S. No. 5 20M.1-16-12

CERTIFICATE OF DEATH

1. PLACE OF DEATH

County of Bannock

City of Downey

If death occurs away from usual residence, give facts called for under special information.

Registration District No. 11

Primary Registration District No. 2046

(No. _____ St.)

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

File No. 4848

Registered No. 37

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Ruth May Coffin

PERSONAL AND STATISTICAL PARTICULARS

3. SEX

Female

4. COLOR OR RACE

White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED.

(Write the word.)

6. DATE OF BIRTH

March 4 1913
(Month) (Day) (Year)

7. AGE

1 yrs. 12 mos. 12 ds.

IF LESS than 1 day
how many _____ hrs. or
_____ mins.?

8. OCCUPATION

- (a) Trade, profession or particular kind of work
(b) General nature of industry business, or establishment in which employed (or employer)

9. BIRTHPLACE

(State or Country) Idaho

10. NAME OF FATHER

Daniel Coffin

11. BIRTHPLACE OF FATHER

(State or Country) Idaho

12. MAIDEN NAME OF MOTHER

Jella Pine

13. BIRTHPLACE OF MOTHER

(State or Country) Kansas

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Mrs Daniel Coffin

(Address) Downey

15.

Filed May 14 1913 E. E. Keady

Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

April 16 1913
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from

April 15 1913 to April 16 1913

that I last saw her alive on 11/6 apr 1913

and that death occurred on the date stated above, at 4 P.M.

The CAUSE OF DEATH* was as follows:

Pneumonia

(Duration) 3 yrs. 5 mos. 5 ds.

Contributory
(Secondary)

(Duration) _____ yrs. _____ mos. _____ ds.

(Signed) Caeser W. M. D.

Apr 19 1913 (Address) Downey Idaho

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death _____ yrs. _____ mos. _____ days. In the State _____ yrs. _____ mos. _____ days.

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

Downey 1913

20. UNDERTAKER

ADDRESS

C. E. Rayton Downey

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Form V. S. No. 5 20M.1-16-12

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH.

Registration District No. 11County of BlainePrimary Registration District No. 2048City of Central(No.)

St.)

File No. 4849Registered No. 21

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Bertha Qualman

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX F4. COLOR OR RACE W5. SINGLE, MARRIED, WID-
OWED OR DIVORCED.single
(Write the word.)

6. DATE OF BIRTH

Mar281911

(Month)

(Day)

(Year)

7. AGE

2 yrs.mos. 28 ds.IF LESS than 1 day
how many hrs. or
..... mins.?

8. OCCUPATION

(a) Trade, profession or
particular kind of worknone(b) General nature of industry
business, or establishment in
which employed (or employer)

9. BIRTHPLACE

(State or Country)

Idaho10. NAME OF
FATHERJohn Qualman11. BIRTHPLACE
OF FATHER

1. **PLACE OF DEATH.**
 County of Danmark
 City of Central

Registration District No. 11
 Primary Registration District No. 2048
 (No. _____, _____ St.)

Bureau of Vital Statistics
 File No. 4850
 Registered No. 23

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

Annie Alpha Anderson

If death occurred in a hospital, institution or camp give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX f 4. COLOR OR RACE w 5. SINGLE, MARRIED, WIDOWED OR DIVORCED.
married
 (Write the word.)

6. DATE OF BIRTH Nov 19 1884
 (Month) (Day) (Year)

7. AGE 28 yrs 4 mos 3 ds IF LESS than 1 day
 how many _____ hrs. or _____ min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work Wife
 (b) General nature of industry business or establishment in which employed (or employer)

9. BIRTHPLACE

(State or Country) Utah

10. NAME OF FATHER

Anders G. Anderson

11. BIRTHPLACE OF FATHER

(State or Country) Sweden

12. MAIDEN NAME OF MOTHER

Hedda Romlin

13. BIRTHPLACE OF MOTHER

(State or Country) Sweden

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Mrs. August Sanders
1 Bancroft St. Ida
 (Address)

15.

Filed May 19 1913 E. C. K. Carey
 Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH Mar 22 1913
 (Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from Jan 28 1913, to Mar 19 1913, that I last saw h alive on Mar 19 1913, and that death occurred on the date stated above, at 6 a M.

The CAUSE OF DEATH* was as follows:

Acute Bright's
 (Duration) _____ yrs. _____ mos. _____ ds.

Contributory (Secondary)

(Signed) Russell J. Smith M.D.
Apr 17 1913 (Address) 1 Bancroft St. Ida

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state 1) MEANS OF INJURY; and 2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death _____ yrs. _____ mos. _____ ds. In the State _____ yrs. _____ mos. _____ ds.
 Where was disease contracted, If not at place of death?
 Former or usual residence.

19. PLACE OF BURIAL OR REMOVAL

Central

DATE OF BURIAL

Mar 24 1913

20. UNDERTAKER

J. J. Jorgensen

ADDRESS

Central

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Form V. S. No. 5. 10M. 6-20-11.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH.

Registration District No. 11County of BannockPrimary Registration District No. 2048City of Land, Ida(No. George O. Spackman St.)File No. 4851Registered No. 24

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

George O. Spackman

If death occurred in a hospital, institution or camp give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX

m

4. COLOR OR RACE

w

5. SINGLE, MARRIED, WIDOWED OR DIVORCED.

married

(Write the word.)

6. DATE OF BIRTH

Apr

(Month)

5

(Day)

1889

(Year)

7. AGE

24

yrs.

mos.

3

ds.

IF LESS than 1 day

how many hrs. or min.

8. OCCUPATION

(a) Trade, profession or particular kind of work

Farming

(b) General nature of industry business, or establishment in which employed (or employer)

9. BIRTHPLACE

(State or Country)

Utah

10. NAME OF FATHER

Brigham Spackman

11. BIRTHPLACE OF FATHER

(State or Country)

England

12. MAIDEN NAME OF MOTHER

Laura Pitkin

13. BIRTHPLACE OF MOTHER

(State or Country)

Utah

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

Wm. G. Spackman

(Address)

Bannock Co. Ida

15.

Filed

May 10, 1913Oleis Kury

Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

Apr

(Month)

8

(Day)

1913

(Year)

17. I HEREBY CERTIFY, That I attended deceased from

Apr 31 1913, to Apr 7 1913that I last saw him alive on Apr 7 1913and that death occurred on the date stated above, at 1:45 A. M.

The CAUSE OF DEATH* was as follows:

Pneumonia lobar double(Duration) 10 yrs. 10 mos. 10 ds.

Contributory (Secondary)

(Duration) 10 yrs. 10 mos. 10 ds.(Signed) Russell J. Smith M. D.Apr 12 1913 (Address) Bannock Co. Ida

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death. 10 yrs. 10 mos. 10 ds. State. 10 yrs. 10 mos. 10 ds.

Where was disease contracted.

If not at place of death?

Former or

usual residence.

19. PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

LandApr 19, 1913

20. UNDERTAKER

ADDRESS

Geo. FisherBannock

MARGIN RESERVED FOR BINDING
WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Form V. S. No. 5 20M.1-16-12

CERTIFICATE OF DEATH

1. PLACE OF DEATH.

Registration District No. _____

County of Bannock

Primary Registration District No. 2048

City of Soda Springs

(No. _____)

St. _____

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

Laura Marie Roberts

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics
File No. 4852

Registered No. 19

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX

4. COLOR OR RACE

5. SINGLE, MARRIED, WIDOWED OR DIVORCED.

Female

White

Married

6. DATE OF BIRTH

Nov

9

1892

(Month)

(Day)

(Year)

7. AGE

20 yrs. 6 mos. — ds.

IF LESS than 1 day
how many _____ hrs. or
_____ mins.?

8. OCCUPATION

(a) Trade, profession or particular kind of work

Housewife

(b) General nature of industry business, or establishment in which employed (or employer)

9. BIRTHPLACE

(State or Country)

Bannock Co. Ida

10. NAME OF FATHER

Frank Warner

11. BIRTHPLACE OF FATHER

(State or Country)

Germany

12. MAIDEN NAME OF MOTHER

Cordelia Gay

13. BIRTHPLACE OF MOTHER

(State or Country)

Wyoming

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

John Henry Roberts

(Address)

Soda Springs

15.

Filed

May 10, 1913

E. C. Casley
Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH

May

9

1913

(Month)

(Day)

(Year)

17. I HEREBY CERTIFY, That I attended deceased from

May 1, 1913, to May 9, 1913

that I last saw him alive on May 9, 1913

and that death occurred on the date stated above, at 3 P.M.

The CAUSE OF DEATH* was as follows:

Purpural Infection

(Duration) _____ yrs. _____ mos. 9 ds.

Contributory
(Secondary)

None

(Duration) _____ yrs. _____ mos. _____ ds.

(Signed)

E. C. Casley M. D.

May 10, 1913 (Address) Soda Springs

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death _____ yrs. _____ mos. _____ days. In the State _____ yrs. _____ mos. _____ days.

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL DATE OF BURIAL

Deerley

May 10, 1913

20. UNDERTAKER

ADDRESS

Ray Russell Dr. C. C. Dr. C. C.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Form V. S. No. 5. 12½ M. 7-24-11

CERTIFICATE OF DEATH

1. PLACE OF DEATH.
County of Grogh
City of D Hamor

Registration District No. 30
Primary Registration District No. 2123
(No. _____ St.)

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics
File No. 4552
Registered No. _____

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

Frank Kunitomo

If death occurred in a hospital, institution or camp give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX Male 4. COLOR OR RACE Mongolian 5. SINGLE, MARRIED, WIDOWED OR DIVORCED. Do not know
(Write the word.)

6. DATE OF BIRTH _____
(Month) (Day) (Year) 1879

7. AGE 34 yrs. _____ mos. _____ ds.
IF LESS than 1 day how many _____ hrs. or _____ min?

8. OCCUPATION
(a) Trade, profession or particular kind of work. Domestic Cook
(b) General nature of industry business or establishment in which employed (or employer)

9. BIRTHPLACE
(State or Country) Japan

10. NAME OF FATHER
Japan

11. BIRTHPLACE OF FATHER
(State or Country) Japan

12. MAIDEN NAME OF MOTHER

13. BIRTHPLACE OF MOTHER
(State or Country) Japan

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) H. H. Bonnell
(Address) D Hamor Idaho

15. Filed Mar 18 1913 J. D. Famer
Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH March 11 1913
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from _____ 191____, to _____ 191____
that I last saw h. _____ alive on _____ 191____
and that death occurred on the date stated above, at _____ M.

The CAUSE OF DEATH* was as follows:

Exhaustion from exposure to ice in snow. Laid out 2 months before found
(Duration) _____ yrs. _____ mos. _____ ds.

Contributory (Secondary) _____
(Duration) _____ yrs. _____ mos. _____ ds.

(Signed) J. D. Famer M. D.
May 13 1913 (Address) D Hamor Idaho

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place _____ In the _____
of death _____ yrs. _____ mos. _____ ds. State _____ yrs. _____ mos. _____ ds.
Where was disease contracted, _____
If not at place of death? _____
Former or _____
usual residence _____

19. PLACE OF BURIAL OR REMOVAL DATE OF BURIAL

By The Big Eye May 17 1913

20. UNDERTAKER ADDRESS

John Route Shelby City

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

35

Form V. S. No. 5. 12½M.7-24-11

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics
File No. 4854
Registered No. 2

1. PLACE OF DEATH. Registration District No. 30
County of Cwyher Primary Registration District No. 2123
City of Delamar (No. , St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

John Horv

If death occurred in a hospital, institution or camp give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX Male 4. COLOR OR RACE White 5. SINGLE, MARRIED, WIDOWED OR DIVORCED. Married
(Write the word.)

6. DATE OF BIRTH Jan 19 1873
(Month) (Day) (Year)

7. AGE 40 yrs. 3 mos. 27 ds. IF LESS than 1 day how many hrs. or min?

8. OCCUPATION
(a) Trade, profession or particular kind of work. Living Man
(b) General nature of industry business or establishment in which employed (or employer)

9. BIRTHPLACE
(State or Country) Cornwall Eng.

10. NAME OF FATHER James Horv

11. BIRTHPLACE OF FATHER Cornwall Eng.
(State or Country)

12. MAIDEN NAME OF MOTHER Amelia Hooper.

13. BIRTHPLACE OF MOTHER Cornwall England
(State or Country)

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) James H. Horv Jr.
(Address) Delamar

15. Filed May 18 1913 T. D. Farrer
Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH May 16 1913
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from Nov 26 1912, to May 16 1913
that I last saw him alive on May 16 1913
and that death occurred on the date stated above, at 8 P. M.
The CAUSE OF DEATH* was as follows:
Ascho -

(Duration) yrs. 5 mos. 15 ds.
Contributory Ascho -
(Secondary)

(Duration) yrs. 5 mos. 15 ds.
(Signed) T. D. Farrer M. D.
May 18 1913 (Address) Delamar

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place In the
of death yrs. mos. ds. State yrs. mos. ds.
Where was disease contracted,
If not at place of death?
Former or usual residence.

19. PLACE OF BURIAL OR REMOVAL DATE OF BURIAL
I.O.O.F. Cemetery May 18 1913
20. UNDERTAKER ADDRESS
John. Route. Silver City

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Form V. S. No. 5. 12½ M. 7-24-11

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics
File No. **4855**
Registered No. **26**

1. PLACE OF DEATH
County of Washington
City of Weiser
Registration District No. 26
Primary Registration District No. 1010
(No. _____ St. _____)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

Elizabeth Nash

If death occurred in a hospital, institution or camp give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX Female 4. COLOR OR RACE Wht 5. SINGLE, MARRIED, WIDOWED OR DIVORCED. married
(Writes the word.)

6. DATE OF BIRTH June 24 1885
(Month) (Day) (Year)

7. AGE 77 yrs. 9 mos. 8 ds. IF LESS than 1 day how many _____ hrs. or _____ min?

8. OCCUPATION

(a) Trade, profession or particular kind of work. Housewife
(b) General nature of industry business or establishment in which employed (or employer)

9. BIRTHPLACE

(State or Country) No Carolina

10. NAME OF FATHER

Mr. R. Knox

11. BIRTHPLACE OF FATHER

(State or Country) No Carolina

12. MAIDEN NAME OF MOTHER

Jella Foster

13. BIRTHPLACE OF MOTHER

(State or Country) No Carolina

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Mrs. Elisha Swisher

(Address) Indian Valley, Ida

15.

Filed April 3rd 1913

W. R. Hamblin
Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

April 2nd 1913
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from December 1912, to April 2nd 1913

that I last saw her alive on April 2nd 1913
and that death occurred on the date stated above, at 1:30 P.M.

The CAUSE OF DEATH* was as follows:

Chronic Intestinal Disruption

(Duration) Several yrs. _____ mos. _____ ds.

Contributory (Secondary)

(Duration) _____ yrs. _____ mos. _____ ds.

(Signed) Dr. R. Hamblin M. D.

April 3rd 1913 (Address) Weiser, Ida

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; (2) whether ACCIDENTAL, SUICIDAL OR HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place _____ In the _____
of death _____ yrs. _____ mos. _____ ds. State _____ yrs. _____ mos. _____ ds.

Where was disease contracted,

If not at place of death?

Former or

usual residence

19. PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

Eagle Valley, Ave

1913

20. UNDERTAKER

ADDRESS

L. C. Northam

Weiser, Ida

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Form V. S. No. 5. 12½ M. 7-24-11

CERTIFICATE OF DEATH

1. PLACE OF DEATH.
County of Washington
City of Wenatchee

Registration District No. 26
Primary Registration District No. 2112
(No. _____, St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Herman Bernard Ropien

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics
File No. 4856
Registered No. 27

If death occurred in a hospital, institution or camp give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX Male 4. COLOR OR RACE Wht 5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.)

6. DATE OF BIRTH April 18 1911
(Month) (Day) (Year)

7. AGE 1 yrs. 11 mos. 18 ds. IF LESS than 1 day how many _____ hrs. or _____ min?

8. OCCUPATION
(a) Trade, profession or particular kind of work.
(b) General nature of industry business or establishment in which employed (or employer)

9. BIRTHPLACE Weiser
(State or Country)

10. NAME OF FATHER Bern Ropien

11. BIRTHPLACE OF FATHER Germany
(State or Country)

12. MAIDEN NAME OF MOTHER Irma Miller

13. BIRTHPLACE OF MOTHER Prussia
(State or Country)

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Bern Ropien
(Address) Weiser, Ida

15. Filed April 7 1913 W. B. Haevel
Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH April 6th 1913
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from _____ 191____, to _____ 191____ that I last saw h _____ alive on _____ 191____ and that death occurred on the date stated above, at _____ M.

The CAUSE OF DEATH was as follows:
was found dead in bed

_____ (Duration) _____ yrs. _____ mos. _____ ds.

Contributory (Secondary) _____

_____ (Duration) _____ yrs. _____ mos. _____ ds.

(Signed) James J. McCann
_____ 19____ (Address)

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place _____ In the _____
of death _____ yrs. _____ mos. _____ ds. State _____ yrs. _____ mos. _____ ds.
Where was disease contracted, _____
If not at place of death? _____
Former or _____
usual residence _____

19. PLACE OF BURIAL OR REMOVAL DATE OF BURIAL

Weiser April 7 1913
20. UNDERTAKER ADDRESS
L. B. Northman Weiser, Ida

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Form V. S. No. 5. 12½M.7-24-11

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH. Registration District No. 26
County of Washington Primary Registration District No. 1010
City of Wilder (No. _____, St.)

File No. 185
Registered No. 28

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

Jeannette Beck

If death occurred in a hospital, institution or camp give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX Female 4. COLOR OR RACE Wht. 5. SINGLE, MARRIED, WIDOWED OR DIVORCED. Widow
(Write the word.)

6. DATE OF BIRTH May 21 1851
(Month) (Day) (Year)

7. AGE 61 yrs. 10 mos. 18 ds. IF LESS than 1 day
how many _____ hrs. or _____ min?

8. OCCUPATION Housewife
(a) Trade, profession or particular kind of work.
(b) General nature of industry business or establishment in which employed (or employer)

9. BIRTHPLACE Canada
(State or Country)

10. NAME OF FATHER Francis Gilmer

11. BIRTHPLACE OF FATHER Ireland
(State or Country)

12. MAIDEN NAME OF MOTHER _____

13. BIRTHPLACE OF MOTHER _____
(State or Country)

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Fred Beck

(Address) _____

15. Filed April 9th 1913 M. R. Hamill
Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH 4 9 1913
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from Apr. 5 1913, to Apr. 9 1913
that I last saw her alive on Apr. 8 1913
and that death occurred on the date stated above, at 2:00 P.M.

The CAUSE OF DEATH* was as follows:
Intestinal Obstruction

(Duration) _____ yrs. _____ mos. 10 ds.
Contributory Exhaustion
(Secondary)

(Duration) _____ yrs. _____ mos. _____ ds.
(Signed) Ernest J. Hamill, M. D.
4 9 1913 (Address) Wilder Idaho.

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place Wilder Idaho In the Wilder General Hospital
of death _____ yrs. _____ mos. 4 ds. State Idaho yrs. _____ mos. _____ ds.
Where was disease contracted, Council Idaho.
If not at place of death?
Former or usual residence. Council Idaho.

19. PLACE OF BURIAL OR REMOVAL DATE OF BURIAL

Council Ida 191

20. UNDERTAKER ADDRESS

L. C. Northrup Wilder Ida

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Form V. S. No. 5 20M.1-16-12

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH. Registration District No. 26
County of Washington Primary Registration District No. 1010
City of Waiser (No. First Street East St.)

File No. 4858
Registered No. 29

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Elora Nutting

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX Female 4. COLOR OR RACE White 5. SINGLE, MARRIED, WID-
OWED OR DIVORCED. Single
(Write the word.)

6. DATE OF BIRTH Feb - 22 - 1913
(Month) (Day) (Year)

7. AGE 1 yrs. 37 mos. 27 ds.
IF LESS than 1 day
how many hrs. or
..... mins.?

8. OCCUPATION
(a) Trade, profession or particular kind of work none
(b) General nature of industry business, or establishment in which employed (or employer)

9. BIRTHPLACE
(State or Country) Waiser; Idaho

10. NAME OF FATHER R. L. Nutting

11. BIRTHPLACE OF FATHER
(State or Country) Denison Texas

12. MAIDEN NAME OF MOTHER Ronnie Fay

13. BIRTHPLACE OF MOTHER
(State or Country) McKinney, Texas

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) R. L. Nutting
(Address) Waiser Idaho

15. Filed April 20 1913, M. R. Hamblin
Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH April - 19 - 1913
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from 4/14 1913, to 4/20 1913,
that I last saw her alive on 4/19 1913,
and that death occurred on the date stated above, at 3:45 P. M.

The CAUSE OF DEATH* was as follows:

Pneumonia
(Duration) yrs. mos. 4 1/2 ds.

Contributory (Secondary)
(Duration) yrs. mos. ds.
(Signed) E. T. Anderson M. D.
4/20 1913. (Address) Waiser

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death yrs. mos. days. In the State yrs. mos. days.

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL Waiser Idaho DATE OF BURIAL April 20 1913

20. UNDERTAKER A. G. Cordell ADDRESS Waiser, Idaho

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Form V. S. No. 5 20M.1-16-12

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH.

Registration District No. 26County of WashPrimary Registration District No. 2114City of Cambridge

(No. _____)

St.)

File No. 4860Registered No. 31

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Helin Annbell Kope

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX

4. COLOR OR RACE

5. SINGLE, MARRIED, WIDOWED OR DIVORCED.

FemaleCaucasianSingle
(Write the word.)

6. DATE OF BIRTH

July
(Month)7
(Day)1904
(Year)

7. AGE

9 yrs.

mos.

ds.

IF LESS than 1 day
how many hrs. or
..... mins.?

8. OCCUPATION

(a) Trade, profession or particular kind of work

school girl

(b) General nature of industry business, or establishment in which employed (or employer)

9. BIRTHPLACE

(State or Country)

Hamper Idaho

10. NAME OF FATHER

W. F. Kope

11. BIRTHPLACE OF FATHER

(State or Country)

State Montana

12. MAIDEN NAME OF MOTHER

Anna Powell

13. BIRTHPLACE OF MOTHER

(State or Country)

Caldwell Idaho

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

W. F. Kope

(Address)

Cambridge; Idaho.

15.

Filed April 20

1913

C. E. Schmitz

Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH

April
(Month)19
(Day)1913
(Year)

17. I HEREBY CERTIFY, That I attended deceased from

April 18

1913, to

April 19

1913,

that I last saw her alive on April 19 1913,and that death occurred on the date stated above, at 3 ¹⁵ M.

The CAUSE OF DEATH* was as follows:

Laceration of skull at the base and internal injury

(Duration)

yrs.

mos.

ds.

Contributory being thrown from a horse
(Secondary)

(Duration)

yrs.

mos.

ds.

(Signed)

C. E. Schmitz

M. D.

April 20 1913

(Address)

Cambridge Ida.

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place

of death.

yrs.

mos.

days.

In the

State.

yrs.

mos.

days.

Where was disease contracted if not at place of death?

Former or

usual residence.

19. PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

Caldwell Ida4/21

1913

20. UNDERTAKER

ADDRESS

R. W. BowenHamper

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Form V. S. No. 5. 12½ M. 7-24-11

CERTIFICATE OF DEATH

1. PLACE OF DEATH.

County of WashingtonCity of CambridgeRegistration District No. 26Primary Registration District No. 5114

(No. _____, _____ St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

Lester M. SchmittState of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics
File No. 4861Registered No. 32

If death occurred in a hospital, institution or camp give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX

Male

4. COLOR OR RACE

White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED.

Single
(Write the word.)

6. DATE OF BIRTH

April 26 1913
(Month) (Day) (Year)

7. AGE

_____ yrs. _____ mos. _____ ds.

IF LESS than 1 day
how many 5 hrs. or
_____ min?

8. OCCUPATION

(a) Trade, profession or particular kind of work. None

(b) General nature of industry business or establishment in which employed (or employer)

9. BIRTHPLACE

(State or Country)

Cambridge

10. NAME OF FATHER

Lester M. Schmitt

11. BIRTHPLACE OF FATHER

(State or Country)

Missouri

12. MAIDEN NAME OF MOTHER

Effie Clark

13. BIRTHPLACE OF MOTHER

(State or Country)

Mo

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

Mrs E. E. Lorton

(Address)

Cambridge

15.

Filed

April 26 1913C. E. Schmitt

Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH

April 26 1913
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from

April 26 1913, to April 26 1913that I last saw him alive on April 26 1913and that death occurred on the date stated above, at 5 P.M.

The CAUSE OF DEATH* was as follows:

Innervation

(Duration) _____ yrs. _____ mos. _____ ds.

Contributory
(Secondary)

(Duration) _____ yrs. _____ mos. _____ ds.

(Signed)

C. E. Schmitt M. D.
April 26 1913 (Address) Cambridge, Ida

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place _____ In the _____
of death _____ yrs. _____ mos. _____ ds. State _____ yrs. _____ mos. _____ ds.Where was disease contracted,
If not at place of death?Former or
usual residence.

19. PLACE OF BURIAL OR REMOVAL DATE OF BURIAL

Cambridge April 27 1913

20. UNDERTAKER

Jas. Rudelsam

ADDRESS

Cambridge, Ida

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Form V. S. No. 5 20M.1-16-12

CERTIFICATE OF DEATH

1. PLACE OF DEATH

Registration District No. 26

County of Washington

Primary Registration District No. 2114

City of Cambridge

(No. _____, _____ St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

Lucia Cox

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics
File No. 4862
Registered No. 33

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX

Female

4. COLOR OR RACE

White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED.

(Write the word.)

6. DATE OF BIRTH

Aug 18 1837
(Month) (Day) (Year)

7. AGE

75 yrs. 8 mos. 10 ds.

IF LESS than 1 day
how many _____ hrs. or
_____ mins.?

8. OCCUPATION

(a) Trade, profession or particular kind of work

House Wife

(b) General nature of industry, business, or establishment in which employed (or employer)

9. BIRTHPLACE

(State or Country)

Illinois

10. NAME OF FATHER

Samuel Tucker

11. BIRTHPLACE OF FATHER

(State or Country)

12. MAIDEN NAME OF MOTHER

Lucia Tucker

13. BIRTHPLACE OF MOTHER

(State or Country)

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

J E Cox

(Address)

Cambridge Idaho

15.

Filed

April 29 1913

C C Schmitt

Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

April 28 1913
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from

April 1 1913, to April 4 1913,

that I last saw her alive on April 4 1913,

and that death occurred on the date stated above, at 2 A M.

The CAUSE OF DEATH* was as follows:

Senility

(Duration) 2 yrs. _____ mos. _____ ds.

Contributory General Break down
(Secondary)

(Duration) 2 yrs. _____ mos. _____ ds.

(Signed) C C Schmitt M. D.

1913 (Address) Cambridge Idaho

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death _____ yrs. _____ mos. _____ days. In the State _____ yrs. _____ mos. _____ days.

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL DATE OF BURIAL

Cambridge Ida. April 30 1913

20. UNDERTAKER

ADDRESS

Jas Huddleston

Cambridge Ida

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSI-
CIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact state-
ment of OCCUPATION is very important. See instructions on back of certificate.

Form V. S. No. 5. 12½ M. 7-24-11

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics
File No. **4863**
Registered No. **34**

1. PLACE OF DEATH.
County of Washington
City of Wenatch

Registration District No.
Primary Registration District No. 21+2,
(No. R. P. D. No. 2, St.)

If death occurs away from us-
ual residence, give facts called
for under special information.

2. FULL NAME Grace Ethel Tapilgade

If death occurred in a hospital, in-
stitution or camp give its NAME
instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX 4. COLOR OR RACE 5. SINGLE, MARRIED, WID-
OWED OR DIVORCED.

Female white single
(Write the word.)

6. DATE OF BIRTH Sept. 3 1905
(Month) (Day) (Year)

7. AGE 8 yrs. 0 mos. 0 ds. IF LESS than 1 day
how many.....hrs. or
.....min?

8. OCCUPATION

(a) Trade, profession or
particular kind of work. not employed
(b) General nature of industry
business or establishment in
which employed (or employer)

9. BIRTHPLACE

(State or Country) Idaho

10. NAME OF
FATHER

Owen Tapilgade

11. BIRTHPLACE
OF FATHER

(State or Country) Idaho

12. MAIDEN NAME
OF MOTHER

Hattie E. Sawtelle

13. BIRTHPLACE
OF MOTHER

(State or Country) Calif.

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) O. Tapilgade
(Address) Wenatch Idaho R.R. #2

15. Filed May 1 1913 Faschnitz
Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH April 27 1913
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from
April 16 1913, to April 27 1913
that I last saw her alive on April 22 1913
and that death occurred on the date stated above, at 100 A.M.

The CAUSE OF DEATH* was as follows:

Scarlet Fever (malignant)

(Duration) yrs. mos. 11 ds.

Contributory hemorrhage
(Secondary)

(Duration) yrs. mos. ds.

(Signed) F. Faschnitz M. D.

19 (Address) Medvale Ida

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1)
MEANS OF INJURY; (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions,
Transients or Recent Residents.)

At place In the
of death yrs. mos. ds. State yrs. mos. ds.
Where was disease contracted,
If not at place of death?
Former or
usual residence.

19. PLACE OF BURIAL OR REMOVAL DATE OF BURIAL

Wenatch Ida April 27 1913

20. UNDERTAKER ADDRESS

L. G. Vary Medvale

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Form V. S. No. 5. 12½ M. 7-24-11

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics
File No. **4565**
Registered No. _____

1. PLACE OF DEATH.
County of Shoshone
City of Mullan

Registration District No. 25
Primary Registration District No. 2108
(No. _____, _____ St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

John Rowland Jones

If death occurred in a hospital, institution or camp give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX Male 4. COLOR OR RACE White 5. SINGLE, MARRIED, WIDOWED OR DIVORCED. Married
(Write the word.)

6. DATE OF BIRTH April 21 1865
(Month) (Day) (Year)

7. AGE 48 yrs. 1 mos. 2 ds. IF LESS than 1 day how many _____ hrs. or _____ min?

8. OCCUPATION

(a) Trade, profession or particular kind of work
(b) General nature of industry business or establishment in which employed (or employer)

9. BIRTHPLACE Wales
(State or Country)

10. NAME OF FATHER John Jones

11. BIRTHPLACE OF FATHER Wales
(State or Country)

12. MAIDEN NAME OF MOTHER Catherine Davis

13. BIRTHPLACE OF MOTHER Wales
(State or Country)

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Mrs. J. R. Jones
(Address) _____

15. Filed May 23 1913

F. W. Ralph
Local Registrar
Dr. Charles E. Witham
Coroner

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH May 23 1913
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from _____ 191____, to May 23 1913
that I last saw him alive on 22 day of May 1913
and that death occurred on the date stated above, at 6 P. M.
The CAUSE OF DEATH* was as follows:
Mine accident

(Duration) _____ yrs. _____ mos. _____ ds.
Contributory (Secondary) _____
(Duration) _____ yrs. _____ mos. _____ ds.
(Signed) F. W. Ralph M. D.
May 23 1913 (Address) Mullan

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place _____ In the _____
of death _____ yrs. _____ mos. _____ ds. State _____ yrs. _____ mos. _____ ds.
Where was disease contracted, _____
If not at place of death? _____
Former or usual residence _____

19. PLACE OF ~~BURIAL~~ OR REMOVAL Wallace Ida DATE OF BURIAL May 1913

20. UNDERTAKER Worstell ADDRESS Wallace Ida

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Form V. S. No. 5 20M.1-16-12		CERTIFICATE OF DEATH		State of Idaho BOARD OF HEALTH Bureau of Vital Statistics	
1. PLACE OF DEATH.		Registration District No. 25		File No. 4866	
County of Shoshone		Primary Registration District No. 2105		Registered No.	
City of Kellogg		(No.) St.)		If death occurred in a hospital, institution or camp, give its NAME instead of street and number.	
If death occurs away from usual residence, give facts called for under special information.					
2. FULL NAME Paddy Kennedy					
PERSONAL AND STATISTICAL PARTICULARS			MEDICAL CERTIFICATE OF DEATH.		
3. SEX Male		4. COLOR OR RACE White		5. SINGLE, MARRIED, WIDOWED OR DIVORCED. single (Write the word.)	
6. DATE OF BIRTH Do not know 1 (Month) (Day) (Year)					
7. AGE 27 yrs. mos. ds.			IF LESS than 1 day how many hrs. or mins.?		
8. OCCUPATION (a) Trade, profession or particular kind of work Carpenter (b) General nature of industry business, or establishment in which employed (or employer) Stewart Mining Co.					
9. BIRTHPLACE (State or Country) Escanaba, Michigan					
10. NAME OF FATHER Do not know					
11. BIRTHPLACE OF FATHER (State or Country) Eastern Ontario					
12. MAIDEN NAME OF MOTHER X X					
13. BIRTHPLACE OF MOTHER X X					
14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE (Informant) (Address)					
15. Filed June 10 1913 M. H. G. Britton Local Registrar					
16. DATE OF DEATH May 30 1913 (Month) (Day) (Year)			17. I HEREBY CERTIFY, That I attended deceased from 1913 to 1913, that I last saw h. alive on 1913, and that death occurred on the date stated above, at M. The CAUSE OF DEATH* was as follows: Killed in mine Physician (Duration) yrs. mos. ds. Contributory (Secondary) (Duration) yrs. mos. ds. (Signed) M. D. 19 (Address)		
*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.					
18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.) At place of death yrs. mos. days. In the State yrs. mos. days. Where was disease contracted if not at place of death? Former or usual residence.					
19. PLACE OF BURIAL OR REMOVAL Shipped to Ashland, Wis.			DATE OF BURIAL 1913		
20. UNDERTAKER Bruce G. Hartsch			ADDRESS Wallace, Ida.		

Corner Case

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Form V. S. No. 5 20M.1-16-12

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics
File No. 4867

1. PLACE OF DEATH

Registration District No. 25County of ShoshonePrimary Registration District No. 2104City of North Fork

(No. _____)

St.)

Registered No. _____

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

Lempi Silvela

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX

Female

4. COLOR OR RACE

white

5. SINGLE, MARRIED, WIDOWED OR DIVORCED.

married
(Write the word.)

6. DATE OF BIRTH

(Month)

(Day)

(Year)

7. AGE

19 yrs. — mos. — ds.

IF LESS than 1 day
how many hrs. or
mins.?

8. OCCUPATION

(a) Trade, profession or particular kind of work

(b) General nature of industry
business, or establishment in
which employed (or employer)

housewife

9. BIRTHPLACE

(State or Country)

Finland

10. NAME OF FATHER

Farragut

11. BIRTHPLACE OF FATHER

(State or Country)

Finland

12. MAIDEN NAME OF MOTHER

Lempi Farragut

13. BIRTHPLACE OF MOTHER

(State or Country)

Finland

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

(Address)

15.

Filed

May 251913A. Charles Witham
Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

(Month)

(Day)

1913
(Year)

17. I HEREBY CERTIFY, That I attended deceased from

Jan 1913, to Feb 1913that I last saw him alive on Feb 1913and that death occurred on the date stated above, at M.

The CAUSE OF DEATH* was as follows:

Pulmonary Tuberculosis

(Duration) yrs. mos. ds.

Contributory

(Secondary)

(Duration) yrs. mos. ds.

(Signed)

May 21 1913

(Address)

Dr. Mowery
Wallace Ida

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death yrs. mos. days. In the State yrs. mos. days.

Where was disease contracted
if not at place of death?

Former or
usual residence.

19. PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

Kingston Ida1913

20. UNDERTAKER

ADDRESS

Wallace Ida

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Form V. S. No. 5 20M.1-16-12

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics
File No. 4568

1. PLACE OF DEATH.

Registration District No. 25

County of Blaine

Primary Registration District No. 2104

City of Ketchikan

(No. St.)

Registered No.

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

Charles Sanford Lamb

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX

M

4. COLOR OR RACE

W.

5. SINGLE, MARRIED, WIDOWED OR DIVORCED.

Single
(Write the word.)

6. DATE OF BIRTH

Mar. 23 1872
(Month) (Day) (Year)

7. AGE

40 yrs. 5 mos. 28 ds.

IF LESS than 1 day
how many hrs. or
mins.?

8. OCCUPATION

(a) Trade, profession or particular kind of work

Prospector

(b) General nature of industry business, or establishment in which employed (or employer)

9. BIRTHPLACE

(State or Country)

Lee Mornie, Iowa

10. NAME OF FATHER

Henry Lamb

11. BIRTHPLACE OF FATHER

(State or Country)

Iowa

12. MAIDEN NAME OF MOTHER

Phlura Brinkerhoff

13. BIRTHPLACE OF MOTHER

(State or Country)

New York

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

Truman Lamb

(Address)

Wardner, Ida.

15.

Filed May 23 1913

A. C. H. R. R. R.
Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH

May 21 1913
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from

1911, to 1911,

that I last saw him alive on 1911,

and that death occurred on the date stated above, at M.

The CAUSE OF DEATH was as follows:

Accidental Drowning
(Duration) yrs. mos. ds.
Contributory (Secondary) No Physician
(Duration) yrs. mos. ds.
(Signed) M. D.
19 (Address)

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death yrs. mos. days. In the State yrs. mos. days.

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

Keellogg, Ida

May 25 1913

20. UNDERTAKER

ADDRESS

E. B. Karnhill

Keellogg

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Form V. S. No. 5 20M.1-16-12

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics
1869

1. PLACE OF DEATH.

Registration District No. 25

County of *Gooding*

Primary Registration District No. 2124

City of *Keelogg*

(No. _____)

St.)

Registered No. _____

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

John Henry Marion Dawson

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX

M

4. COLOR OR RACE

W

5. SINGLE, MARRIED, WIDOWED OR DIVORCED.

married
(Write the word.)

6. DATE OF BIRTH

July
(Month)*14*
(Day)*1857*
(Year)

7. AGE

55 yrs. 9 mos. 28 ds.

IF LESS than 1 day
how many hrs. or
..... mins.?

8. OCCUPATION

(a) Trade, profession or particular kind of work
(b) General nature of industry business, or establishment in which employed (or employer)

Farmer

9. BIRTHPLACE

(State or Country)

Indiana

10. NAME OF FATHER

Elias Dawson

11. BIRTHPLACE OF FATHER

(State or Country)

Indiana

12. MAIDEN NAME OF MOTHER

Elizabeth Wiseman

13. BIRTHPLACE OF MOTHER

(State or Country)

Indiana

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

F.M. Dawson

(Address)

Keelogg, Idaho

15.

Filed

May 20

1913

A. H. Harrison
Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

May
(Month)*10*
(Day)*1913*
(Year)

17. I HEREBY CERTIFY, That I attended deceased from

191

to

191

that I last saw him alive on

191

and that death occurred on the date stated above, at

M.

The CAUSE OF DEATH* was as follows:

Accidental Drowning

(Duration)

yrs.

mos.

ds.

Contributory
(Secondary)

(Duration)

yrs.

mos.

ds.

(Signed)

M. D.

19

(Address)

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death

..... yrs. mos. days.

In the State

..... yrs. mos. days.

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

*Keelogg, Ida.**May 17* 1913

20. UNDERTAKER

ADDRESS

*E. B. Hankins**Keelogg, Ida.*

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Form V. S. No. 5. 10M. 6-20-11.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics
File No. 4870

1. PLACE OF DEATH

Registration District No.

County of Canyon

Primary Registration District No.

City of Emmett

(No. St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

Mrs. Alberta Bird

Registered No.

If death occurred in a hospital, institution or camp give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX

female

4. COLOR OR RACE

white

5. SINGLE, MARRIED, WIDOWED OR DIVORCED.

married
(Write the word.)

6. DATE OF BIRTH

June 9 1864
(Month) (Day) (Year)

7. AGE

48 yrs. 11 mos. 8 ds.

IF LESS than 1 day
how many hrs. or
..... min.?

8. OCCUPATION

(a) Trade, profession, or particular kind of work
(b) General nature of industry, business, or establishment in which employed (or employer)

housewife

9. BIRTHPLACE

(State or Country)

Ohio

10. NAME OF FATHER

Don't know

11. BIRTHPLACE OF FATHER

(State or Country)

" "

12. MAIDEN NAME OF MOTHER

" "

13. BIRTHPLACE OF MOTHER

(State or Country)

" "

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

A. Bird

(Address)

Emmett Idaho

15.

Filed 5-28-1913

J. L. Reynolds
Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

May 17 1913
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from

1910, to May 15 1913
that I last saw her alive on May 15 1913

and that death occurred on the date stated above, at M.

The CAUSE OF DEATH* was as follows:

Thyroidosis resulting from exophthalmic goitre

About 1.5 yrs. (Duration) mos. ds.

Contributory (Secondary)

(Duration) yrs. mos. ds.

(Signed) E. A. Cummings M. D.

May 7 1913 (Address) Emmett

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL,

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place In the
of death yrs. mos. ds. State yrs. mos. ds.

Where was Disease contracted,

If not at place of death?

Former or

usual residence.

19. PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

Emmett Cemetery May 19 1913

20. UNDERTAKER

ADDRESS

C. D. Bucknum Emmett

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Form V. S. No. 5. 12½ M. 7-24-11

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics
File No. 4571
Registered No. 16

1. PLACE OF DEATH. Registration District No. 27
County of Lemhi Primary Registration District No. 2116
City of _____ (No. _____, _____ St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Harriet Sabende Walker

If death occurred in a hospital, institution or camp give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX female 4. COLOR OR RACE white 5. SINGLE, MARRIED, WIDOWED OR DIVORCED. married
(Write the word.)

6. DATE OF BIRTH _____ 1897
(Month) (Day) (Year)

7. AGE 46 yrs. _____ mos. _____ ds. IF LESS than 1 day how many _____ hrs. or _____ min?

8. OCCUPATION

(a) Trade, profession or particular kind of work. housewife
(b) General nature of industry business or establishment in which employed (or employer)

9. BIRTHPLACE _____
(State or Country) Mo.

10. NAME OF FATHER a. Hopper

11. BIRTHPLACE OF FATHER Doubt know
(State or Country)

12. MAIDEN NAME OF MOTHER Doubt know

13. BIRTHPLACE OF MOTHER Doubt know
(State or Country)

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Battie Beecher
(Address) Challis

15. Filed May 14 1913 Henry L. Smith
Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH Apr. 23 1913
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from Sept 1912, to Apr 23 1913
that I last saw her alive on Apr 23 1913
and that death occurred on the date stated above, at 12:30 A.M.

The CAUSE OF DEATH* was as follows:

Diabetic coma.

(Duration) _____ yrs. _____ mos. 1 ds.
Contributory (Secondary) Diabetes

(Duration) 1 yrs. _____ mos. _____ ds.
(Signed) J. W. Keely M. D.
Apr. 24 1913 (Address) Challis

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place _____ In the _____
of death _____ yrs. _____ mos. _____ ds. State _____ yrs. _____ mos. _____ ds.
Where was disease contracted, _____
If not at place of death? _____
Former or _____
usual residence _____

19. PLACE OF BURIAL OR REMOVAL _____ DATE OF BURIAL _____
1913

20. UNDERTAKER _____ ADDRESS _____
No Undertaker

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Form V, S. No. 5. 12% M. 7-24-11

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics
File No. 4572

1. PLACE OF DEATH.
County of Terrebonne
City of Salmon

Registration District No. 27
Primary Registration District No. 2116
(No. St.)

Registered No. 17

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Henry V Williams

If death occurred in a hospital, institution or camp give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX Male 4. COLOR OR RACE White 5. SINGLE, MARRIED, WIDOWED OR-DIVORCED. Divorced
(Write the word.)

6. DATE OF BIRTH January 21 1889
(Month) (Day) (Year)

7. AGE 54 yrs. mos. ds.
IF LESS than 1 day
how many hrs. or min?

8. OCCUPATION
(a) Trade, profession or particular kind of work. Ranchman
(b) General nature of industry business or establishment in which employed (or employer)

9. BIRTHPLACE
(State or Country) Kansas

10. NAME OF FATHER James R Williams

11. BIRTHPLACE OF FATHER
(State or Country) Do not know

12. MAIDEN NAME OF MOTHER Do not know

13. BIRTHPLACE OF MOTHER
(State or Country) Do not know

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Roll M. Williams
(Address) Salmon

15. Filed 5/14 1913 Helen L Smith
Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH May 13 1913
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from March 3 1913, to May 13 1913
that I last saw him alive on May 13 1913
and that death occurred on the date stated above, at 9 P. M.
The CAUSE OF DEATH* was as follows:

Fracture of Base of Skull
(Duration) 2 yrs. mos. ds.

Contributory (Secondary)
(Duration) yrs. mos. ds.
(Signed) F. Wright M. D.
May 14 1913 (Address) Salmon

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place In the
of death yrs. mos. ds. State yrs. mos. ds.
Where was disease contracted,
If not at place of death?
Former or usual residence

19. PLACE OF BURIAL OR REMOVAL DATE OF BURIAL
Salmon Ida May 15 1913

20. UNDERTAKER ADDRESS
J. M. O'Connell Salmon
Ida

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. N. B.—Every item of information should be carefully supplied. All should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Form V. S. No. 5. 12½M.7-24-11

CERTIFICATE OF DEATH

1. PLACE OF DEATH.

Registration District No. 27

County of Lemhi

Primary Registration District No. 2116

City of Salmon

(No. St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

Flora I Pugh

State of Idaho

BOARD OF HEALTH
Bureau of Vital Statistics

File No. 4873

Registered No. 18

If death occurred in a hospital, institution or camp give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX

Female

4. COLOR OR RACE

White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED.

Married
(Write the word.)

6. DATE OF BIRTH

June 4th

(Month)

(Day)

1884
(Year)

7. AGE

28 yrs. 11 mos. 13 ds.

IF LESS than 1 day
how many hrs. or min?

8. OCCUPATION

(a) Trade, profession or particular kind of work.

House wife

(b) General nature of industry business or establishment in which employed (or employer)

9. BIRTHPLACE

(State or Country)

Idaho

10. NAME OF FATHER

L. S. Johnson

11. BIRTHPLACE OF FATHER

(State or Country)

Norway

12. MAIDEN NAME OF MOTHER

Elizabeth A. Olson

13. BIRTHPLACE OF MOTHER

(State or Country)

Wisconsin

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

(Address)

D. S. Johnson

Salmon, Ida.

15.

Filed May 19 1913

Kenneth Smith
Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH

May 15th

(Month)

(Day)

1913
(Year)

I HEREBY CERTIFY, That I attended deceased from

May 7 1913, to May 15 1913

that I last saw him alive on May 15 1913

and that death occurred on the date stated above, at 10 P. M.

The CAUSE OF DEATH* was as follows:

Septicemia

(Duration) yrs. mos. ds.

Contributory
(Secondary)

(Duration) yrs. mos. ds.

(Signed) W. B. Whitwell M. D.

May 17 1913 (Address) Salmon, Idaho

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place In the

of death. yrs. mos. ds. State. yrs. mos. ds.

Where was disease contracted,

If not at place of death?

Former or

usual residence.

19. PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

Salmon, Ida.

May 17 1913

20. UNDERTAKER

ADDRESS

J. M. O. Doeber

Salmon
Ida.

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Form V. S. No. 5. 12½ M. 7-24-11

CERTIFICATE OF DEATH

1. PLACE OF DEATH.
County of Lemhi
City of Sahnon

Registration District No. 27
Primary Registration District No. 2116
(No. _____, _____ St.)

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics
File No. _____
Registered No. 19

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Derringer E. Cooper

If death occurred in a hospital, institution or camp give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX Female 4. COLOR OR RACE White 5. SINGLE, MARRIED, WIDOWED OR DIVORCED. Single
(Write the word.)

6. DATE OF BIRTH September 8 1911
(Month) (Day) (Year)

7. AGE 2 yrs. 6 mos. 9 ds. IF LESS than 1 day
how many hrs. or min?

8. OCCUPATION
(a) Trade, profession or particular kind of work. None
(b) General nature of industry business or establishment in which employed (or employer)

9. BIRTHPLACE (State or Country) Idaho

10. NAME OF FATHER Went. Cooper

11. BIRTHPLACE OF FATHER (State or Country) Arkansas

12. MAIDEN NAME OF MOTHER Lillian Johnson

13. BIRTHPLACE OF MOTHER (State or Country) Idaho

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) L. Johnson
(Address) Sahnon, Ida.

15. Filed May 19 1913 Helen L. Smith
Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH May 17 1913
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from May 15 1913, to May 16 1913
that I last saw him alive on May 16 1913
and that death occurred on the date stated above, at 1:30 A.M.

The CAUSE OF DEATH* was as follows:
Acute anterior folliculitis

..... (Duration) yrs. mos. two ds.

Contributory (Secondary)

..... (Duration) yrs. mos. ds.

(Signed) Chas. F. Hammer M. D.
May 17 1913 (Address) Sahnon

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place In the
of death yrs. mos. ds. State yrs. mos. ds.
Where was disease contracted,
If not at place of death?
Former or
usual residence

19. PLACE OF BURIAL OR REMOVAL DATE OF BURIAL
Sahnon Ida. May 17 1913

20. UNDERTAKER ADDRESS
Wm. O. Taabbe Sahnon

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Form V. S. No. 5. 12½ M. 7-24-11

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics
File No. 1875
Registered No. 20

1. PLACE OF DEATH. Registration District No. 27
County of Lewia Primary Registration District No. 2116
City of Salmon (No. _____ St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

J. M. Riding

If death occurred in a hospital, institution or camp give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX Male 4. COLOR OR RACE White 5. SINGLE, MARRIED, WIDOWED OR DIVORCED. married
(Write the word.)
6. DATE OF BIRTH About 1868
(Month) (Day) (Year)

7. AGE About 45 yrs. mos. ds. IF LESS than 1 day how many hrs. or min?

8. OCCUPATION
(a) Trade, profession or particular kind of work. Ranchman
(b) General nature of industry business or establishment in which employed (or employer)

9. BIRTHPLACE (State or Country) Do not know.

10. NAME OF FATHER Do not know.

11. BIRTHPLACE OF FATHER (State or Country) Do not know.

12. MAIDEN NAME OF MOTHER Do not know.

13. BIRTHPLACE OF MOTHER (State or Country) Do not know.

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE (Informant) J. M. Daehler
(Address) Salmon Ida.

15. Filed May 17 1913 Allen L. Smith
Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH May 14 1913
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from 191 , to 191
that I last saw h. alive on 191
and that death occurred on the date stated above, at M.

The CAUSE OF DEATH* was as follows:
Jumping in Salmon river
Cause of death probably shock
suicidal.

(Duration) yrs. mos. ds.

Contributory (Secondary)

(Duration) yrs. mos. ds.

(Signed) O. B. Hally M. D.
5/19 1913 (Address) Salmon, Ida.

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place In the
of death. yrs. mos. ds. State. yrs. mos. ds.
Where was disease contracted,
If not at place of death?
Former or
usual residence.

19. PLACE OF BURIAL OR REMOVAL DATE OF BURIAL
Salmon Cemetery May 19 1913

20. UNDERTAKER ADDRESS
J. M. Daehler Salmon, Ida.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Form V. S. No. 5 20M.1-16-12

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics
File No. 4876
Registered No. 21

1. PLACE OF DEATH. Registration District No. 27
County of Lemhi Primary Registration District No. 2116
City of Salmon (No. , St.)
If death occurs away from usual residence, give facts called for under special information. 2. FULL NAME David M. Muth

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX Male 4. COLOR OR RACE White 5. SINGLE, MARRIED, WIDOWED OR DIVORCED. Single (Write the word.)

6. DATE OF BIRTH August 12th 1899
(Month) (Day) (Year)

7. AGE 84 yrs. 9 mos. 13 ds. IF LESS than 1 day how many hrs. or mins.?

8. OCCUPATION (a) Trade, profession or particular kind of work Retired business man (b) General nature of industry business, or establishment in which employed (or employer)

9. BIRTHPLACE (State or Country) Scotland

10. NAME OF FATHER Do not know

11. BIRTHPLACE OF FATHER Scotland (State or Country)

12. MAIDEN NAME OF MOTHER Do not know

13. BIRTHPLACE OF MOTHER Scotland (State or Country)

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE (Informant) E. S. Edwards (Address) Salmon Ida

15. Filed May 26 1913 Helen L. Smith Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH May 25th 1913
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from 191 to 191, that I last saw him alive on May 17th 1913, and that death occurred on the date stated above, at M.

The CAUSE OF DEATH* was as follows: found dead in bed, death taking place between 11:30 P.M. + 4:30 A.M. Chronic pulmonary nephritis with uraemia

Contributory Chronic alcoholism (Secondary) (Duration) yrs. mos. ds.

(Signed) A. Stratton M.D. 5/26 1913 (Address) Salmon, Ida.

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death.....yrs.....mos.....days. In the State.....yrs.....mos.....days.

Where was disease contracted if not at place of death?.....

Former or usual residence.....

19. PLACE OF BURIAL OR REMOVAL DATE OF BURIAL Salmon Idaho May 27th 1913

20. UNDERTAKER ADDRESS Wm. O. Doebls Salmon Ida

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Form V. S. No. 5 20M.1-16-12

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH.

Registration District No. 27

County of Lemhi

Primary Registration District No. 2116

City of Munroe Park Camp

(No. _____, St.)

File No. 457

Registered No. 22

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

Dorothy E. Williams

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX

Female

4. COLOR OR RACE

White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED.

Single
(Write the word.)

6. DATE OF BIRTH

May 1st

1910

(Month)

(Day)

(Year)

7. AGE

3 yrs.

mos. 30

ds.

IF LESS than 1 day
how many _____ hrs. or
_____ mins.?

8. OCCUPATION

(a) Trade, profession or particular kind of work

(b) General nature of industry business, or establishment in which employed (or employer)

9. BIRTHPLACE

(State or Country)

Idaho

10. NAME OF FATHER

Isaac W. Williams

11. BIRTHPLACE OF FATHER

(State or Country)

Kansas

12. MAIDEN NAME OF MOTHER

Julia C. Withington

13. BIRTHPLACE OF MOTHER

(State or Country)

Idaho

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

Mrs. Julia C. Williams

(Address)

Salmon Ida

15.

Filed

June 1

1910

Helena L. Smith

Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH

May 30th

1913

(Month)

(Day)

(Year)

17. I HEREBY CERTIFY, That I attended deceased from

1913, to

1913,

that I last saw him alive on

1913,

and that death occurred on the date stated above, at

M.

The CAUSE OF DEATH* was as follows:

Drowned
by accidentally falling into
Munroe Park
(Duration) _____ yrs. _____ mos. _____ ds.

Contributory

(Secondary)

(Duration)

yrs.

mos.

ds.

(Signed)

Wm. E. Doeller, Coroner M.D.

19

(Address)

Salmon Idaho

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place

of death.

yrs.

mos.

days.

In the

State.

yrs.

mos.

days.

Where was disease contracted if not at place of death?

Former or

usual residence.

19. PLACE OF BURIAL OR REMOVAL DATE OF BURIAL

Salmon Cemetery

June 1st 1913

20. UNDERTAKER

ADDRESS

Wm. E. Doeller

Salmon

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Form V. S. No. 5 20M.1-16-12

CERTIFICATE OF DEATH

 State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH.

Registration District No. 27County of LemhiPrimary Registration District No. 2116City of Salmon

(No. _____, St.)

File No. 1578Registered No. 24

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

James P. Nixon

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX

Male

4. COLOR OR RACE

White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED.

Single
(Write the word.)

6. DATE OF BIRTH

March 4th - 1886June 30 1913
(Month) (Day) (Year)

7. AGE

27 yrs. _____ mos. _____ ds.
 IF LESS than 1 day
how many _____ hrs. or
_____ mins.?

8. OCCUPATION

 (a) Trade, profession or particular kind of work
(b) General nature of industry business, or establishment in which employed (or employer)
Lawyer

9. BIRTHPLACE

(State or Country) Missouri

10. NAME OF FATHER

J. P. Nixon

11. BIRTHPLACE OF FATHER

(State or Country) Illinois

12. MAIDEN NAME OF MOTHER

Ella S Ward

13. BIRTHPLACE OF MOTHER

(State or Country) St Louis Missouri

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) P. J. Nixon(Address) Springfield Missouri

15.

Filed June 6 1913
Kelley Smith
Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH

June 30 1913
(Month) (Day) (Year)

 17. I HEREBY CERTIFY, That I attended deceased from May 30 1913, to June 3 1913,

 that I last saw him alive on June 30 1913,
and that death occurred on the date stated above, at 3:15 P.M.

The CAUSE OF DEATH* was as follows:

Appendicitis(Duration) _____ yrs. _____ mos. 9 ds.

Contributory (Secondary)

(Duration) _____ yrs. _____ mos. _____ ds.

(Signed)

W. C. Whitall M. D.19. (Address) Salmon Ida

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death _____ yrs. _____ mos. _____ days. In the State _____ yrs. _____ mos. _____ days.

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

Lebanon Missouri1913

20. UNDERTAKER

ADDRESS

W. C. DoeblSalmon Ida

Form V. S. No. 5 20M.1-16-12

CERTIFICATE OF DEATH

 State of Idaho
 BOARD OF HEALTH
 Bureau of Vital Statistics

1. PLACE OF DEATH.

Registration District No. 27

County of Lemhi

Primary Registration District No. 2153

City of Elmore

(No. St.)

File No. 4870

Registered No. 25

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME E. J. Moore

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX

Male

4. COLOR OR RACE

White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED.

Married
(Write the word.)

6. DATE OF BIRTH

March

(Month)

(Day)

1

(Year)

7. AGE

53

yrs.

mos.

ds.

 IF LESS than 1 day
 how many hrs. or
 mins.?

8. OCCUPATION

(a) Trade, profession or particular kind of work

Quartz Mines

(b) General nature of industry business, or establishment in which employed (or employer)

9. BIRTHPLACE

(State or Country)

New York

10. NAME OF FATHER

Canada

11. BIRTHPLACE OF FATHER

(State or Country)

Canada

12. MAIDEN NAME OF MOTHER

Elizabeth Byrne

13. BIRTHPLACE OF MOTHER

(State or Country)

New York

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

Mrs Ella Moore

(Address)

White hall Mountain

15.

Filed

June 6

1913

K. L. Smith

Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH

January 15th

(Month)

(Day)

1913

(Year)

17. I HEREBY CERTIFY, That I attended deceased from

191

to

191

that I last saw h. alive on 191

and that death occurred on the date stated above, at M.

The CAUSE OF DEATH* was as follows:

 Suffocation Buried in
 Snow Slide

(Duration)

yrs.

mos.

ds.

Contributory

(Secondary)

(Duration)

yrs.

mos.

ds.

(Signed)

W. P. Doebl, Coroner

M. D.

May 29th 1913

(Address)

Salmon Ida

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place

of death

yrs.

mos.

days.

In the

State

yrs.

mos.

days.

 Where was disease contracted
 if not at place of death?

 Former or
 usual residence

19. PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

Butte Montana

May 31st 1913

20. UNDERTAKER

ADDRESS

W. P. Doebl

Salmon Ida

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Form V. S. No. 5 20M.1-16-12

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics
File No. **1884**
Registered No. **26**

1. PLACE OF DEATH, Registration District No. **27**
County of **Blaine** Primary Registration District No. **2116**
City of **Mysses** (No. _____ St.)
If death occurs away from usual residence, give facts called for under special information. 2. FULL NAME **Autone Emil Crnkovic**

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX **male** 4. COLOR OR RACE **white** 5. SINGLE, MARRIED, WIDOWED OR DIVORCED. **single**
(Write the word.)

6. DATE OF BIRTH **June 13 1911**
(Month) (Day) (Year)

7. AGE **11 yrs. 11 mos. 22 ds.** IF LESS than 1 day how many hrs. or mins.?

8. OCCUPATION
(a) Trade, profession or particular kind of work
(b) General nature of industry, business, or establishment in which employed (or employer)

9. BIRTHPLACE **Idaho**
(State or Country)

10. NAME OF FATHER **Wine Crnkovic**

11. BIRTHPLACE OF FATHER **austria**
(State or Country)

12. MAIDEN NAME OF MOTHER **antonio Palsjow**

13. BIRTHPLACE OF MOTHER **austria**
(State or Country)

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) **Mike Crnkovic**
(Address) **Mysses, Ida**

15. Filed **June 6 1913** **Helene Smith**
Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH **June 6 1913**
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from **191**, to **191**, that I last saw him alive on **June 23rd 191**, and that death occurred on the date stated above, at **P. M.**

The CAUSE OF DEATH* was as follows:
Found dying from history would judge that cause was organic heart disease or status lymphatic
(Duration) _____ yrs. _____ mos. _____ ds.
Contributory (Secondary) _____
(Signed) **O. P. Stratton** M. D.
19 (Address) **Salmon, Ida.**

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death _____ yrs. _____ mos. _____ days. In the State _____ yrs. _____ mos. _____ days.

Where was disease contracted if not at place of death? _____

Former or usual residence _____

19. PLACE OF BURIAL OR REMOVAL **Salmon Cemetery** DATE OF BURIAL **June 7th 1913**

20. UNDERTAKER **W. C. Tackler** ADDRESS **Salmon Ida.**

Form V. S. No. 5. 10M. 6-20-11.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics
File No. 45881

1. PLACE OF DEATH.

Registration District No. 1County of AdaPrimary Registration District No. 2003City of Meridian

(No. _____, _____ St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

Martin S. SmithRegistered No. 37

If death occurred in a hospital, institution or camp give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX

4. COLOR OR RACE 5. SINGLE, MARRIED, WIDOWED OR DIVORCED.

Male AmericanMarried
(Write the word.)

6. DATE OF BIRTH

March 11th 1848
(Month) (Day) (Year)

7. AGE

65 yrs. 1 mos. 10 ds.

IF LESS than 1 day
how many _____ hrs. or
_____ min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work
(b) General nature of industry business or establishment in which employed (or employer)

Farmer

9. BIRTHPLACE

(State or Country)

Illinois

10. NAME OF FATHER

Henry Smith

11. BIRTHPLACE OF FATHER

(State or Country)

Do not know

12. MAIDEN NAME OF MOTHER

Do not know

13. BIRTHPLACE OF MOTHER

(State or Country)

Do not know

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Edward A. Smith

(Address) _____

15.

Filed April 23 1913
May 8 1913E. L. Sutton
J. M. Taylor

Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

April 21st 1913
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from

April 21st 1913 to April 21st 1913that I last saw him alive on April 21st 1913and that death occurred on the date stated above, at 10:15 A.M.

The CAUSE OF DEATH* was as follows:

Intestinal Toxemia Causing
with Collapse & heart failure

(Duration) _____ yrs. _____ mos. _____ ds.

Contributory (Secondary)

(Duration) _____ yrs. _____ mos. _____ ds.

(Signed)

E. L. Sutton

M. D.

5710 1913 (Address) Meridian

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and 2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place _____ yrs. _____ mos. _____ ds. State _____ yrs. _____ mos. _____ ds.

Where was disease contracted,

If not at place of death?

Former or usual residence.

19. PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

Meridian Cemetery April 23 1913

20. UNDERTAKER

ADDRESS

J. M. Anderson Meridian

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Form V. S. No. 5. 10M. 6-20-11.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics
File No. 4883
Registered No. _____

1. PLACE OF DEATH.

Registration District No. 5

County of Lincoln

Primary Registration District No. 2017

City of Jerome

(No. _____, _____ St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

Irene Robinson

If death occurred in a hospital, institution or camp give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX

F

4. COLOR OR RACE

W

5. SINGLE, MARRIED, WIDOWED OR DIVORCED.

(Write the word.)

6. DATE OF BIRTH

June

13

1913

(Month)

(Day)

(Year)

7. AGE

— yrs. — mos. 3 ds.

IF LESS than 1 day
how many . . . hrs. or
. . . min.?

8. OCCUPATION

- (a) Trade, profession, or particular kind of work
(b) General nature of industry business, or establishment in which employed (or employer)

new born

9. BIRTHPLACE

(State or Country)

Jerome Idaho

10. NAME OF FATHER

William Robinson

11. BIRTHPLACE OF FATHER

(State or Country)

Pennsylvania

12. MAIDEN NAME OF MOTHER

Daisy Rowe

13. BIRTHPLACE OF MOTHER

(State or Country)

Michigan

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

Daisy Rowe Robinson

(Address)

Jerome Idaho

15.

Filed June 13 1913

E. D. Piper

Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

June

15

1913

(Month)

(Day)

(Year)

17. I HEREBY CERTIFY, That I attended deceased from

June 13 1913, to June 15 1913

that I last saw her alive on June 15 1913,

and that death occurred on the date stated above, at 8 P. M.

The CAUSE OF DEATH* was as follows:

Premature Birth (7 mos)
Lack of vitality.

(Duration) — yrs. — mos. 2 ds.

Contributory
(Secondary)

(Duration) — yrs. — mos. — ds.

(Signed) Edward D. Piper M. D.

June 13 1913 (Address) Jerome Ida

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place In the
of death yrs. mos. ds. State yrs. mos. ds.

Where was Disease contracted,

If not at place of death?

Former or

usual residence.

19. PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

Jerome Cemetery

June 16 1913

20. UNDERTAKER

ADDRESS

D. L. L. Harrison Jerome Ida

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Form V. S. No. 5 20M.1-16-12

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH.

Registration District No. 1

County of Ada

Primary Registration District No. 2004

City of _____

(No. near Main Hill Branch)

File No. 4884

Registered No. 38

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Robert Eastman

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX

Male

4. COLOR OR RACE

White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED.

Single
(Write the word.)

6. DATE OF BIRTH

March 26 1913
(Month) (Day) (Year)

7. AGE

_____ yrs. 1 mos. 9 ds.

IF LESS than 1 day
how many _____ hrs. or
_____ mins.?

8. OCCUPATION

(a) Trade, profession or particular kind of work

none

(b) General nature of industry business, or establishment in which employed (or employer)

9. BIRTHPLACE

(State or Country)

Boise

10. NAME OF FATHER

Fred Eastman

11. BIRTHPLACE OF FATHER

(State or Country)

Iowa

12. MAIDEN NAME OF MOTHER

Ida Norris

13. BIRTHPLACE OF MOTHER

(State or Country)

Ill.

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Fred Eastman

(Address) Boise

15.

Filed May 30th 1913 J. M. Taylor
Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

May 2 1913
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from

May 1 — 1913, to May 2 — 1913

that I last saw him alive on May 1 — 1913

and that death occurred on the date stated above, at _____ M.

The CAUSE OF DEATH* was as follows:

Brucellosis

(Duration) _____ yrs. _____ mos. 3 1/4 ds.

Contributory
(Secondary)

(Duration) _____ yrs. _____ mos. _____ ds.

(Signed) Mallen Cavanaugh M. D.

4/3/ 1913 (Address) Boise, Ida

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death _____ yrs. _____ mos. _____ days. In the State _____ yrs. _____ mos. _____ days.

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL DATE OF BURIAL

Ada County Cemetery 5/3 1913

20. UNDERTAKER

ADDRESS

Schreiber & Sidenfaden Boise
6 clarks.

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Form V. S. No. 5 20M.1-16-12

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics
4885

1. PLACE OF DEATH.

Registration District No. 1

County of Ada
City of Boise

Primary Registration District No. 2004

File No.

(No. Bench 3/21 North Crossing)

Registered No. 39

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

J. S. D. Morrisville

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX

Male

4. COLOR OR RACE

white American

5. SINGLE, MARRIED, WIDOWED OR DIVORCED.

Married
(Write the word.)

6. DATE OF BIRTH

March 24 1845
(Month) (Day) (Year)

7. AGE

68 yrs. 1 mos. 14 ds.

IF LESS than 1 day
how many hrs. or
..... mins.?

8. OCCUPATION

(a) Trade, profession or particular kind of work
(b) General nature of industry business, or establishment in which employed (or employer)

Retired Business Man

9. BIRTHPLACE

(State or Country)

Pa.

10. NAME OF FATHER

F. Morrisville

11. BIRTHPLACE OF FATHER

(State or Country)

N. York

12. MAIDEN NAME OF MOTHER

Miss Dye

13. BIRTHPLACE OF MOTHER

(State or Country)

not obtainable

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

J. S. D. Morrisville

(Address) 1174 Ford St

15.

Filed

May 9th 1913

J. M. Taylor
Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH

May 8 1913
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from May 7 1913, to May 8 1913, that I last saw him alive on May 7 1913

and that death occurred on the date stated above, at 8 P. M.

The CAUSE OF DEATH* was as follows:

Uremia

(Duration) 8 yrs. 0 mos. 0 ds.

Contributory (Secondary)

Bright's disease

(Duration) 6 yrs. 0 mos. 0 ds.

(Signed)

Dr. F. J. Forney M. D.

19 (Address) Boise, Ida.

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death yrs. mos. days. In the State yrs. mos. days.

Where was disease contracted if not at place of death?

Former or usual residence.

19. PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

Boise Morris Hill May 10 1913

20. UNDERTAKER

ADDRESS

J. J. Summers & Co Boise

MARGIN RESERVED FOR BINDING
WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Form V. S. No. 5 20M.1-16-12

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH.

Registration District No. 1

County of Ada

Primary Registration District No. 0004

File No. 4886

City of Soldiers Home

(No. Soldiers Home, St.)

Registered No. 41

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME William F. Bodenkamp

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX

4. COLOR OR RACE

5. SINGLE, MARRIED, WID-
OWED OR DIVORCED.

male

white
American

Single
(Write the word.)

6. DATE OF BIRTH

Not obtainable
(Month)

1848
(Day) (Year)

7. AGE

73 yrs. mos. ds.

IF LESS than 1 day
how many hrs. or
..... mins.

8. OCCUPATION

(a) Trade, profession or
particular kind of work

Veteran Civil war

(b) General nature of industry
business, or establishment in
which employed (or employer)

9. BIRTHPLACE

(State or Country)

Kansas

10. NAME OF
FATHER

Not obtainable

11. BIRTHPLACE
OF FATHER

(State or Country)

Not obtainable

12. MAIDEN NAME
OF MOTHER

Not obtainable

13. BIRTHPLACE
OF MOTHER

(State or Country)

Not obtainable

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

E. E. Burnett

(Address)

Soldiers Home

15.

Filed

May 10 1913

J. M. Taylor
Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH

May 13 1913
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from

May 2 1913, to May 10 1913

that I last saw him alive on May 10 1913

and that death occurred on the date stated above, at 1 P.M.

The CAUSE OF DEATH* was as follows:

Bright's disease

(Duration) yrs. mos. ds.

Contributory
(Secondary)

(Duration) yrs. mos. ds.

(Signed)

Geo. C. Smith M. D.

19. (Address)

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death yrs. mos. days. In the State yrs. mos. days.

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

Morris Hill Pl

May 15 1913

20. UNDERTAKER

ADDRESS

Joy & Summers

Boise Idaho

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Form V. S. No. 5 20M.1-16-12

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics
File No. 4887

1. PLACE OF DEATH.

Registration District No. 1

County of AdairPrimary Registration District No. 2004City of Four Bases(No. Soldiers Home, St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

David E. BanksRegistered No. 42

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX

Male

4. COLOR OR RACE

White American

5. SINGLE, MARRIED, WIDOWED OR DIVORCED.

Single
(Write the word.)

6. DATE OF BIRTH

Feb 21 1839
(Month) (Day) (Year)

7. AGE

74 yrs. 3 mos. 10 ds.

IF LESS than 1 day
how many hrs. or
..... mins.?

8. OCCUPATION

(a) Trade, profession or particular kind of work

(b) General nature of industry, business, or establishment in which employed (or employer)

Veteran Civil War

9. BIRTHPLACE

(State or Country)

Illinois

10. NAME OF FATHER

Frank Banks

11. BIRTHPLACE OF FATHER

(State or Country)

Penn.

12. MAIDEN NAME OF MOTHER

Mac. Smith

13. BIRTHPLACE OF MOTHER

(State or Country)

Virginia

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

E. G. Burnett

(Address)

Soldiers Home

15.

Filed

May 31 1913

Local Registrar

J. M. Taylor

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH

5 31 1913
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from

7/31 1912 to 5/31 1913,
that I last saw him alive on 5/29 1913

and that death occurred on the date stated above, at 2 A M.

The CAUSE OF DEATH* was as follows:

Consuming of Smokey

(Duration) yrs. mos. ds.

Contributory

(Secondary)

(Duration) yrs. mos. ds.

(Signed) Fred A. Summers M. D.5/31 1913 (Address) Fish Lake

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death yrs. mos. days. In the State yrs. mos. days.

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

Morris Hill Cemetery June 1 1913

20. UNDERTAKER

ADDRESS

Fry & Summers Boise Id.

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Form V. S. No. 5. 12½ M. 7-24-11

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics
File No. 4889
Registered No. _____

1. PLACE OF DEATH. Registration District No. _____
County of Power Primary Registration District No. _____
City of American Falls No. _____ St. _____

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Victor Andrew Wade

If death occurred in a hospital, institution or camp give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX Male 4. COLOR OR RACE W. 5. SINGLE, MARRIED, WIDOWED OR DIVORCED. Single
(Write the word.)
6. DATE OF BIRTH 2 25 1913
(Month) (Day) (Year)

7. AGE 15 yrs. 10 mos. 8 ds. IF LESS than 1 day how many _____ hrs. or _____ min?

8. OCCUPATION
(a) Trade, profession or particular kind of work. Student
(b) General nature of industry business or establishment in which employed (or employer) _____

9. BIRTHPLACE (State or Country) Utah

10. NAME OF FATHER Charles B Wade

11. BIRTHPLACE OF FATHER (State or Country) North Ogden Utah

12. MAIDEN NAME OF MOTHER Marion M. Driscoll

13. BIRTHPLACE OF MOTHER (State or Country) Utah

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE (Informant) Charles B Wade

(Address) American Falls, Id.

15. Filed Feb. 27 1913 R. F. T. T. T.

Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH Feb. 25 1913
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from Feb. 20th 1913, to Feb. 25th 1913 that I last saw him alive on Feb. 25th 1913 and that death occurred on the date stated above, at 10 P. M.

The CAUSE OF DEATH was as follows:
Grippe Pneumonia

(Duration) _____ yrs. _____ mos. 7 ds.
Contributory (Secondary) General peritonitis

(Duration) _____ yrs. _____ mos. 3 ds.
(Signed) Richard F. T. T. T. M. D.
Feb. 27 1913 (Address) Richard F. T. T. T.

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place In the
of death _____ yrs. _____ mos. _____ ds. State _____ yrs. _____ mos. _____ ds.
Where was disease contracted,
If not at place of death? _____
Former or
usual residence _____

19. PLACE OF BURIAL OR REMOVAL DATE OF BURIAL
Pocatello Feb. 28 1913

20. UNDERTAKER ADDRESS
W. J. Walker Pocatello

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH. Registration District No. _____
County of Power Primary Registration District No. _____
City of American Falls No. _____, _____ (St.)

File No. _____
Registered No. _____

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

Walter William Richardson

If death occurred in a hospital, institution or camp give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX Male 4. COLOR OR RACE White 5. SINGLE, MARRIED, WIDOWED OR DIVORCED. Married

6. DATE OF BIRTH

May 17 1889
(Month) (Day) (Year)

7. AGE

23 yrs. 9 mos. 9 ds.

IF LESS than 1 day
how many hrs. or
..... min?

8. OCCUPATION

(a) Trade, profession or particular kind of work. Farmer
(b) General nature of industry business or establishment in which employed (or employer)

9. BIRTHPLACE

(State or Country)

Henry's Fork Idaho

10. NAME OF FATHER

John Richardson

11. BIRTHPLACE OF FATHER

(State or Country)

12. MAIDEN NAME OF MOTHER

Louisa Clark

13. BIRTHPLACE OF MOTHER

(State or Country)

Mass

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Louis Richardson
(Address) Rockland Ida

15. Feb 27 1913 R. F. Mott
Filed Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

Feb 26

(Month)

(Day)

1913
(Year)

17. I HEREBY CERTIFY, That I attended deceased from

1913 to 1913

that I last saw h..... alive on 1913

and that death occurred on the date stated above, at M.

The CAUSE OF DEATH* was as follows:-

Accidental electrocution at Power plant at American Falls

(Duration) yrs. mos. ds.

Contributory
(Secondary)

(Duration) yrs. mos. ds.

(Signed)

Richard F. Mott M. D.
American Falls (Address)

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place In the
of death yrs. mos. ds. State yrs. mos. ds.

Where was disease contracted,

If not at place of death?

Former or

usual residence.

19. PLACE OF BURIAL OR REMOVAL DATE OF BURIAL

Rockland

Feb 28 1913

20. UNDERTAKER

ADDRESS

H. R. Hager

American Falls

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics
File No. **1890**
Registered No. _____

1. PLACE OF DEATH. Registration District No. _____
County of Power Primary Registration District No. _____
City of American (No. _____, _____ St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Franklin Pierce Tague

If death occurred in a hospital, institution or camp give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX Male 4. COLOR OR RACE White 5. SINGLE, MARRIED, WIDOWED OR DIVORCED. Married
(Write the word.)

6. DATE OF BIRTH Dec 14 1882
(Month) (Day) (Year)

7. AGE 35 yrs. 5 mos. 1 ds. IF LESS than 1 day how many _____ hrs. or _____ min?

8. OCCUPATION
(a) Trade, profession or particular kind of work. Farmer
(b) General nature of industry business or establishment in which employed (or employer) _____

9. BIRTHPLACE
(State or Country) Iowa

10. NAME OF FATHER F. M. Tague

11. BIRTHPLACE OF FATHER
(State or Country) Georgia

12. MAIDEN NAME OF MOTHER Celesta Smith

13. BIRTHPLACE OF MOTHER
(State or Country) Missouri

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) 1890
(Address) _____

15. R. P. Tague
Filed _____ 191 _____
Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH April 15 1913
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from April 6 1913, to April 15 1913 that I last saw him alive on April 15 1913 and that death occurred on the date stated above, at 8 P. M.

The CAUSE OF DEATH* was as follows:
Appendicitis and abscess

(Duration) _____ yrs. _____ mos. 10 ds.
Contributory General Peritonitis
(Secondary)
(Duration) _____ yrs. _____ mos. 3 ds.
(Signed) Richard T. North M. D.
Apr 16 1913 (Address) American Falls, Id.

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place Bethany Hospital In the _____
of death _____ yrs. _____ mos. _____ ds. State _____ yrs. _____ mos. _____ ds.
Where was disease contracted. From near American Falls
If not at place of death?
Former or usual residence American Falls

19. PLACE OF BURIAL OR REMOVAL DATE OF BURIAL
Removal to Danville, Iowa Apr 1913

20. UNDERTAKER ADDRESS
H. R. Hager American Falls, Ida

MARGIN RESERVED FOR BINDING
WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Form V. S. No. 5 20M.1-16-12

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics
File No. 4897

1. PLACE OF DEATH

Registration District No. 5

County of Bonner

Primary Registration District No. 2036

City of Sandpoint

(No. , St.)

Registered No. 220

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME J. M. Baum

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX

Male

4. COLOR OR RACE

white

5. SINGLE, MARRIED, WIDOWED OR DIVORCED.

Widowed
(Write the word.)

6. DATE OF BIRTH

unknown
(Month)

1
(Day)

(Year)

7. AGE

64 yrs.

mos.

ds.

IF LESS than 1 day
how many hrs. or
mins.?

8. OCCUPATION

(a) Trade, profession or
particular kind of work

Laborer

(b) General nature of industry
business, or establishment in
which employed (or employer)

well digging

9. BIRTHPLACE

(State or Country)

New York state

10. NAME OF
FATHER

deceased

11. BIRTHPLACE
OF FATHER

(State or Country)

unknown

12. MAIDEN NAME
OF MOTHER

do

13. BIRTHPLACE
OF MOTHER

(State or Country)

do

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

John C. Baum

(Address)

Welcome Minn.

15.

Filed

5/16

1913

M. M. Kinn
Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

May

15

1913

(Month)

(Day)

(Year)

17. I HEREBY CERTIFY, That I attended deceased from

May 5 1913, to May 15 1913

that I last saw him alive on May 13 1913

and that death occurred on the date stated above, at Sandpoint

The CAUSE OF DEATH* was as follows:

Cause of the Cancer.

(Duration) — yrs. 9 mos. — ds.

Contributory
(Secondary)

(Duration) — yrs. — mos. — ds.

(Signed)

Roscoe N. Jackson M. D.

May 15 1913

(Address) Sandpoint Ida

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death — yrs. — mos. — ds. In the State — yrs. — mos. — ds.

Where was disease contracted if not at place of death?

Forest River Idaho

Former or usual residence.

Forest River Idaho

19. PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

Sandpoint, Idaho.

May 17 1913

20. UNDERTAKER

ADDRESS

E. M. Brower

Sandpoint, Ida

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Form V. S. No. 5 20M.1-16-12

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH

Registration District No.

County of Bonner

Primary Registration District No.

City of Sandpoint

(No. _____, _____ St.)

File No. 4898

Registered No. 279

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Joseph Arseneau

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX

male

4. COLOR OR RACE

white

5. SINGLE, MARRIED, WIDOWED OR DIVORCED.

single
(Write the word.)

6. DATE OF BIRTH

_____ 1 _____
(Month) (Day) (Year)

7. AGE

52 yrs. mos. ds.

IF LESS than 1 day
how many hrs. or
mins.?

8. OCCUPATION

(a) Trade, profession or particular kind of work Miner, & Lumber-jack
(b) General nature of industry business, or establishment in which employed (or employer)

9. BIRTHPLACE

(State or Country) Canada

10. NAME OF FATHER

11. BIRTHPLACE OF FATHER

(State or Country)

12. MAIDEN NAME OF MOTHER

13. BIRTHPLACE OF MOTHER

(State or Country)

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

(Address) Sandpoint, Idaho.

15.

Filed May 12 1913

M. McKenion
Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

May 10 1913
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from

1913, to 1913,

that I last saw him alive on May 10 1913,

and that death occurred on the date stated above, at 5 AM.

The CAUSE OF DEATH* was as follows:

Acute Alcoholism

(Duration) yrs. mos. ds.

Contributory
(Secondary)

(Duration) yrs. mos. ds.

(Signed) E. C. Starhouse M. D.

5/10 1913 (Address) Sandpoint.

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death. yrs. mos. days. In the State. yrs. mos. days.

Where was disease contracted if not at place of death?

Former or usual residence.

19. PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

Buried in Idaho

May 13 1913

20. UNDERTAKER

ADDRESS

E. M. Brower

Sandpoint,

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Form V. S. No. 5 20M.1-16-12

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH

Registration District No. 8

County of Bonner

Primary Registration District No. 2036

City of Sandpoint

(No. , St.)

File No. 4899

Registered No. 216

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Robert Jermiah Ashton.

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX

Male

4. COLOR OR RACE

White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED.

Single
(Write the word.)

6. DATE OF BIRTH

May 9 1911
(Month) (Day) (Year)

7. AGE

I yrs. II mos. 28 ds.

IF LESS than 1 day
how many hrs. or
mins.?

8. OCCUPATION

(a) Trade, profession or particular kind of work None

(b) General nature of industry business, or establishment in which employed (or employer)

9. BIRTHPLACE

(State or Country) Sandpoint, Idaho.

10. NAME OF FATHER

Maurice H. Ashton

11. BIRTHPLACE OF FATHER

(State or Country) Ill

12. MAIDEN NAME OF MOTHER

Agnes Burke,

13. BIRTHPLACE OF MOTHER

(State or Country) Washington

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

(Address) Sandpoint, Idaho.

15.

Filed May 10th 1913

M. McKinn
Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH

May 7 1913
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from April 27 1913, to May 7 1913,

that I last saw him alive on May 7 1913

and that death occurred on the date stated above, at 5 P.M.

The CAUSE OF DEATH* was as follows:

Gastro enteritis

(Duration) yrs. mos. 11 ds.

Contributory Probably phosphorus poison
(Secondary) from eating matches.

(Duration) yrs. mos. ds.

(Signed) C. C. Sweeney M. D.

5/7 1913 (Address) Sandpoint

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death. yrs. mos. days. In the State. yrs. mos. days.

Where was disease contracted if not at place of death?

Former or usual residence.

19. PLACE OF BURIAL OR REMOVAL

Sandpoint, Idaho.

DATE OF BURIAL

May 9th 1913

20. UNDERTAKER

E. M. Brown

ADDRESS

Sandpoint, Idaho

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Form V. S. No. 5 20M.1-16-12

CERTIFICATE

State of Idaho
BUREAU OF HEALTH
Bureau of Vital Statistics
File No. 4900

1. PLACE OF DEATH.

Registration District No. 8

County of Bonner

Primary Registration District No. 2034

City of Bonners Ferry (No. St.)

Registered No. 217

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Belle Conklin
If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX

4. COLOR OR RACE

5. SINGLE, MARRIED, WIDOWED OR DIVORCED.

Female

White

Married
(Write the word.)

6. DATE OF BIRTH

Nov

18th

1865

7. AGE

47 yrs. 5 mos. 10 ds.

IF LESS than 1 day
how many hrs. or mins.?

8. OCCUPATION

(a) Trade, profession or particular kind of work
(b) General nature of industry business, or establishment in which employed (or employer)

Housewife

9. BIRTHPLACE

(State or Country)

Virginia

10. NAME OF FATHER

John H. Davis

11. BIRTHPLACE OF FATHER

(State or Country)

Virginia

12. MAIDEN NAME OF MOTHER

Margaret Mason

13. BIRTHPLACE OF MOTHER

(State or Country)

Missouri

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) James J. Conklin

(Address) Bonners Ferry, Idaho

15.

Filed April 29th 1913.

Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH

April

29th

1913.

(Month)

(Day)

(Year)

17. I HEREBY CERTIFY, That I attended deceased from March 3rd 1913, to April 29th 1913.

that I last saw her alive on April 1913, and that death occurred on the date stated above, at 2 A. M.

The CAUSE OF DEATH* was as follows:

Pernicious Anaemia

(Duration) yrs. mos. ds.

Contributory
(Secondary)

(Duration) yrs. mos. ds.

(Signed) E. E. Mc

4/30 1913. (Address) Bonners Ferry, Ida.

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death.....yrs.....mos.....days. In the State.....yrs.....mos.....days.

Where was disease contracted if not at place of death?

Former or usual residence.....

19. PLACE OF BURIAL OR REMOVAL DATE OF BURIAL

Edmo Kansas

1913

20. UNDERTAKER

ADDRESS

John J. Moore Bonners Ferry Ida

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Form V. S. No. 5 20M.1-16-12

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH

Registration District

8

County of

Bonner

Primary Registration District No.

2034

City of

Bonner Ferry, Idaho

St.)

File No.

4901

Registered No.

216

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

Catherine B. Mahoney

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX

Female

4. COLOR OR RACE

White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED.

Widow
(Write the word.)

6. DATE OF BIRTH

March 14th 1867
(Month) (Day) (Year)

7. AGE

66 yrs. 1 mos. 21 ds.

IF LESS than 1 day
how many hrs. or
mins?

8. OCCUPATION

(a) Trade, profession or particular kind of work

Housewife

(b) General nature of industry business, or establishment in which employed (or employer)

9. BIRTHPLACE

(State or Country)

Ireland

10. NAME OF FATHER

John Lyons

11. BIRTHPLACE OF FATHER

(State or Country)

Ireland

12. MAIDEN NAME OF MOTHER

13. BIRTHPLACE OF MOTHER

(State or Country)

Ireland

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

W. B. Mahoney

(Address)

Bonner Ferry, Idaho

15.

Filed

April 26th 1913

Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH

April 25th 1913
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from
Mar 31 1913, to April 25th 1913,

that I last saw her alive on April 24th 1913,

and that death occurred on the date stated above, at 9 A.M.

The CAUSE OF DEATH* was as follows:

Cerebral hemorrhage.

(Duration) yrs. mos. ds.

Contributory
(Secondary)

(Duration) yrs. mos. ds.

(Signed)

E. E. Fry, M. D.

4/27 1913 (Address) Bonner Ferry, Idaho

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death yrs. mos. days. In the State yrs. mos. days.

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

Walters town S. D.

1913

20. UNDERTAKER

ADDRESS

John J. Moore

Bonner Ferry Idaho

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Form V. S. No. 5 20M.1-16-12

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics
File No. **4903**

1. PLACE OF DEATH.

Registration District No. **8**

County of **Bonner**

Primary Registration District No. **2034**

City of **Bonner Ferry** (No. _____, St.)

Registered No. **213**

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME **Malcolm Hall**

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX

Male

4. COLOR OR RACE

White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED.

(Write the word.)

6. DATE OF BIRTH

May 1st 1913
(Month) (Day) (Year)

7. AGE

____ yrs. ____ mos. **11** ds.

IF LESS than 1 day
how many _____ hrs. or
_____ mins.

8. OCCUPATION

(a) Trade, profession or particular kind of work

(b) General nature of industry, business, or establishment in which employed (as employer)

9. BIRTHPLACE

(State or Country) **Bonner Ferry Ida**

10. NAME OF FATHER

Joe Hall

11. BIRTHPLACE OF FATHER

(State or Country) **Peel Canada**

12. MAIDEN NAME OF MOTHER

Barah Hall

13. BIRTHPLACE OF MOTHER

(State or Country) **Idaho Canada**

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) **Joe Hall**

(Address) **Bonner Ferry Ida**

15.

May 24th

Filed **May 24th 1913**

E. E. Fry
Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

May 21 1913
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from **May 14th 1913**, to **May 21st 1913**, that I last saw him alive on **May 17th 1913**.

and that death occurred on the date stated above, at **8 P. M.**

The CAUSE OF DEATH* was as follows:

Acute indigestion

(Duration) ____ yrs. ____ mos. **11** ds.

Contributory (Secondary)

(Duration) ____ yrs. ____ mos. ____ ds.

(Signed)

May 21 1913 (Address) **Bonner Ferry Ida**

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death ____ yrs. ____ mos. ____ days. In the State ____ yrs. ____ mos. ____ days.

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

Bonner Ferry Ida

May 25 1913

20. UNDERTAKER

ADDRESS

John J. Moore

Bonner Ferry Ida

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate

Form V. S. No. 5 20M.1-16-12

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH
County of *Blaine*
City of *Pocatello*

Registration District No. *19*
Primary Registration District No. *1002*
(No. *130*, *Do Arthur* St.)

File No. *1504*
Registered No. *64*

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME *Elizabeth R Potter*

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX *Female* 4. COLOR OR RACE *White* 5. SINGLE, MARRIED, WIDOWED OR DIVORCED *Widowed*

6. DATE OF BIRTH *Oct 14 1886*
(Month) (Day) (Year)

7. AGE *86* yrs. *7* mos. *14* ds.
IF LESS than 1 day how many hrs. or mins.?

8. OCCUPATION
(a) Trade, profession or particular kind of work? *Retired*
(b) General nature of industry business, or establishment in which employed (or employer)

9. BIRTHPLACE
(State or Country)

10. NAME OF FATHER *John Barnes*

11. BIRTHPLACE OF FATHER
(State or Country)

12. MAIDEN NAME OF MOTHER *Rachel Vauderstam*

13. BIRTHPLACE OF MOTHER
(State or Country)

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) *G. W. Derr*

(Address) *Pocatello Ida*

15. Filed *May 28 1913*
Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH *May 28* 191*3*
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from *May 25* 191*3* to *May 28* 191*3*
that I last saw her alive on *May 28* 191*3*
and that death occurred on the date stated above, at *8:45* P. M.

The CAUSE OF DEATH* was as follows:
Cerebral Hemorrhage

(Duration) yrs. mos. ds.
Contributory (Secondary)

(Signed) *S. A. Castle* M. D.
May 29 1913 (Address) *Pocatello Ida*

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death. yrs. mos. days. In the State. yrs. mos. days.

Where was disease contracted if not at place of death?
Former or usual residence.

19. PLACE OF BURIAL OR REMOVAL *St. Andrew's* DATE OF BURIAL *May 31* 191*3*

20. UNDERTAKER *W. Walker* ADDRESS *Pocatello Ida*

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Form V. S. No. 5 20M.1-16-12

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics
File No. **4205**
Registered No. **61**

1. PLACE OF DEATH. *Barrock*
County of *Barrock*
City of *Pocatello*
Registration District No. *19*
Primary Registration District No. *1002*
(No. *Gulf Hospital* St.)
2. FULL NAME *Bessie Rawson*

If death occurs away from usual residence, give facts called for under special information.

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX *Female* 4. COLOR OR RACE *White* 5. SINGLE, MARRIED, WIDOWED OR DIVORCED *Married*

6. DATE OF BIRTH *Feb 8 1877*
(Month) (Day) (Year)

7. AGE *36 yrs. 3 mos. 10 ds.*
IF LESS than 1 day how many hrs. or mins.?

8. OCCUPATION
(a) Trade, profession or particular kind of work *Housewife*
(b) General nature of industry business, or establishment in which employed (or employer)

9. BIRTHPLACE *Illinois*
(State or Country)

10. NAME OF FATHER *George W. Whipple*

11. BIRTHPLACE OF FATHER *Michigan*
(State or Country)

12. MAIDEN NAME OF MOTHER *Eva Warner*

13. BIRTHPLACE OF MOTHER *Vermont*
(State or Country)

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) *L. N. Kullor*
(Address) *Pocatello Ida*

15. Filed *May 20 1913* *O. B. Kullor*
Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH *May 18 1913*
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from *5/20 1913* to *May 18 1913* that I last saw her alive on *May 18 1913* and that death occurred on the date stated above, at *6-4 A. M.*

The CAUSE OF DEATH* was as follows:
Septicemia from Streptococcus infection of Pelvis & Acute Nephritis.

(Duration) *7* yrs. *3* mos. *3* ds.
Contributory (Secondary) *Septicemia*
(Duration) *3* yrs. *3* mos. *3* ds.
(Signed) *W. A. Grisham* M. D.
5/20 1913 (Address) *Pocatello, Idaho*

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death *3* yrs. *3* mos. *3* days. In the State *Ar Home*
Where was disease contracted if not at place of death?
Former or usual residence *Pocatello, Idaho*

19. PLACE OF BURIAL OR REMOVAL *Los Angeles* DATE OF BURIAL *May 22 1913*

20. UNDERTAKER *H. H. Mackay* ADDRESS *Pocatello, Idaho*

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Form V. S. No. 5 20M.1-16-12

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH

Registration District No. 19

County of

Primary Registration District No. 1002

City of

(No. County Jail

St.)

File No. 5000

Registered No. 60

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

James Bradley

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX

Male

4. COLOR OR RACE

White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED.

(Write the word.)

6. DATE OF BIRTH

(Month)

(Day)

(Year)

7. AGE

yrs. mos. ds.

IF LESS than 1 day
how many hrs. or
mins.?

8. OCCUPATION

(a) Trade, profession or particular kind of work

(b) General nature of industry business, or establishment in which employed (or employer)

Hold up tramp

9. BIRTHPLACE

(State or Country)

10. NAME OF FATHER

11. BIRTHPLACE OF FATHER

(State or Country)

12. MAIDEN NAME OF MOTHER

13. BIRTHPLACE OF MOTHER

(State or Country)

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

(Address)

15.

Filed

May 23 1913

1913

Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

May 21

21

1913

(Month)

(Day)

(Year)

17. I HEREBY CERTIFY, That I attended deceased from

May 21 1913 to May 21 1913

that I last saw him alive on May 21 1913

and that death occurred on the date stated above, at 2 P. M.

The CAUSE OF DEATH* was as follows:

Korshak's Disease supposedly
before with suicidal intent

(Duration) yrs. mos. ds.

Contributory

(Secondary)

(Duration) yrs. mos. ds.

(Signed)

May 19 1913 (Address) Pocahontas

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death yrs. mos. days. In the State yrs. mos. days.

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

Mt Lawton

May 23 1913

20. UNDERTAKER

ADDRESS

Mt Lawton

Pocahontas

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Form V. S. No. 5 20M.1-16-12

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH

Registration District No. 19

County of Burnham

Primary Registration District No. 40.02

City of Blackfoot

(No. State of Idaho St.)

File No. 1917

Registered No. 51

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

Jessie Race

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX

Male

4. COLOR OR RACE

White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED

Married
(Write the word.)

6. DATE OF BIRTH

Feb

17

1860

(Month)

(Day)

(Year)

7. AGE

53 yrs. 3 mos. 4 ds.

IF LESS than 1 day
how many hrs. or mins.?

8. OCCUPATION

(a) Trade, profession or particular kind of work
(b) General nature of industry business, or establishment in which employed (or employer)

Retired

9. BIRTHPLACE

(State or Country)

Pennyan. N. Y.

10. NAME OF FATHER

Sam H. Race

11. BIRTHPLACE OF FATHER

(State or Country)

Pennyan N. Y.

12. MAIDEN NAME OF MOTHER

Eliz Cook

13. BIRTHPLACE OF MOTHER

(State or Country)

N. Y.

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

Edith (arrived)

(Address)

Pocatello

15.

Filed

May 23 1913

1913

Officer

Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

May

20

1913

(Month)

(Day)

(Year)

17. I HEREBY CERTIFY, That I attended deceased from

June 9

1913

to May 21

1913

that I last saw him alive on May 20 1913

and that death occurred on the date stated above, at 12:30 A.M.

The CAUSE OF DEATH* was as follows:

Killed by mine patent

(Duration)

2 yrs.

mos.

ds.

Contributory

(Secondary)

(Duration)

hrs.

mos.

ds.

(Signed)

James H. Boone

M. D.

May 21 1913

(Address) Blackfoot, Ida

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place

of death

1 yrs. 11 mos. 19 days.

In the

State

22 yrs. 22 mos. 22 days.

Where was disease contracted if not at place of death?

Pocatello

Former or usual residence

Pocatello, Idaho

19. PLACE OF BURIAL OR REMOVAL

N. H. Walker

DATE OF BURIAL

May 21 1913

20. UNDERTAKER

N. H. Walker

ADDRESS

Pocatello, Ida

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Form V. S. No. 5 20M.1-16-12

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH

Registration District No. 19

County of Blaine

Primary Registration District No. 1002

City of Pocatello

(No. 721, N. Harrison St.)

File No. 4908

Registered No. 58

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Doris Leon Clements

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX Male

4. COLOR OR RACE White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write word.)

6. DATE OF BIRTH

Oct 6 1910
(Month) (Day) (Year)

7. AGE

2 yrs. 7 mos. 10 ds.

IF LESS than 1 day
how many hrs. or mins.?

8. OCCUPATION

(a) Trade, profession or particular kind of work

None

(b) General nature of industry, business, or establishment in which employed (or employer)

9. BIRTHPLACE

(State or Country)

Pocatello Idaho

10. NAME OF FATHER

E. S. Clements

11. BIRTHPLACE OF FATHER

(State or Country)

Logan Utah

12. MAIDEN NAME OF MOTHER

Mabel Davis

13. BIRTHPLACE OF MOTHER

(State or Country)

Beary Lake Ida.

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

E. S. Clements

(Address)

Pocatello Ida

15.

Filed

May 26 1913

Local Registrar

Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

May 25 1913
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from May 19 1913, to May 25 1913,

that I last saw her alive on May 25 1913,

and that death occurred on the date stated above, at 4 P.M.

The CAUSE OF DEATH* was as follows:

Lobar pneumonia

(Duration) yrs. mos. 10 ds.

Contributory (Secondary)

measles

(Duration) yrs. mos. 14 ds.

(Signed)

E. S. Clements M. D.

726 1913 (Address) Pocatello Idaho

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death yrs. mos. days. In the State yrs. mos. days.

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

Pocatello Ida

1913

20. UNDERTAKER

ADDRESS

W. B. Mackay Pocatello

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Form V. S. No. 5 20M.1-16-12

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital StatisticsFile No. 4909Registered No. 57

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

1. PLACE OF DEATH

Registration District No. 19County of BannockPrimary Registration District No. 1002City of Pocatello(No. 10, 60 Harrison Ave. St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Emma V. Wade

PERSONAL AND STATISTICAL PARTICULARS

3. SEX Female4. COLOR OR RACE White5. SINGLE, MARRIED, WIDOWED OR DIVORCED.
Widow
(Write the word.)

6. DATE OF BIRTH

April 22 1899
(Month) (Day) (Year)

7. AGE

74 yrs. 1 mos. — ds.IF LESS than 1 day
how many hrs. or
..... mins.

8. OCCUPATION

(a) Trade, profession or particular kind of work
(b) General nature of industry business, or establishment in which employed (or employer)Housewife

9. BIRTHPLACE

(State or Country)

Leeds Eng.

10. NAME OF FATHER

John Muggatroyd

11. BIRTHPLACE OF FATHER

(State or Country)

England

12. MAIDEN NAME OF MOTHER

- Dewhurst

13. BIRTHPLACE OF MOTHER

(State or Country)

England

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

L. L. Martin

(Address)

Pocatello Ida

15.

Filed

May 241913O. B. Sneyd
Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

May 22 1913
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from

1913, to May 22 1913,
that I last saw her alive on May 21 1913,
and that death occurred on the date stated above, at 6 a.m.

The CAUSE OF DEATH* was as follows:

Thromboplegia(Duration) yrs. 2 mos. — ds.Contributory
(Secondary)

(Duration) yrs. mos. ds.

(Signed)

5-23-1913 (Address) O. B. Sneyd, M. D.
Pocatello Idaho

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death yrs. mos. days. In the State yrs. mos. days.

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL DATE OF BURIAL

Pocatello Idaho May 23 1913

20. UNDERTAKER

ADDRESS

W. M. Walker Pocatello Ida

MARGIN RESERVED FOR BINDING
WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Form V. S. No. 5 20M.1-16-12

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics
File No. 4911

1. PLACE OF DEATH

Registration District No. 19

County of Bannock

Primary Registration District No. 1002

City of Princeton

(No. 540 N. Main St.)

Registered No. 56

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

Infant of R. H. Reed

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX

Female

4. COLOR OR RACE

White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED.

Single
(Write the word.)

6. DATE OF BIRTH

May
(Month)

25
(Day)

1913
(Year)

7. AGE

1 yrs. 1 mos. 1 ds.

IF LESS than 1 day
how many 21 hrs. or
2 mins.

8. OCCUPATION

(a) Trade, profession or particular kind of work

None

(b) General nature of industry business, or establishment in which employed (or employer)

9. BIRTHPLACE

(State or Country)

Princeton Idaho

10. NAME OF FATHER

R. H. Reed

11. BIRTHPLACE OF FATHER

(State or Country)

Bowling Green Ohio

12. MAIDEN NAME OF MOTHER

Lillian Carpenter

13. BIRTHPLACE OF MOTHER

(State or Country)

Princeton Wis

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

R. H. Reed

(Address)

Princeton Idaho

15.

Filed

May 27 1913

Officer

Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

May
(Month)

25
(Day)

1913
(Year)

17. I HEREBY CERTIFY, That I attended deceased from

May 25 1913, to May 25 1913

that I last saw her alive on May 25 1913

and that death occurred on the date stated above, at 12:30

The CAUSE OF DEATH* was as follows:

Failure of foramen
osculi to close

(Duration) yrs. mos. ds.

Contributory
(Secondary)

(Duration) yrs. mos. ds.

(Signed)

W. J. Steeg

M. D.

5-26 1913 (Address) Princeton Idaho

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death yrs. mos. days. In the State yrs. mos. days.

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

St. Louis August

May 28 1913

20. UNDERTAKER

ADDRESS

W. J. Steeg Princeton

Form V. S. No. 5 20M.1-16-12

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics
File No. **4911**

1. PLACE OF DEATH.

Registration District No. **14**County **Custer**Primary Registration District No. **2064**City of **Mackay**

(No. _____)

St. _____

Registered No. _____

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

Harry Humphrey

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX

4. COLOR OR RACE

5. SINGLE, MARRIED, WID-

OWED OR DIVORCED

Male**White****Married**
(Write the word.)

6. DATE OF BIRTH

Nov. 23 1873
(Month) (Day) (Year)

7. AGE

39 yrs. 5 mos. 18 ds.IF LESS than 1 day
how many hrs. or
..... mins.?

8. OCCUPATION

(a) Trade, profession or
particular kind of work
(b) General nature of industry
business, or establishment in
which employed (or employer)**Rancher**

9. BIRTHPLACE

(State or Country)

Ohio10. NAME OF
FATHER**John Humphrey**11. BIRTHPLACE
OF FATHER

(State or Country)

Ky.12. MAIDEN NAME
OF MOTHER**Margoultte Fenn**13. BIRTHPLACE
OF MOTHER

(State or Country)

England

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

Mrs H Humphrey

(Address)

Mackay Idaho

15.

Filed

May 10th 1913**W. H. Hunt**

Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH

May 1 1913
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from

May 1st 1913, to May 1st 1913,that I last saw him alive on **May 1st 1913**and that death occurred on the date stated above, at **2:35 P.M.**

The CAUSE OF DEATH* was as follows:

Homicidal -
Stab wound of right chest
penetrating muscle of heart.
Chorea (Duration) yrs mos dsContributory
(Secondary)**6 hrs (Duration) yrs mos ds**(Signed) **Francis P. Richards** M. D.**5/8 1913 (Address) Mackay, Idaho**

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death yrs mos days. In the State yrs mos days.

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

Idaho Falls**Shipped 1913**

20. UNDERTAKER

ADDRESS

W. H. Hunt**Idaho Falls**

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Form V. S. No. 5. 10M. 6-20-11.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics
File No. 4912

1. PLACE OF DEATH.
County of Canyon
City of Nampa

Registration District No. 3
Primary Registration District No. 1006
(No. _____, _____ St.)

Registered No. 68

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Harrett Bockerman

If death occurred in a hospital, institution or camp give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX Female 4. COLOR OR RACE white 5. SINGLE, MARRIED, WIDOWED OR DIVORCED. Widowed
(Write the word.)

6. DATE OF BIRTH March 19 (Month) 1892 (Day) 2 (Year)

7. AGE 61 yrs. 2 mos. 17 ds. IF LESS than 1 day how many _____ hrs. or _____ min.)

8. OCCUPATION
(a) Trade, profession, or particular kind of work Housewife
(b) General nature of industry, business, or establishment in which employed (or employer)

9. BIRTHPLACE
(State or Country) Indiana

10. NAME OF FATHER William James

11. BIRTHPLACE OF FATHER New York

12. MAIDEN NAME OF MOTHER Elija Davis

13. BIRTHPLACE OF MOTHER Indiana

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Sarah Rinker
(Address) Nampa Idaho

15. Filed June 6 1913 John D. Meyer
Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH May 26 1913
(Month) (Day) (Year)

17. I HEREBY CERTIFY That I attended deceased from Harrett Bockerman 5/26 1913

that I last saw her alive on May 25 1913, and that death occurred on the date stated above, at 11 PM,

The CAUSE OF DEATH* was as follows:

Structure of rectum
supposedly carcinoma
Operation & autopsy denied
(Duration) 70 yrs. 7 mos. 7 ds.

Contributory (Secondary) Dant & Kuswetter Hospital
(Duration) 5 yrs. 5 mos. 5 ds.

(Signed) D. D. Calonge M. D.
5/26 1913 (Address) Nampa Ida.

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place In the
of death _____ yrs. _____ mos. _____ ds. State _____ yrs. _____ mos. _____ ds.
Where was Disease contracted,
If not at place of death?
Former or usual residence.

19. PLACE OF BURIAL OR REMOVAL Fairview Cem DATE OF BURIAL 5/27 1913

20. UNDERTAKER F. H. Baum ADDRESS Nampa

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Form V. S. No. 5. 10M. 6-20-11.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics
4913

1. PLACE OF DEATH. Registration District No. 3
County of Canyon Primary Registration District No. 1006
City of Naupha (No. _____, St.)

File No. _____ Registered No. 69

If death occurs away from usual residence, give facts called for under special information.

If death occurred in a hospital, institution or camp give its NAME instead of street and number.

2. FULL NAME Otto Felix Waigand

PERSONAL AND STATISTICAL PARTICULARS

3. SEX Male 4. COLOR OR RACE White 5. SINGLE, MARRIED, WIDOWED OR DIVORCED. Single
(Write the word)

6. DATE OF BIRTH Nov 2 1889
(Month) (Day) (Year)

7. AGE 23 yrs. 5 mos. ds. IF LESS than 1 day how many _____ hrs. or _____ min.?

8. OCCUPATION
(a) Trade, profession, or particular kind of work Butcher
(b) General nature of industry, business, or establishment in which employed (or employer)

9. BIRTHPLACE (State or Country) Ill

10. NAME OF FATHER Chas Waigand

11. BIRTHPLACE OF FATHER (State or Country) Germany

12. MAIDEN NAME OF MOTHER Wilhelmina Horing

13. BIRTHPLACE OF MOTHER (State or Country) Mo.

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Charles Waigand
(Address) Naupha Idaho

15. Filed June 6 1913 J. H. Meyer
Local Registrar
Caldwell

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH May 27 1913
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from never 191____, to 191____

that I last saw h_____ alive on 191____,

and that death occurred on the date stated above, at 4:30 P. M.

The CAUSE OF DEATH* was as follows:
Lightning (instantaneous)

(Duration) _____ yrs. _____ mos. _____ ds.
Contributory (Secondary)

(Duration) _____ yrs. _____ mos. _____ ds.
(Signed) H. P. Ross M. D.
May 30 1913 (Address) Naupha

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL,

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place _____ In the _____
of death _____ yrs. _____ mos. _____ ds. State _____ yrs. _____ mos. _____ ds.

Where was Disease contracted,
If not at place of death?
Former or
usual residence.

19. PLACE OF BURIAL OR REMOVAL DATE OF BURIAL
Kohlerlawn Cem 5/30 1913

20. UNDERTAKER ADDRESS
F. K. Robinson Naupha Ida

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Form V. S. No. 5. 10M. 6-20-11.

CERTIFICATE OF DEATH

1. PLACE OF DEATH.

County of Canyon

City of _____

If death occurs away from usual residence, give facts called for under special information.

Registration District No. _____

Primary Registration District No. 2006

(No. _____, St.)

Bureau of Vital Statistics

File No. 4914Registered No. 70

If death occurred in a hospital, institution or camp give its NAME instead of street and number.

2. FULL NAME

Mary A Brammorus

PERSONAL AND STATISTICAL PARTICULARS

3. SEX

Female

4. COLOR OR RACE

White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED

Widowed

(Write the word.)

6. DATE OF BIRTH

Feb241837

(Month)

(Day)

(Year)

7. AGE

76 yrs.3 mos.4 ds.

IF LESS than 1 day

how many _____ hrs. or

_____ min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work

Housewife

(b) General nature of industry business or establishment in which employed (or employer)

9. BIRTHPLACE

(State or Country)

Germany

10. NAME OF FATHER

Grover

11. BIRTHPLACE OF FATHER

(State or Country)

Germany

12. MAIDEN NAME OF MOTHER

Grover

13. BIRTHPLACE OF MOTHER

(State or Country)

Germany

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

Barbara Gilmore

(Address)

Lewiston Idaho

15.

Filed

June 6, 1913John J. Meyer

Local Registrar

Caldwell

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

May291913

(Month)

(Day)

(Year)

17. I HEREBY CERTIFY, That I attended deceased from

river

191

to

191

that I last saw h. _____ alive on _____ 191

and that death occurred on the date stated above, at 39 M.

The CAUSE OF DEATH* was as follows:

Heart failure - died on the train(Duration) About yrs. Know mos. ds.

Contributory (Secondary)

(Duration) _____ yrs. _____ mos. _____ ds.

(Signed) H. P. Ross M. D.May 29 1913 (Address) Nampa Ida

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death none yrs. _____ mos. _____ ds. In the State 2 yrs. 6 mos. _____ ds.

Where was disease contracted,

If not at place of death?

Former or

usual residence

Lewiston, Ida

19. PLACE OF BURIAL OR REMOVAL

Youngstown Ohio

DATE OF BURIAL

don't know 191

20. UNDERTAKER

S. B. Shellabarger

ADDRESS

Nampa Ida

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Form V. S. No. 5. 10M. 6-20-11.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH.
County of Canyon
City of Peck Flat

Registration District No. 3
Primary Registrar District No. 2006
(No. _____ St.)

File No. 4915
Registered No. 71

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME George A. Busch

If death occurred in a hospital, institution or camp give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX Male 4. COLOR OR RACE white 5. SINGLE, MARRIED, WIDOWED OR DIVORCED Single
(Write the word.)

6. DATE OF BIRTH _____
(Month) (Day) (Year)

7. AGE 43 yrs. _____ mos. _____ ds. IF LESS than 1 day how many _____ hrs. or _____ min.?

8. OCCUPATION
(a) Trade, profession, or particular kind of work Farmer
(b) General nature of industry, business, or establishment in which employed (or employer)

9. BIRTHPLACE
(State or Country)

10. NAME OF FATHER

11. BIRTHPLACE OF FATHER
(State or Country)

12. MAIDEN NAME OF MOTHER

13. BIRTHPLACE OF MOTHER
(State or Country)

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) J. H. Robinson
(Address) Naupaka Ida

15. Filed June 6 - 1913 J. H. Meyer
Local Registrar Caldwell

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH _____
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from _____ 191____, to _____ 191____
that I last saw him alive on _____ 191____,
and that death occurred on the date stated above, at _____ M.

The CAUSE OF DEATH* was as follows:
Supposed to have drank himself to death - Reported when whiskey was all gone - drank 3 gallons of wine.
(Duration) _____ yrs. _____ mos. _____ ds.
Contributory Has found dead in bed - stomach starved & empty.
(Secondary) _____
(Duration) _____ yrs. _____ mos. _____ ds.
(Signed) no physician in attendance. M. D.
_____ 19____ (Address)

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place _____ In the _____
of death _____ yrs. _____ mos. _____ ds. State _____ yrs. _____ mos. _____ ds.
Where was Disease contracted, _____
If not at place of death? _____
Former or usual residence _____

19. PLACE OF BURIAL OR REMOVAL Hohlerlawn Cem DATE OF BURIAL 5/12 1913

20. UNDERTAKER J. H. Robinson ADDRESS Naupaka Ida

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Form V. S. No. 5. 12½ M. 7-24-11

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics
4916
File No. _____
Registered No. 65

1. PLACE OF DEATH. Registration District No. 3
County of Canyon Primary Registration District No. 2005
City of Greenleaf (No. _____, St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

Martha B. Harney

If death occurred in a hospital, institution or camp give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX 4. COLOR OR RACE 5. SINGLE, MARRIED, WIDOWED OR DIVORCED.

Female White (Write the word.)

6. DATE OF BIRTH Feb 5 1849
(Month) (Day) (Year)

7. AGE 64 yrs. 3 mos. 7 ds. IF LESS than 1 day how many hrs. or min?

8. OCCUPATION
(a) Trade, profession or particular kind of work. Housewife
(b) General nature of industry business or establishment in which employed (or employer)

9. BIRTHPLACE North Carolina
(State or Country)

10. NAME OF FATHER Wm Hutton

11. BIRTHPLACE OF FATHER N.C.
(State or Country)

12. MAIDEN NAME OF MOTHER Elizabeth Cummings

13. BIRTHPLACE OF MOTHER N.C.
(State or Country)

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Charles Harney
(Address) Greenleaf

15. Filed May 17- 1913 John S. Meyer Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH May 15 1913
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from May 6 1913, to May 14 1913, that I last saw her alive on May 14 1913, and that death occurred on the date stated above, at M. The CAUSE OF DEATH* was as follows:

Paralysis

(Duration) yrs. mos. 9 ds.

Contributory (Secondary)

(Signed) J. M. Meyer M. D.
May 16 1913, (Address) North Idaho

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place In the
of death yrs. mos. ds. State yrs. mos. ds.
Where was disease contracted,
If not at place of death?
Former or usual residence.

19. PLACE OF BURIAL OR REMOVAL DATE OF BURIAL

Greenleaf May 17 1913
20. UNDERTAKER ADDRESS

Platt-Reckham Lealwell

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Form V. S. No. 5 20M.1-16-12

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH.

Registration District No. 3

County of Canyon

Primary Registration District No. 2005

City of Middleton

(No. , St.)

File No. 4917

Registered No. 66

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Allen B Seydell

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX

F.

4. COLOR OR RACE

W.

5. SINGLE, MARRIED, WIDOWED OR DIVORCED.

Married

(Write the word.)

6. DATE OF BIRTH

June 16

(Month)

1853

(Day)

(Year)

7. AGE

60. yrs. 3 mos. 28. ds.

IF LESS than 1 day
how many hrs. or
mins.?

8. OCCUPATION

(a) Trade, profession or particular kind of work

House Keeping

(b) General nature of industry business, or establishment in which employed (or employer)

9. BIRTHPLACE

(State or Country)

don't know

10. NAME OF FATHER

"

"

11. BIRTHPLACE OF FATHER

(State or Country)

"

12. MAIDEN NAME OF MOTHER

13. BIRTHPLACE OF MOTHER

(State or Country)

Laura Morley

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

C. W. Seydell

(Address)

Middleton

15.

Filed

May 20 - 1913

John H. Meyer

Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH

May

(Month)

14

(Day)

1913

(Year)

17. I HEREBY CERTIFY, That I attended deceased from

6-8-1913, to 6-13-1913,

that I last saw her alive on 6-13-1913,

and that death occurred on the date stated above, at 5 A.M.

The CAUSE OF DEATH* was as follows:

Stomach and Bowel Inflammation

(Duration) yrs. mos. 6 ds.

Contributory Spinal and Rheumatic (Secondary)

(Duration) yrs. mos. ds.

(Signed) J. W. Haines M. D.

5-15-1913 (Address) Middleton

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death yrs. mos. days. In the State yrs. mos. days.

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

Middleton

May 16 1913

20. UNDERTAKER

ADDRESS

W. G. Dyer

Calderwell

Form V. S. No. 5 20M.1-16-12

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH.

Registration District No. 3County of CalaverasPrimary Registration District No. 2005File No. 491City of Merced, Calif. (No. _____, St.)Registered No. 67

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

Woodrow Shaffer

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX

male

4. COLOR OR RACE

white

5. SINGLE, MARRIED, WIDOWED OR DIVORCED.

(Write the word.)

6. DATE OF BIRTH

Dec
(Month)1st
(Day)1912
(Year)

7. AGE

_____ yrs. 4 mos. _____ ds.IF LESS than 1 day
how many _____ hrs. or
_____ mins.

8. OCCUPATION

(a) Trade, profession or particular kind of work

(b) General nature of industry business, or establishment in which employed (or employer)

9. BIRTHPLACE

(State or Country)

Calaveras County

10. NAME OF FATHER

T J Shaffer

11. BIRTHPLACE OF FATHER

(State or Country)

Missouri

12. MAIDEN NAME OF MOTHER

Etta Beshears

13. BIRTHPLACE OF MOTHER

(State or Country)

Missouri

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

(Address)

J W Shaffer
Star

15.

Filed

May 11 -1913John S. Meyer
Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH

May 11
(Month) (Day)1913
(Year)17. I HEREBY CERTIFY, That I attended deceased from May 9 1913 to May 10 1913that I last saw him alive on May 10 1913and that death occurred on the date stated above, at 7 A.M.

The CAUSE OF DEATH* was as follows:

Empyema.(Duration) _____ yrs. _____ mos. 6 ds.Contributory
(Secondary)none

(Duration) _____ yrs. _____ mos. _____ ds.

(Signed)

O. W. Hall M. D.
19 _____ (Address) Star, Idaho

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death _____ yrs. _____ mos. _____ days. In the State _____ yrs. _____ mos. _____ days.

Where was disease contracted if not at place of death?

Former or usual residence _____

19. PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

W. G. Dyer Star May 12 1913

20. UNDERTAKER

ADDRESS

W. Dyer Caldwell

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Form V. S. No. 5. 12½ M. 7-24-11

CERTIFICATE OF DEATH

1. PLACE OF DEATH. Registration District No. 32
 County of Sevier Primary Registration District No. 2127
 City of Winchester (No. _____, St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Rachel S. Shues

Idaho
 BOARD OF HEALTH
 Bureau of Statistics
 File No. _____
 Registered No. _____

If death occurred in hospital, institution or camp, give NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX Female 4. COLOR OR RACE White 5. SINGLE, MARRIED, WIDOWED OR DIVORCED. Married
 (Write the word.)

6. DATE OF BIRTH July 16th 1878
 (Month) (Day) (Year)

7. AGE 74 yrs. 10 mos. 2 ds. IF LESS than 1 day how many hrs. or min?

8. OCCUPATION

(a) Trade, profession or particular kind of work. Housewife
 (b) General nature of industry business or establishment in which employed (or employer)

9. BIRTHPLACE

(State or Country) Bedford Co., Pa.

10. NAME OF FATHER

George Elder

11. BIRTHPLACE OF FATHER

(State or Country) Don't know

12. MAIDEN NAME OF MOTHER

Margaret (—)?

13. BIRTHPLACE OF MOTHER

(State or Country) Don't know

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Rae Shues

(Address) Ido., Idaho

15.

Filed 5-18-1913 Elmer B. Rogers
 Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH

May 18- 1913
 (Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from April 1911, to May 18 1913
 that I last saw her alive on May 17 1913
 and that death occurred on the date stated above, at 12th

The CAUSE OF DEATH* was as follows:

Carcinoma of Stomach

..... (Duration) 5 yrs. mos. ds.

Contributory (Secondary)

..... (Duration) yrs. mos. ds.

(Signed) Elmer B. Rogers M. D.

5-18-1913 (Address) Winchester

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place In the
 of death yrs. mos. ds. State yrs. mos. ds.

Where was disease contracted,

If not at place of death?

Former or

usual residence

19. PLACE OF BURIAL OR REMOVAL DATE OF BURIAL

2005 Cemetery, Ido 5-20 1913

20. UNDERTAKER

ADDRESS

Ido Hdw & Drup Co. Ido., Idaho

Form V. S. No. 5. 10M. 6-20-11.

CERTIFICATE OF DEATH

1. PLACE OF DEATH.

Registration District No. 3County of CanyonPrimary Registration District No. 1006City of Hampa

(No. _____, _____ St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

Louise Victoria WilliamsState of Idaho
BOARD OF HEALTH
Bureau of Vital StatisticsFile No. 4920Registered No. 60

If death occurred in a hospital, institution or camp give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX

Female

4. COLOR OR RACE

White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED.

(Write the word.)

6. DATE OF BIRTH

Feb 19 -

(Month)

(Day)

1846

(Year)

7. AGE

67 yrs. 2 mos. 1 ds.IF LESS than 1 day
how many _____ hrs. or
_____ min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work

Housekeeper

(b) General nature of industry business or establishment in which employed (or employer)

9. BIRTHPLACE

(State or Country)

Ohio

10. NAME OF FATHER

Gas - Mc Burney

11. BIRTHPLACE OF FATHER

(State or Country)

12. MAIDEN NAME OF MOTHER

13. BIRTHPLACE OF MOTHER

(State or Country)

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

Robert Williams

(Address)

Hampa

15.

Filed May 23 - 1913John S. Meyer

Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

April

(Month)

20th

(Day)

1913

(Year)

17. I HEREBY CERTIFY, That I attended deceased from

Nov. 2, 1913, to Apr. 24 1913that I last saw her alive on Apr. 17, 1913and that death occurred on the date stated above, at 9 A. M.

The CAUSE OF DEATH* was as follows:

Hypostatic Pneumonia(Duration) _____ yrs. _____ mos. 3 ds.Contributory
(Secondary)mitral insufficiency(Duration) 8 yrs. 5 mos. _____ ds.(Signed) Geo. D. A. Kelley, M. D.Apr. 21, 1913 (Address) Hampa, Ida

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death _____ yrs. _____ mos. _____ ds. State _____ yrs. _____ mos. _____ ds.

Where was disease contracted.

If not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

S. B. Shullaker 4-22-1913

20. UNDERTAKER

ADDRESS

Hampa

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Form V. S. No. 5. 10M. 6-20-11.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics
File No. **4921**

1. PLACE OF DEATH.

Registration District No. **3**County of **Canyon**Primary Registration District No. **1006**City of **Nampa**(No. **1**)

St.)

Registered No. **61**

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

Benjamin Franklin Hastings

If death occurred in a hospital, institution or camp give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX

4. COLOR OR RACE 5. SINGLE, MARRIED, WIDOWED OR DIVORCED.

Male White**married**

(Write the word.)

6. DATE OF BIRTH

August 31 1848

(Month)

(Day)

(Year)

7. AGE

64 yrs. 7 mos. 23 ds.

IF LESS than 1 day
how many hrs. or
min.?

8. OCCUPATION

- (a) Trade, profession, or particular kind of work
(b) General nature of industry business, or establishment in which employed (or employer)

Mining Man

9. BIRTHPLACE

(State or Country)

Miss.

10. NAME OF FATHER

B. F. Hastings

11. BIRTHPLACE OF FATHER

(State or Country)

12. MAIDEN NAME OF MOTHER

A. C. Baker

13. BIRTHPLACE OF MOTHER

(State or Country)

England

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

Margaret Hastings Shea

(Address)

Garden Valley, Ore.

15.

Filed **May 23 - 1913****J. H. Meyer**

Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

April 23 1913

(Month)

(Day)

(Year)

17. I HEREBY CERTIFY, That I attended deceased **on****April 23 1913**, to **1913**that I last saw him alive on **April 23 1913**and that death occurred on the date stated above, at **3:20 P.M.**

The CAUSE OF DEATH* was as follows:

Cancer - affecting frontal portion of head + one eye(Duration) **84** yrs. mos. ds.

Contributory (Secondary)

(Duration) yrs. mos. ds.

(Signed) **J. H. Murray** M. D.**April 25 1913** (Address) **Nampa Idaho**

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place **X** In the
of death yrs. mos. ds. State yrs. mos. ds.

Where was Disease contracted,

If not at place of death?

Former or usual residence.

19. PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

Stohrerlawn**4/25 1913**

20. UNDERTAKER

ADDRESS

J. H. Meyer**Nampa Ida**

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Form V. S. No. 5. 10M. 6-20-11.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics
File No. 4925

1. PLACE OF DEATH. Registration District No. 9
County of Canyon Primary Registration District No. 2006
City of Nampa (No. _____ St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME John S. KinderRegistered No. 62

If death occurred in a hospital, institution or camp give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX Male 4. COLOR OR RACE white 5. SINGLE, MARRIED, WIDOWED OR DIVORCED. married
(Write the word.)

6. DATE OF BIRTH

Mar 25 1852
(Month) (Day) (Year)

7. AGE

60 yrs. 1 mos. 11 ds.

IF LESS than 1 day
how many hrs. or
min.?

8. OCCUPATION

(a) Trade, profession, or particular kind of work
(b) General nature of industry, business, or establishment in which employed (or employer)

Farmer

9. BIRTHPLACE

(State or Country)

Ill

10. NAME OF FATHER

Alexander Kinder

11. BIRTHPLACE OF FATHER

(State or Country)

Ireland

12. MAIDEN NAME OF MOTHER

Permelia White

13. BIRTHPLACE OF MOTHER

(State or Country)

Kentucky

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

J. M. Robertson

(Address)

Nampa, Ida

15.

Filed May 23 - 1913John S. Meyer

Local Registrar

Caldwell-Idaho.

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

May 6 1913
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from

Apr 28 1913 to May 5 1913

that I last saw him alive on May 5 1913,and that death occurred on the date stated above, at 29 M.

The CAUSE OF DEATH* was as follows:

meningitis following
accidental injury

(Duration) yrs. mos. 8 ds.

Contributory (Secondary)

(Duration) yrs. mos. ds.

(Signed)

H. P. Ross M. D.
May 6 1913 (Address) Nampa, Ida

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place In the
of death yrs. mos. ds. State yrs. mos. ds.

Where was Disease contracted,

If not at place of death?

Former or usual residence.

19. PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

Kohlerlaum517 1913

20. UNDERTAKER

ADDRESS

F. H. RobinsonNampa Ida

MARGIN RESERVED FOR BINDING
WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Form V. S. No. 5. 10M. 6-20-11.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics
File No. 4923

1. PLACE OF DEATH.
County of Canyon
City of Nampa

Registration District No. 3
Primary Registration District No. 1006
(No. _____, _____ St.)

Registered No. 63

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Harry Graham Hickey

If death occurred in a hospital, institution or camp give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX 4. COLOR OR RACE 5. SINGLE, MARRIED, WIDOWED OR DIVORCED.

Male white Single
(Write the word.)

6. DATE OF BIRTH

Oct 4 1910
(Month) (Day) (Year)

7. AGE

2 yrs. 7 mos. 4 ds. IF LESS than 1 day
how many _____ hrs. or _____ min.?

8. OCCUPATION

(a) Trade, profession, or particular kind of work none
(b) General nature of industry business, or establishment in which employed (or employer)

9. BIRTHPLACE

(State or Country)

Louisiana

10. NAME OF FATHER

T. N. Hickey

11. BIRTHPLACE OF FATHER

(State or Country)

Mo

12. MAIDEN NAME OF MOTHER

King

13. BIRTHPLACE OF MOTHER

(State or Country)

England

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

A. E. Biddlebarger

(Address)

Nampa, Idaho.

15.

Filed

May 23 - 1913

J. H. Meyer

Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

May 9 1913
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from

April 30 1913, to May 9 1913.

that I last saw him alive on May 9 1913,

and that death occurred on the date stated above, at 2:45 A. M.

The CAUSE OF DEATH* was as follows:

Acute Enteritis

(Duration) _____ yrs. _____ mos. 12 ds.

Contributory (Secondary)

(Duration) _____ yrs. _____ mos. _____ ds.

(Signed)

J. H. Murray

M. D.

May 9 1913 (Address) Nampa, Idaho

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL,

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place

In the

of death _____ yrs. _____ mos. _____ ds. State _____ yrs. _____ mos. _____ ds.

Where was Disease contracted,

If not at place of death?

Former or

usual residence.

19. PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

Kohlman

5/9 1913

20. UNDERTAKER

ADDRESS

F. E. Robinson

Nampa

If death occurred in a hospital, institution or camp give its NAME instead of street and number.

MEDICAL CERTIFICATE OF DEATH

Local Registrar

ADDRESS

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Form V. S. No. 5. 10M. 6-20-11.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH.

County of Idaho

City of Grangeville

If death occurs away from usual residence, give facts called for under special information.

Registration District No. 10

Primary Registration District No. 1001

(No. _____ St.)

File No. 4923

Registered No. 131

If death occurred in a hospital, institution or camp give its NAME instead of street and number.

2. FULL NAME Daily Brock

PERSONAL AND STATISTICAL PARTICULARS

3. SEX

male

4. COLOR OR RACE

white

5. SINGLE, MARRIED, WIDOWED OR DIVORCED.

married
(Write the word.)

6. DATE OF BIRTH

(G.R.)

March

12

1871

May

1st

1913

May

(Month)

14

(Day)

(Year)

7. AGE

42

one

mos.

20

ds.

IF LESS than 1 day

how many _____ hrs. or

_____ min.

8. OCCUPATION

(a) Trade, profession or particular kind of work

Mechanic

(b) General nature of industry business or establishment in which employed (or employer)

9. BIRTHPLACE

(State or Country)

Oregon

Douglas Co.

10. NAME OF FATHER

Joseph Brock

11. BIRTHPLACE OF FATHER

(State or Country)

Illinois

12. MAIDEN NAME OF MOTHER

Elith Ridenour

13. BIRTHPLACE OF MOTHER

(State or Country)

Indiana

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

Mrs. Daisy Brock

(Address)

Grangeville

15.

Filed

May 5

1913

Jose L. Rains

Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

May

1

1913

(Month)

(Day)

(Year)

17. I HEREBY CERTIFY, That I attended deceased from

April 5

1913

to May 1

1913

that I last saw him alive on May 1

1913

and that death occurred on the date stated above, at 7 A. M.

The CAUSE OF DEATH* was as follows:

abscess of liver

(Duration) _____ yrs. _____ mos. 26 ds.

Contributory (Secondary)

(Duration) _____ yrs. _____ mos. _____ ds.

(Signed)

H. S. Stettin

M. D.

May 2 1913

(Address) Grangeville Id.

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and 2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death _____ yrs. _____ mos. _____ ds. State _____ yrs. _____ mos. _____ ds.

Where was disease contracted,

If not at place of death?

Former or

usual residence.

19. PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

Prarie View

May 5 1913

20. UNDERTAKER

ADDRESS

26 Hancock

Grangeville

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Form V. S. No. 5. 12½ M. 7-24-11

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics
File No. 4926
Registered No. 132

1. PLACE OF DEATH. Registration District No. 10
County of Idaho Primary Registration District No. 2044
City of Grangeville (No. _____, _____ St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Mary Elizabeth Horning

If death occurred in a hospital, institution or camp give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX 7 4. COLOR OR RACE white 5. SINGLE, MARRIED, WIDOWED OR DIVORCED. Single
(Write the word.)

6. DATE OF BIRTH August 28 1883
(Month) (Day) (Year)

7. AGE 20 yrs. 8 mos. 9 ds. IF LESS than 1 day how many _____ hrs. or _____ min?

8. OCCUPATION
(a) Trade, profession or particular kind of work. at home
(b) General nature of industry business or establishment in which employed (or employer)

9. BIRTHPLACE Idaho
(State or Country)

10. NAME OF FATHER Louis F. Horning

11. BIRTHPLACE OF FATHER Oregon
(State or Country)

12. MAIDEN NAME OF MOTHER Endora Spooner

13. BIRTHPLACE OF MOTHER Missouri
(State or Country)

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Christie C. Page
(Address) Grangeville, Ida.

15. May 8 1913 Jose L. Rains
Filed _____ Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH May 7 1913
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from May 6 1913, to May 7 1913, that I last saw her alive on May 6 1913 and that death occurred on the date stated above, at 3 A.M.
The CAUSE OF DEATH* was as follows:

diabetic Coma

(Duration) unknown yrs. _____ mos. _____ ds.

Contributory (Secondary)

(Duration) _____ yrs. _____ mos. _____ ds.

(Signed) 488 Street M. D. May 8 1913 (Address) Grangeville Ida

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place _____ In the _____
of death _____ yrs. _____ mos. _____ ds. State _____ yrs. _____ mos. _____ ds.
Where was disease contracted, _____
If not at place of death? _____
Former or _____
usual residence _____

19. PLACE OF BURIAL OR REMOVAL Grangeville Ida DATE OF BURIAL May 8 1913

20. UNDERTAKER E. S. Hancock ADDRESS Grangeville

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. N. B.—Every item of information should be carefully supplied. AGE should be state EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Form V. S. No. 5. 10M. 6-20-11.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics
File No. 4927
Registered No. 133

1. PLACE OF DEATH.

Registration District No. 10County of IdahoPrimary Registration District No. 2044City of Flourville

(No. _____ St.)

Registered No. 133

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

Robert J. Carr

If death occurred in a hospital, institution or camp give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX

Male

4. COLOR OR RACE

White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED.

Probably single
(Write the word.)

6. DATE OF BIRTH

Unknown

(Month)

(Day)

(Year)

7. AGE

About 45

yrs.

mos.

ds.

IF LESS than 1 day

how many.....hrs. or
.....min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work

Miner

(b) General nature of industry business or establishment in which employed (or employer)

9. BIRTHPLACE

(State or Country)

Not obtainable,

10. NAME OF FATHER

but information at

11. BIRTHPLACE OF FATHER

(State or Country)

hand is that he has

12. MAIDEN NAME OF MOTHER

a sister, Elsie Carr,

13. BIRTHPLACE OF MOTHER

(State or Country)

living at Dayton,Washington.

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

Jose L. Rains

(Address)

Flourville

15.

Filed

May 91913Jose L. Rains

Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

Supposed to be April 29

(Month)

(Day)

1913

(Year)

17. I HEREBY CERTIFY, ~~that I attended deceased from~~1913

to

1913that I last saw him alive on 1913and that death occurred on the date stated above, at M.

The CAUSE OF DEATH* was as follows:

That the body of Robert J. Carr was found on May 2, 1913, at 2 p.m. Cause of death is unknown, but there is no suspicion of foul means or accident.

Contributory

(Secondary)

(Duration)

yrs.

mos.

ds.

(Signed)

Jose L. Rains

M. D.

May 9 1913

(Address)

Flourville, Idaho

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place

In the

of death.....yrs.....mos.....ds.

State.....yrs.....mos.....ds.

Where was disease contracted.

If not at place of death?

Former or

usual residence.

19. PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

Portland, Oregon1913

20. UNDERTAKER

E. L. Hancock

ADDRESS

Flourville

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Form V. S. No. 5. 12½M.7-24-11

CERTIFICATE OF DEATH

State of Idaho

BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH.

Registration District No. 10County of IdahoPrimary Registration District No. 2042 2044File No. 4928

City of _____

(No. _____, _____ St.)

Registered No. 133a

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

Loarr

If death occurred in a hospital, institution or camp give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX

Male

4. COLOR OR RACE

White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED.

(Write the word.)

6. DATE OF BIRTH

(Month)

(Day)

(Year)

7. AGE

_____ yrs. _____ mos. _____ ds.

IF LESS than 1 day
how many _____ hrs. or
_____ min?

8. OCCUPATION

- (a) Trade, profession or particular kind of work.....
(b) General nature of industry business or establishment in which employed (or employer)

9. BIRTHPLACE

(State or Country)

10. NAME OF FATHER

11. BIRTHPLACE OF FATHER

(State or Country)

12. MAIDEN NAME OF MOTHER

13. BIRTHPLACE OF MOTHER

(State or Country)

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) _____

(Address) _____

15.

Filed May 9 1913Jose L. Rains
Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH

April

(Month)

(Day)

1913

(Year)

17. I HEREBY CERTIFY, That I attended deceased from
investigated the death of deceased
191, to 191That I last saw him alive on or about 191and that death occurred on the date stated above, at M

The CAUSE OF DEATH* was as follows:

Natural Causes unknown

(Duration) _____ yrs. _____ mos. _____ ds.

Contributory
(Secondary)

(Duration) _____ yrs. _____ mos. _____ ds.

(Signed)

Henry B. Blake M. D.
May 9 1913 (Address) Corner of Idaho County & Kootenai Sts.

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place _____ In the _____
of death _____ yrs. _____ mos. _____ ds. State _____ yrs. _____ mos. _____ ds.

Where was disease contracted,

If not at place of death? _____

Former or

usual residence. _____

19. PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

1913

20. UNDERTAKER

ADDRESS

WRITE PLAINLY, WITH UNFADE INK—THIS IS A PERMANENT RECORD.
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Form V. S. No. 5. 10M. 6-20-11.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics
File No. 4929
Registered No. 134

1. PLACE OF DEATH.

Registration District No. 10

County of Idaho

Primary Registration District No. 2041

City of Whitebird

(No. _____, _____ St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Samuel Overton

If death occurred in a hospital, institution or camp give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX

4. COLOR OR RACE 5. SINGLE, MARRIED, WIDOWED OR DIVORCED.

Male white

Single
(Write the word.)

6. DATE OF BIRTH

Jan 28 1888
(Month) (Day) (Year)

7. AGE

33 yrs. 3 mos. 28 ds.

IF LESS than 1 day
how many _____ hrs. or
_____ min.?

8. OCCUPATION

(a) Trade, profession, or particular kind of work
(b) General nature of industry business, or establishment in which employed (or employer)

Ferryman

9. BIRTHPLACE

(State or Country)

Knopville Iowa

10. NAME OF FATHER

11. BIRTHPLACE OF FATHER

(State or Country)

12. MAIDEN NAME OF MOTHER

13. BIRTHPLACE OF MOTHER

(State or Country)

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Harmon Overton

(Address) Woodbridge Ore

15.

Filed June 6 1913

Jose L. Rains

Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

May 23 1913
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from

Mar 1 1913, to May 23 1913
that I last saw him alive on 18 1913,

and that death occurred on the date stated above, at 6 A.M.

The CAUSE OF DEATH* was as follows:

Tuberculosis of lungs

(Duration) 10 yrs. _____ mos. _____ ds.

Contributory (Secondary)

(Duration) _____ yrs. _____ mos. _____ ds.

(Signed) W. A. Fiskett M. D.

May 24 1913 (Address) Whitebird Ida

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place _____ In the _____
of death _____ yrs. _____ mos. _____ ds. State _____ yrs. _____ mos. _____ ds.

Where was Disease contracted,
If not at place of death?

Former or
usual residence.

19. PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

Whitebird Ida

May 24 1913

20. UNDERTAKER

ADDRESS

E. S. Hancock

Grangerille

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Form V. S. No. 5. 12½ M. 7-24-11

CERTIFICATE OF DEATH

1. PLACE OF DEATH.

County of Idaho
City of Pollock

Registration District No. 10
Primary Registration District No. 2041
(No. _____, _____ St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

Dolores E. Adley

State of Idaho

BOARD OF HEALTH
Bureau of Vital Statistics

File No. 4930Registered No. 135

If death occurred in a hospital, institution or camp give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX

Female

4. COLOR OR RACE

white

5. SINGLE, MARRIED, WIDOWED OR DIVORCED.

(Write the word.)

6. DATE OF BIRTH

Oct 30

(Month)

(Day)

(Year) 1899

7. AGE

Three

Three yrs. six mos. six ds.

IF LESS than 1 day
how many hrs. or
..... min?

8. OCCUPATION

(a) Trade, profession or particular kind of work.....

(b) General nature of industry business or establishment in which employed (or employer).....

9. BIRTHPLACE

(State or Country)

Ferdinand Idaho

10. NAME OF FATHER

Walter G. Adley

11. BIRTHPLACE OF FATHER

(State or Country)

Burnside
Lapeer co. Michigan

12. MAIDEN NAME OF MOTHER

Mary A. Fry

13. BIRTHPLACE OF MOTHER

(State or Country)

Bronaugh
Missouri

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

(Address)

15.

Filed June 6

J. Hains
Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH

May

6

1913

(Month)

(Day)

(Year)

17. I HEREBY CERTIFY, That I attended deceased from

May 4 1913, to May 6 1913

that I last saw her alive on May 3 1913

and that death occurred on the date stated above, at 9 A.M.

The CAUSE OF DEATH* was as follows:

Typhoid fever

..... (Duration) yrs. mos. 3 wks ds.

Contributory
(Secondary)

..... (Duration) yrs. mos. ds.

(Signed) W. A. Fookett M. D.

May 12 1913 (Address) Whitebird 2da

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place In the
of death yrs. mos. ds. State yrs. mos. ds.

Where was disease contracted,

If not at place of death?.....

Former or

usual residence.....

19. PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

Pollock

May 9 1913

20. UNDERTAKER

ADDRESS

E. Stranevebe

Grangeville

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Form V. S. No. 5 20M.1-16-12

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics
File No. **4931**
Registered No. **136**

1. PLACE OF DEATH.

Registration District No. **2015 10**

County of **Idaho**

Primary Registration District No. **2042**

City of **Cottawood**

(No. _____, St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME **Prematurely born infant of Minnie Hacke**
If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX **male** 4. COLOR OR RACE **White** 5. SINGLE, MARRIED, WIDOWED OR DIVORCED. **Single**
(Write the word.)

6. DATE OF BIRTH

3 (Month) **3** (Day) **1913** (Year)

7. AGE

— yrs. — mos. — ds.

IF LESS than 1 day
how many _____ hrs. or
10 _____ mins.

8. OCCUPATION

(a) Trade, profession or particular kind of work **None**
(b) General nature of industry business, or establishment in which employed (or employer)

9. BIRTHPLACE

(State or Country) **Cottawood, Mo**

10. NAME OF FATHER

Unknown

11. BIRTHPLACE OF FATHER

(State or Country) **Unknown**

12. MAIDEN NAME OF MOTHER

Minnie Hacke

13. BIRTHPLACE OF MOTHER

(State or Country) **Illinois**

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) **J. D. Shinnick**
(Address) **Cottawood, Idaho**

15.

Filed **May 6** 1913 **James E. Rains**
Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH

May (Month) **5** (Day) **1913** (Year)

17. I HEREBY CERTIFY, That I attended deceased from

May 5 1913, to **May 5** 1913,
that I last saw him alive on **May 5** 1913,

and that death occurred on the date stated above, at **7:30** A.M.

The CAUSE OF DEATH* was as follows:

**Unknown but natural cause
(prematurely born)**

(Duration) _____ yrs. _____ mos. _____ ds.

Contributory
(Secondary)

(Duration) _____ yrs. _____ mos. _____ ds.

(Signed) **J. D. Shinnick** M. D.

May 5 1913 (Address) **Cottawood, Idaho**

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death _____ yrs. _____ mos. _____ days. In the State _____ yrs. _____ mos. _____ days.

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

Catholic Cemetery

May 8 1913

20. UNDERTAKER

ADDRESS

Joseph McBlackey

Cottawood

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Form V. S. No. 5 20M.1-16-12

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics
File No. 4932

1. PLACE OF DEATH

Registration District No. 7

County of Bonneville

Primary Registration District No. 2027

City of Idaho Falls

(No. _____ St. _____)

Registered No. 29

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

Adolf M. Hirschfeld

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX

4. COLOR OR RACE

5. SINGLE, MARRIED, WIDOWED OR DIVORCED.

Male

White

Single

6. DATE OF BIRTH

Aug 25 1878
(Month) (Day) (Year)

7. AGE

34 yrs. 2 mos. 11 ds.

IF LESS than 1 day
how many hrs. or mins.

8. OCCUPATION

(a) Trade, profession or particular kind of work
(b) General nature of industry business, or establishment in which employed (or employer)

Labour

9. BIRTHPLACE

(State or Country)

New York

10. NAME OF FATHER

Adolf Hirschfeld

11. BIRTHPLACE OF FATHER

(State or Country)

Germany

12. MAIDEN NAME OF MOTHER

Frederika Bauerfeld

13. BIRTHPLACE OF MOTHER

(State or Country)

Germany

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

Adolf Hirschfeld

(Address)

Mesopotamia Ohio

15.

Filed

May 12 1913

1913

Channing

Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

May 6 1913
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from

191... to 191...
that I last saw him alive on 191...
and that death occurred on the date stated above, at 10 P. M.

The CAUSE OF DEATH* was as follows:

Accident
Cave in - in sewer -

(Duration) yrs. mos. ds.

Contributory
(Secondary)

(Duration) yrs. mos. ds.

(Signed) J. M. D.

1/2 1913 (Address) Idaho Falls Ida

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death... yrs. mos. days. In the State... yrs. mos. days.

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL DATE OF BURIAL

Mesopotamia Ohio 5/7 1913

20. UNDERTAKER

G. H. Hunt

ADDRESS

Idaho Falls

Form V. S. No. 5 20M.1-16-12

CERTIFICATE OF DEATH

1. PLACE OF DEATH

Registration District No.

County of

Primary Registration District No.

City of

(No.

St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

Minnie P. Egan

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

File No.

4933

Registered No.

92

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX

4. COLOR OR RACE

5. SINGLE, MARRIED, WIDOWED OR DIVORCED.

6. DATE OF BIRTH

March

31

1900

(Month)

(Day)

(Year)

7. AGE

13

yrs.

1

mos. 23

ds.

IF LESS than 1 day
how many hrs. or
..... mins.?

8. OCCUPATION

(a) Trade, profession or particular kind of work

(b) General nature of industry business, or establishment in which employed (or employer)

School Girl

9. BIRTHPLACE

(State or Country)

Idaho

10. NAME OF FATHER

Erastus H. Egan

11. BIRTHPLACE OF FATHER

(State or Country)

Nebraska

12. MAIDEN NAME OF MOTHER

Alice Mose

13. BIRTHPLACE OF MOTHER

(State or Country)

Utah

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

Erastus H. Egan

(Address)

Shelton Idaho

15.

Filed

May 14

1913

Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH

May

13

1913

(Month)

(Day)

(Year)

17. I HEREBY CERTIFY, That I attended deceased from

May 4

1913

to May 13

1913

that I last saw her alive on May 13 1913

and that death occurred on the date stated above, at 2 PM.

The CAUSE OF DEATH* was as follows:

Appendicitis

(Duration)

yrs.

mos.

ds.

Contributory

(Secondary)

(Duration)

yrs.

mos.

ds.

(Signed)

E. S. Fuller

M. D.

19

(Address)

Idaho Falls

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death

days

In the State

yrs.

mos.

days

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

Shelton Idaho

May 15 1913

20. UNDERTAKER

ADDRESS

J. H. Hunt

Idaho Falls

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Form V. S. No. 5 20M.1-16-12

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics
File No. **4317**

1. PLACE OF DEATH.

Registration District No. _____

County of BonnervillePrimary Registration District No. 2027City of Idaho Falls

(No. _____) St. _____

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Franklin SaundersRegistered No. 377

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX

Male

4. COLOR OR RACE

White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED.

Single (Write the word.)

6. DATE OF BIRTH

Dec 2 1910
(Month) (Day) (Year)

7. AGE

2 yrs. 6 mos. — ds.

IF LESS than 1 day
how many hrs. or
..... mins.?

8. OCCUPATION

(a) Trade, profession or particular kind of work

none

(b) General nature of industry business, or establishment in which employed (or employer)

9. BIRTHPLACE

(State or Country)

Idaho

10. NAME OF FATHER

Clair Sanders

11. BIRTHPLACE OF FATHER

(State or Country)

Iowa

12. MAIDEN NAME OF MOTHER

Mary Davis

13. BIRTHPLACE OF MOTHER

(State or Country)

Nebr.

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

(Address)

C. G. Sanders
Idaho Falls

15.

Filed

June 3 1913 C. G. Sanders
Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH

June 2 1913
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from

June 1 1913, to June 2nd 1913,
that I last saw him alive on June 2nd 1913,
and that death occurred on the date stated above, at 7 P.M.

The CAUSE OF DEATH* was as follows:

Intestinal obstruction

(Duration) yrs. mos. 3 ds.

Contributory
(Secondary)

(Duration) yrs. mos. ds.

(Signed)

G. H. Hulthard M. D.

6-3-1913 (Address) Idaho Falls Id.

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death yrs. mos. days. In the State yrs. mos. days.

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

Idaho Falls 6/4 1913

20. UNDERTAKER

ADDRESS

G. H. Hulthard Idaho Falls

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
N. B.—Every item of information should be carefully supplied. AGE should be state EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH.

Registration District No. 20

County of Idaho

Primary Registration District No. 2021

City of King Hill

(No. _____, _____ St.)

File No. 4938

Registered No. 16

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

Hubbard

If death occurred in a hospital, institution or camp give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX

4. COLOR OR RACE

5. SINGLE, MARRIED, WID-
OWED OR DIVORCED.

Female

White

(Write the word.)

6. DATE OF BIRTH

May 15 1913
(Month) (Day) (Year)

7. AGE

one yrs. 2 mos. 2 ds.

IF LESS than 1 day
how many _____ hrs. or
_____ min.?

8. OCCUPATION

- (a) Trade, profession, or particular kind of work
(b) General nature of industry business, or establishment in which employed (or employer)

9. BIRTHPLACE

(State or Country)

Hansen Ida

10. NAME OF FATHER

W. E. Hubbard

11. BIRTHPLACE OF FATHER

(State or Country)

St. Joe. Michigan

12. MAIDEN NAME OF MOTHER

Mary Heidenreich

13. BIRTHPLACE OF MOTHER

(State or Country)

Mecklenburg Germany

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

W. E. Hubbard

(Address)

Hansen Ida

15.

Filed

5/17th 1913

B. W. Mather
Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

May 16th 1913
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from

191____, to 191____
that I last saw him alive on May 16 1913

and that death occurred on the date stated above, at 3:30 P.M.

The CAUSE OF DEATH* was as follows:

Cholera morbus and inability to nurse on account of malformation of mouth
(Duration) _____ yrs. _____ mos. _____ ds.

Contributory (Secondary)

Duration _____ yrs. _____ mos. _____ ds.

(Signed) Chas C Smith M. D.

5/17 1913 (Address) King Hill

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place _____ In the _____
of death. _____ yrs. _____ mos. _____ ds. State _____ yrs. _____ mos. _____ ds.

Where was Disease contracted,
If not at place of death?

Former or usual residence _____

19. PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

Hansen, Idaho

May 19th 1913

20. UNDERTAKER

ADDRESS

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Form V. S. No. 5 20M.1-16-12

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics
File No. **4939**
Registered No. _____

1. PLACE OF DEATH
County of **Shoshone**
City of **Mace**
(No. **Mace**, Idaho. _____ St.)
Registration District No. **25**
Primary Registration District No. **2109**

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME **Maxine Pearl Wilbur**

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX **female** 4. COLOR OR RACE **white** 5. SINGLE, MARRIED, WIDOWED OR DIVORCED. **single**
(Write the word.)

6. DATE OF BIRTH

3 (Month) **16** (Day) **1912** (Year)

7. AGE
1 yrs. **1** mos. **8** ds.
IF LESS than 1 day how many _____ hrs. or _____ mins.

8. OCCUPATION
(a) Trade, profession or particular kind of work _____
(b) General nature of industry business, or establishment in which employed (or employer) _____

9. BIRTHPLACE
(State or Country) **Idaho**

10. NAME OF FATHER **Harper Wilbur**

11. BIRTHPLACE OF FATHER
(State or Country) **Kansas**

12. MAIDEN NAME OF MOTHER **Gertrude Smith**

13. BIRTHPLACE OF MOTHER
(State or Country) **Missouri**

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) **Harper Wilbur**
(Address) **Mace, Idaho.**

15. Filed **May 3** 1913 **D. Charles G. Dutton**
Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

4 (Month) **24** (Day) **1913** (Year)

17. I HEREBY CERTIFY, That I attended deceased from _____ 191____, to _____ 191____,
that I last saw h_____ alive on _____ 191____,
and that death occurred on the date stated above, at _____ M.
The CAUSE OF DEATH* was as follows:

Gastro-enteritis

(Duration) _____ yrs. _____ mos. _____ ds.
Contributory _____
(Secondary) _____

(Duration) _____ yrs. _____ mos. _____ ds.
(Signed) **Dr. M. H. Mowbray**
Apr 24 1913 (Address) **Wallace, Idaho**

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death _____ yrs. _____ mos. _____ days. In the State _____ yrs. _____ mos. _____ days.

Where was disease contracted if not at place of death? _____

Former or usual residence _____

19. PLACE OF BURIAL OR REMOVAL **Wallace, Idaho.** DATE OF BURIAL **4 / 24 1913**

20. UNDERTAKER **Bruce G. Mowbray** ADDRESS **Wallace,**

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Form V. S. No. 5, 10M. 6-20-11.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics
File No. 4940

1. PLACE OF DEATH.

Registration District No. 25County of ShoshonePrimary Registration District No. 2105City of Jeollog(No.)

St.)

Registered No.

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

Wida Peterson

If death occurred in a hospital, institution or camp give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX

F

4. COLOR OR RACE

W.

5. SINGLE, MARRIED, WIDOWED OR DIVORCED

widowed
(Write the word.)

6. DATE OF BIRTH

XX1

(Month)

(Day)

(Year)

7. AGE

34

yrs.

mos.

ds.

IF LESS than 1 day
how many hrs. or
min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work
(b) General nature of industry business or establishment in which employed (or employer)

Housewife

9. BIRTHPLACE

(State or Country)

Norway

10. NAME OF FATHER

XX

11. BIRTHPLACE OF FATHER

(State or Country)

XX

12. MAIDEN NAME OF MOTHER

XX

13. BIRTHPLACE OF MOTHER

(State or Country)

Norway

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

J. R. Mason

(Address)

Jeollog

15.

Filed

May 15 1913Wida Peterson

Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

Jan271913

(Month)

(Day)

(Year)

17. I HEREBY CERTIFY, That I attended deceased from

191

to

191

that I last saw him alive on 191

and that death occurred on the date stated above, at M.

The CAUSE OF DEATH* was as follows:

Tuberculosis of lungs

(Duration) yrs. mos. ds.

Contributory (Secondary)

(Duration) yrs. mos. ds.

(Signed) J. R. Mason M. D.May 14 1913 (Address) Jeollog

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and 2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted,

If not at place of death?

Former or

usual residence

19. PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

JeollogJan 29 1913

20. UNDERTAKER

ADDRESS

Feb 1 1913Jeollog

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. PHYSICIANS should be carefully supplied. AGE should be stated EXACTLY. Exact state-ment of OCCUPATION is very important. See instructions on back of certificate.

Form V. S. No. 5. 10M. 6-20-11.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital StatisticsFile No. **4941**

Registered No. _____

If death occurred in a hospital, in-
stitution or camp give its NAME
instead of street and number.

1. PLACE OF DEATH.

Registration District No. **25**County of **Shoshone**Primary Registration District No. **2105**City of **Kellogg**

(No. _____ St.)

If death occurs away from usual
residence, give facts called
for under special information.

2. FULL NAME

Wm. H. Abbell

PERSONAL AND STATISTICAL PARTICULARS

3. SEX

M4. COLOR OR RACE 5. SINGLE, MARRIED, WID-
OWED OR DIVORCED.**W****married**
(Write the word.)

6. DATE OF BIRTH

Jan 9

(Month)

1895
(Year)

7. AGE

68

yrs.

mos.

ds.

IF LESS than 1 day
how many hrs. or
..... min.?

8. OCCUPATION

(a) Trade, profession or
particular kind of work(b) General nature of industry
business or establishment in
which employed (or employer)**Retired**

9. BIRTHPLACE

(State or Country)

Kentucky10. NAME OF
FATHER**J. B. Abbell**11. BIRTHPLACE
OF FATHER

(State or Country)

America12. MAIDEN NAME
OF MOTHER**Sarah Kipper**13. BIRTHPLACE
OF MOTHER

(State or Country)

America

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

J. R. Mason

(Address)

Kellogg

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

Feb 20

(Month)

20

(Day)

1913
(Year)

17. I HEREBY CERTIFY, That I attended deceased from

191, to **191**that I last saw him alive on **191**,and that death occurred on the date stated above, at **M.**

The CAUSE OF DEATH* was as follows:

Dropsy

(Duration) yrs. mos. ds.

Contributory
(Secondary)

(Duration) yrs. mos. ds.

(Signed) **J. R. Mason** M. D.**Mar 14 1913** (Address) **Kellogg***State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1)
MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.18. LENGTH OF RESIDENCE (For Hospitals, Institutions,
Transients or Recent Residents.)

At place of death yrs. mos. ds. State yrs. mos. ds.

Where was disease contracted.

If not at place of death?

Former or

usual residence

19. PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

Kellogg, Ida**Feb 23 1913**

20. UNDERTAKER

ADDRESS

E. B. Mason**Kellogg, Ida**

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Form V. S. No. 5. 10M. 6-20-11.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics
4942

1. PLACE OF DEATH. Registration District No. 25
County of Blaine Primary Registration District No. 2105
City of Kellogg (No. St.)

Registered No.

If death occurs away from usual residence, give facts called for under special information.

If death occurred in a hospital, institution or camp give its NAME instead of street and number.

2. FULL NAME Frank Maricich

PERSONAL AND STATISTICAL PARTICULARS

3. SEX M 4. COLOR OR RACE Austrian 5. SINGLE, MARRIED, WIDOWED OR DIVORCED. married (Write the word.)

6. DATE OF BIRTH December 31 1867 (Month) (Day) (Year)

7. AGE 46 yrs. — mos. — ds. IF LESS than 1 day how many hrs. or min.?

8. OCCUPATION (a) Trade, profession or particular kind of work Miner—lead mine (b) General nature of industry business or establishment in which employed (or employer)

9. BIRTHPLACE Austria (State or Country)

10. NAME OF FATHER Joseph Maricich

11. BIRTHPLACE OF FATHER Austria (State or Country)

12. MAIDEN NAME OF MOTHER Lucia Pickalick

13. BIRTHPLACE OF MOTHER Austria (State or Country)

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Nick Petrinovich

(Address) Gardner, Idaho.

15.

Filed May 2 1913 D. A. A. D. Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH March 29 1913 (Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from March 24 1913, to March 29 1913, that I last saw him alive on March 29 1913, and that death occurred on the date stated above, at 7 A. M.

The CAUSE OF DEATH* was as follows:

Pneumonia (Duration) yrs. 5 mos. ds.

Contributory (Secondary) Asthma

(Duration) 2 yrs. 2 mos. 2 ds.

(Signed) Geo. Keyser M. D. March 31, 1913 (Address) Kellogg

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL OR HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place Kellogg, Idaho In the Gardner State of death yrs. 5 mos. ds. Where was disease contracted? Gardner, Idaho If not at place of death? Former or Gardner, Idaho usual residence.

19. PLACE OF BURIAL OR REMOVAL DATE OF BURIAL

Greenwood Cemetery April 1 1913

20. UNDERTAKEN ADDRESS

E. B. Thurnhill Kellogg, Ida.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Form V. S. No. 5 20M.1-16-12

CERTIFICATE OF DEATH

1. PLACE OF DEATH

Registration District No. 25

County of *Indiana*

Primary Registration District No. 2105

City of *Reezy*

(No. St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME *Robert J. Brown*State of *Indiana*
BOARD OF HEALTH
Bureau of Vital Statistics

File No. 4943

Registered No.

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX

M

4. COLOR OR RACE

White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED.

(Write the word.)

6. DATE OF BIRTH

X
(Month)*X*
(Day)*1885*
(Year)

7. AGE

28
yrs. — mos. — ds.IF LESS than 1 day
how many hrs. or
..... mins?

8. OCCUPATION

(a) Trade, profession or particular kind of work

(b) General nature of industry, business, or establishment in which employed (as employer)

Laborer—lead mine

9. BIRTHPLACE

(State or Country)

Kentucky

10. NAME OF FATHER

James M. Brown

11. BIRTHPLACE OF FATHER

(State or Country)

Kentucky

12. MAIDEN NAME OF MOTHER

Do not know

13. BIRTHPLACE OF MOTHER

(State or Country)

" " "

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

(Address)

15.

Filed

May 10

1913

D. H. G. Williams

Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH

May
(Month)*2*
(Day)*1913*
(Year)

17. I HEREBY CERTIFY, That I attended deceased from

April 25 1913, to *May 2* 1913,that I last saw him alive on *May 2* 1913,and that death occurred on the date stated above, at *7 A.M.*

The CAUSE OF DEATH* was as follows:

Lobar pneumonia(Duration) yrs. mos. *8* ds.Contributory
(Secondary)

(Duration) yrs. mos. ds.

(Signed)

*Geo. H. Bennett M.D.**5/16/1913* (Address) *Reezy, Ind.*

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death. yrs. mos. days. In the State. yrs. mos. days.

Where was disease contracted if not at place of death? *Wardman, Ind.*

Former or usual residence.

19. PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

*Reezy, Ind.**May 17* 1913

20. UNDERTAKER

ADDRESS

E. B. Shankel

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Form V. S. No. 5 20M.1-16-12

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH

Registration District No. 25

County of Shoshone

Primary Registration District No. 2105

City of Pocatello

(No.)

St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

Robert H Parry

Registered No.

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX

M

4. COLOR OR RACE

W

5. SINGLE, MARRIED, WIDOWED OR DIVORCED.

married
(Write the word.)

6. DATE OF BIRTH

X

X

1865

(Month)

(Day)

(Year)

7. AGE

48 yrs. — mos. — ds.

IF LESS than 1 day
how many hrs. or
mins.?

8. OCCUPATION

(a) Trade, profession or particular kind of work

(b) General nature of industry business, or establishment in which employed (or employer)

Labarer - lead mine

9. BIRTHPLACE

(State or Country)

America

10. NAME OF FATHER

Do not know

11. BIRTHPLACE OF FATHER

(State or Country)

America

12. MAIDEN NAME OF MOTHER

Do not know

13. BIRTHPLACE OF MOTHER

(State or Country)

4

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

(Address)

15.

Filed

May 10

1913

D. Charles D. Williams

Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH

May

2

1913

(Month)

(Day)

(Year)

17. I HEREBY CERTIFY, That I attended deceased from

April 27 1913, to May 2 1913,

that I last saw him alive on May 2 1913,

and that death occurred on the date stated above, at 5 P. M.

The CAUSE OF DEATH* was as follows:

Labor
Pneumonia

(Duration) yrs. mos. 6 ds.

Contributory
(Secondary)

(Duration) yrs. mos. ds.

(Signed) Geo. H. Kennel M. D.

5/16 1913 (Address) Kellogg, Idaho

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death yrs. mos. 5 days. In the State yrs. mos. days.

Where was disease contracted if not at place of death? Hardner, Idaho

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

Kellogg, Ida.

May 4 1913

20. UNDERTAKER

ADDRESS

E. B. Hardner

Kellogg, Ida.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Form V. S. No. 5. 12½ M. 7-24-11

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH

Registration District No. 24

County of Bear Lake

Primary Registration District No. 2093

City of Laramie

(No. _____, _____ St.)

File No. 1045

Registered No. 2

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

No name given

If death occurred in a hospital, institution or camp give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX

Male

4. COLOR OR RACE

W

5. SINGLE, MARRIED, WIDOWED OR DIVORCED.

Single
(Write the word.)

6. DATE OF BIRTH

May 7 1913
(Month) (Day) (Year)

7. AGE

_____ yrs. _____ mos. 3 ds.

IF LESS than 1 day
how many _____ hrs. or
_____ min?

8. OCCUPATION

(a) Trade, profession or particular kind of work.
(b) General nature of industry business or establishment in which employed (or employer)

None

9. BIRTHPLACE

(State or Country)

Laramie, Bear Lake Co

10. NAME OF FATHER

Thomas A. Parker

11. BIRTHPLACE OF FATHER

(State or Country)

Liberty, Idaho

12. MAIDEN NAME OF MOTHER

Alice Allen

13. BIRTHPLACE OF MOTHER

(State or Country)

Barnack Co

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

(Address)

F. W. Parry over phone
Laramie

15.

Filed May 11 1913

Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

May 10 1913
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from

_____ 191____, to _____ 191____

that I last saw him _____ alive on _____ 191____

and that death occurred on the date stated above, at _____ M.

The CAUSE OF DEATH* was as follows:

Heart trouble (supposed)
no doctor present at
death or in charge of case

(Duration) _____ yrs. _____ mos. _____ ds.

Contributory

(Secondary)

(Duration) _____ yrs. _____ mos. _____ ds.

(Signed)

A. P. Cooley M. D.

May 10 1913 (Address) Paris, Idaho

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place

In the

of death _____ yrs. _____ mos. _____ ds. State _____ yrs. _____ mos. _____ ds.

Where was disease contracted,

If not at place of death?

Former or

usual residence _____

19. PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

Laramie

191____

20. UNDERTAKER

ADDRESS

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Form V. S.

1. PLACE OF DEATH. Registration District No. 27
County of Boise Lake Primary Registration District No. 2091
City of Bloomington (No. _____, St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Peter Thompson Sr.

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

File No. 4946Registered No. 28

If death occurred in a hospital, institution or camp give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX male 4. COLOR OR RACE white 5. SINGLE, MARRIED, WIDOWED OR DIVORCED. widowed
(Write the word.)

6. DATE OF BIRTH Aug 6 1825
(Month) (Day) (Year)

7. AGE 87 yrs. 9 mos. 6 ds. IF LESS than 1 day
how many hrs. or
..... min?

8. OCCUPATION
(a) Trade, profession or particular kind of work. farmer
(b) General nature of industry business or establishment in which employed (or employer)

9. BIRTHPLACE Denmark
(State or Country)

10. NAME OF FATHER Niels P. Thompson

11. BIRTHPLACE OF FATHER Denmark
(State or Country)

12. MAIDEN NAME OF MOTHER Maren Jensen

13. BIRTHPLACE OF MOTHER Denmark
(State or Country)

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Peter Thompson

(Address) Bloomington Ida

15. AP Cooly
Local Registrar

Filed May 15 1913

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH May 12 1913
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased Aug 1 1912, to only 191
that I last saw him alive on Apr 15 1913
and that death occurred on the date stated above, at 5 P.M.

The CAUSE OF DEATH* was as follows:

Epithelioma on face
just below left eye

(Duration) 5 yrs. 2 mos. 2 ds.

Contributory (Secondary) sensility

(Duration) 5 yrs. 2 mos. 2 ds.

(Signed) L. A. Hottendorf M. D.

May 13 1913 (Address) Bloomington Ida

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place In the
of death yrs mos ds. State yrs mos ds.
Where was disease contracted,
If not at place of death?
Former or
usual residence.

19. PLACE OF BURIAL OR REMOVAL DATE OF BURIAL

Bloomington May 15 1913

20. UNDERTAKER ADDRESS

J. Jacobson Bloomington

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Form V. S. No. 5. 12½ M. 7-24-11

CERTIFICATE OF DEATH

1. PLACE OF DEATH.
County of Bear Lake
City of Bloomington, Idaho.

Registration District No. 24
Primary Registration District No. 2091
(No. _____, _____ St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

Joshua Jarvis

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

File No. 4947
Registered No. 27

If death occurred in a hospital, institution or camp give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX male 4. COLOR OR RACE white 5. SINGLE, MARRIED, WIDOWED OR DIVORCED. married
(Write the word.)

6. DATE OF BIRTH Jan 27 1840
(Month) (Day) (Year)

7. AGE 73 yrs. 3 mos. 17 ds. IF LESS than 1 day
how many hrs. or
..... min?

8. OCCUPATION

(a) Trade, profession or particular kind of work.
(b) General nature of industry business or establishment in which employed (or employer)

postmaster

9. BIRTHPLACE

(State or Country)

England

10. NAME OF FATHER

Henry Jarvis

11. BIRTHPLACE OF FATHER

(State or Country)

England

12. MAIDEN NAME OF MOTHER

Elizabeth Turner

13. BIRTHPLACE OF MOTHER

(State or Country)

England

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

George Jarvis

(Address)

Bloomington, Idaho.

15.

Filed May 15 1913

W. D. Cooley

Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH

May 14 1913
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from May 13 1913, to May 14 1913
that I last saw him alive on May 14 1913
and that death occurred on the date stated above, at 3 30 A. M.

The CAUSE OF DEATH* was as follows:

acute dilatation of heart

(Duration) yrs. mos. ds.
Contributory chronic Organic heart disease
(Secondary)

(Duration) 5 yrs. mos. ds.
(Signed) L. A. Lottendorf M. D.
May 14 1913 (Address) Bloomington, Idaho.

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place In the
of death yrs. mos. ds. State yrs. mos. ds.
Where was disease contracted,
If not at place of death?
Former or
usual residence.

19. PLACE OF BURIAL OR REMOVAL DATE OF BURIAL

Bloomington, Idaho.

May 16 1913

20. UNDERTAKER

ADDRESS

J. Jacobson

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics
File No. **1948**
Registered No. **25**

1. PLACE OF DEATH
County of **Bear Lake**
City of **Sanak**
Registration District No. **24**
Primary Registration District No. **2093**
(No. , St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

Alfred Allen Parker

If death occurred in a hospital, institution or camp give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX **Female** 4. COLOR OR RACE **W.** 5. SINGLE, MARRIED, WIDOWED OR DIVORCED. **Married**
(Write the word.)

6. DATE OF BIRTH **Jan 13 1885**
(Month) (Day) (Year)

7. AGE **28 yrs. 3 mos. 24 ds.** IF LESS than 1 day how many . hrs. or min?

8. OCCUPATION

(a) Trade, profession or particular kind of work.
(b) General nature of industry business or establishment in which employed (or employer)

None

9. BIRTHPLACE

(State or Country)

Barnock ted Idaho

10. NAME OF FATHER

Alexander A. Allen

11. BIRTHPLACE OF FATHER

(State or Country)

Ill.

12. MAIDEN NAME OF MOTHER

Maria E. Cowley

13. BIRTHPLACE OF MOTHER

(State or Country)

Iowa

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

F. W. P. Registrar

(Address)

Sanak

15.

Filed **May 10 1913** **A. P. Cooley**
Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH

May 9 1913
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from **May 4 1913**, to **May 9 1913**, that I last saw her alive on **May 8 1913**, and that death occurred on the date stated above, at **2 A. M.**

The CAUSE OF DEATH* was as follows:

Child birth

(Duration) yrs. mos. **3** ds.

Contributory (Secondary)

Pneumonia

(Duration) yrs. mos. **9** ds.

(Signed)

D. F. Ashley M. D.
May 9 1913 (Address) **Sanak Idaho**

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death yrs. mos. ds. State yrs. mos. ds.

Where was disease contracted,

If not at place of death?

Former or

usual residence.

19. PLACE OF BURIAL OR REMOVAL DATE OF BURIAL

Sanak **May 11 1913**

20. UNDERTAKER

ADDRESS

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Form

1. PLACE OF DEATH. Registration District No. 24
County of Bear Lake Primary Registration District No. 2098
City of Montpelier (No. _____, _____ St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

Blanch Oakley

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

File No. 1949

Registered No. 24

If death occurred in a hospital, institution or camp give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

MEDICAL CERTIFICATE OF DEATH.

3. SEX F 4. COLOR OR RACE W 5. SINGLE, MARRIED, WIDOWED, OR DIVORCED. Single
(Write the word.)

6. DATE OF BIRTH Sept 12 1905
(Month) (Day) (Year)

7. AGE 7 yrs. 7 mos. — ds. IF LESS than 1 day how many _____ hrs. or _____ min?

8. OCCUPATION

(a) Trade, profession or particular kind of work None
(b) General nature of industry business or establishment in which employed (or employer) None

9. BIRTHPLACE

(State or Country)

Bear Lake

10. NAME OF FATHER

Joseph Oakley

11. BIRTHPLACE OF FATHER

(State or Country)

Bear Lake Id

12. MAIDEN NAME OF MOTHER

Rizzie Wilcox

13. BIRTHPLACE OF MOTHER

(State or Country)

Paris, Idaho

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

(Address)

Mrs T Oakley
Paris, Ida

15. Filed May 2 1913

Local Registrar

16. DATE OF DEATH

April 18 1913
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from April 17 1913, to April 18 1913 that I last saw her alive on April 18 1913 and that death occurred on the date stated above, at 11 P. M.

The CAUSE OF DEATH* was as follows:

Suppurative appendicitis

..... (Duration) yrs. mos. 2 ds.

Contributory (Secondary)

Peritonitis

..... (Duration) yrs. mos. 1 ds.

(Signed)

Ashley Cooley M. D.
1913 (Address) Montpelier

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place In the
of death yrs. mos. ds. State yrs. mos. ds.
Where was disease contracted,
If not at place of death?
Former or
usual residence

19. PLACE OF BURIAL OR REMOVAL DATE OF BURIAL

Paris April 21 1913
20. UNDERTAKER ADDRESS

None

None

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Form V. S. No. 5 20M.1-16-12

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH.

Registration District No. 1County of AdaPrimary Registration District No. 2004City of Soldiers Home (No. Soldiers Home St.)File No. 4950Registered No. 43

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME James Dolan

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX

4. COLOR OR RACE

5. SINGLE, MARRIED, WIDOWED OR DIVORCED.

Male White AmericanSingle
(Write the word.)

6. DATE OF BIRTH

Not Obtainable 8/17 June 1912
(Month) (Day) (Year)

7. AGE

46 yrs. — mos. — ds.

IF LESS than 1 day
how many hrs. or
..... mins.?

8. OCCUPATION

(a) Trade, profession or particular kind of work

(b) General nature of industry business, or establishment in which employed (or employer)

Veteran Spanish American War

9. BIRTHPLACE

(State or Country)

Illinois

10. NAME OF FATHER

Not Obtainable

11. BIRTHPLACE OF FATHER

(State or Country)

Not Obtainable

12. MAIDEN NAME OF MOTHER

Not Obtainable

13. BIRTHPLACE OF MOTHER

(State or Country)

Not Obtainable

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

E. G. Burnell

(Address)

Soldiers Home

15.

Filed

June 12 1913J. M. Taylor

Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH

6 1 1913
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from

June 1912, to June 1913that I last saw him alive on May 29 1913.and that death occurred on the date stated above, at 5 A.M.

The CAUSE OF DEATH* was as follows:

Pulmonary Tuberculosis

(Duration) yrs. mos. ds.

Contributory

(Secondary)

(Duration) yrs. mos. ds.

(Signed) Frederic A. Tullinger, M. D.5/2 1913 (Address) Salt Lake

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death yrs. mos. days. In the State yrs. mos. days.

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

Morris Hill Burial June 1913

20. UNDERTAKER

ADDRESS

Fry & Summers Brice St.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHOTOG-
RAPH should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact state-
ment of OCCUPATION is very important. See instructions on back of certificate.

Form V. S. No. 5 20M.1-16-12

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH.

Registration District No. 1

County of, AdaPrimary Registration District No. 2004City of, Hammer(No. Soldiers Home, St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

James W. ButchFile No. 4951Registered No. 44

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX

4. COLOR OR RACE

5. SINGLE, MARRIED, WID-
OWED OR DIVORCED.Male White Single
(Write the word.)

6. DATE OF BIRTH

Not Obtainable 1844
(Month) (Day) (Year)

7. AGE

67 yrs. — mos. — ds.IF LESS than 1 day
how many hrs. or mins.?

8. OCCUPATION

(a) Trade, profession or particular kind of work

(b) General nature of industry business, or establishment in which employed (or employer)

Veteran Civil War

9. BIRTHPLACE

(State or Country)

Kentucky

10. NAME OF FATHER

Not Obtainable

11. BIRTHPLACE OF FATHER

(State or Country)

Not obtainable

12. MAIDEN NAME OF MOTHER

Not obtainable

13. BIRTHPLACE OF MOTHER

(State or Country)

Not obtainable

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

E. G. Burnet

(Address)

Soldiers' Home

15.

Filed

June 3rd 1913J. M. Taylor
Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH

6 2 1913
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from

5/27 1913 to 6/2 1913,
that I last saw him alive on 6/2 1913,
and that death occurred on the date stated above, at 10 P.M.

The CAUSE OF DEATH* was as follows:

Valvular Heart Disease

(Duration) yrs. mos. ds.

Contributory
(Secondary)

(Duration) yrs. mos. ds.

(Signed) Frederic A. Burnet, M.D.6/3 1913 (Address) Gold Bluff

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death yrs. mos. days. In the State yrs. mos. days.

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL DATE OF BURIAL

Morris Hill Cemetery June 4 1913

20. UNDERTAKER

ADDRESS

Fry & Summers Boise Id

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Form V. S. No. 5 20M.1-16-12

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH.

Registration District No. 1County of AdaPrimary Registration District No. 2004City of Boise(No. Soldiers Home St.)File No. 4952Registered No. 45

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Johan Heller

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX

Male

4. COLOR OR RACE

white American

5. SINGLE, MARRIED, WIDOWED OR DIVORCED.

married
(Write the word.)

6. DATE OF BIRTH

not obtainable
(Month) (Day) (Year)

7. AGE

76 yrs. — mos. — ds.

IF LESS than 1 day
how many hrs. or
..... mins.?

8. OCCUPATION

(a) Trade, profession or particular kind of work.

Civil War Veteran

(b) General nature of industry business, or establishment in which employed (or employer)

9. BIRTHPLACE

(State or Country)

not obtainable

10. NAME OF FATHER

11. BIRTHPLACE OF FATHER

(State or Country)

12. MAIDEN NAME OF MOTHER

13. BIRTHPLACE OF MOTHER

(State or Country)

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) E. G. Burnett(Address) Soldiers Home

15.

Filed June 4th 19131913J. M. Saylor
Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH

6 4 1913
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from

May 27 1913 to June 3 1913that I last saw him alive on June 3 1913and that death occurred on the date stated above, at 24 M.

The CAUSE OF DEATH* was as follows:

Valvular Heart Disease

(Duration) yrs. mos. ds.

Contributory
(Secondary)

(Duration) yrs. mos. ds.

(Signed) Ed. C. Thompson M. D.6/4 1913 (Address) 14th Bldg

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death yrs. mos. days. In the State yrs. mos. days.

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL DATE OF BURIAL

Monis Hill Cemetery June 5 1913

20. UNDERTAKER

ADDRESS

Fry & Summers Boise Ida

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Form V. S. No. 5 20M.1-16-12

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics
File No. **4953**

1. PLACE OF DEATH.

Registration District No. /

County of **Ada**

Primary Registration District No. **2001**

City of **Star**

(No. **Star** St.)

Registered No. **46**

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME **Samuel Snyder**

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX

Male

4. COLOR OR RACE

White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED.

Married
(Write the word.)

6. DATE OF BIRTH

Oct 13th

1850

(Month)

(Day)

(Year)

7. AGE

62 yrs. **8** mos. **7** ds.

IF LESS than 1 day
how many hrs. or mins.?

8. OCCUPATION

(a) Trade, profession or particular kind of work

Blacksmithing

(b) General nature of industry business, or establishment in which employed (or employer)

9. BIRTHPLACE

(State or Country)

Kentucky

10. NAME OF FATHER

Pastor Snyder

11. BIRTHPLACE OF FATHER

(State or Country)

Not Obtained

12. MAIDEN NAME OF MOTHER

Conthorin Moore

13. BIRTHPLACE OF MOTHER

(State or Country)

Not Obtained

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

Mrs. Francis Snyder

(Address)

Star, Idaho.

15.

Filed

June 7th

1913

J. M. Taylor

Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH

June 7

1913

(Month)

(Day)

(Year)

17. I HEREBY CERTIFY, That I attended deceased from

May 26, 1913, to June 7, 1913,

that I last saw him alive on **June 6, 1913,**

and that death occurred on the date stated above, at **2:30 P. M.**

The CAUSE OF DEATH* was as follows:

Coronary Insufficiency,

(Duration)

about 6

ds.

Contributory (Secondary)

Cross of Star

(Duration)

unknown

ds.

(Signed)

Overstreet

M. D.

19

(Address)

Star, Idaho

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death

_____ yrs. _____ mos. _____ days.

In the State

_____ yrs. _____ mos. _____ days.

Where was disease contracted if not at place of death?

Former or usual residence

✓

19. PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

Star Cemetery

June 8, 1913

20. UNDERTAKER

ADDRESS

Jay Summers

Boise, Idaho

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Form V. S. No. 5 20M.1-16-12

CERTIFICATE OF DEATH

 State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics
File No. 4954Registered No. 115

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PLACE OF DEATH

Registration District No.

Primary Registration District No.

County of AdaCity of Boise(No. 410, State St.)

If death occurs away from usual residence, give facts called for under special information. 2.

FULL NAME David Walker Tate

PERSONAL AND STATISTICAL PARTICULARS

 3. SEX male 4. COLOR OR RACE white 5. SINGLE, MARRIED, WIDOWED OR DIVORCED. married
(Write the word.)

6. DATE OF BIRTH

November 5th 1852
(Month) (Day) (Year)

7. AGE

60 yrs. 5 mos. 23 ds.

 IF LESS than 1 day
how many hrs. or
..... mins.

8. OCCUPATION

(a) Trade, profession or particular kind of work

(b) General nature of industry business, or establishment in which employed (or employer)

Most of his life agent in R.R. depot in Ill. Also school teacher.

9. BIRTHPLACE

(State or Country)

Tennessee Wilson Co.

10. NAME OF FATHER

Charles Tate

11. BIRTHPLACE OF FATHER

(State or Country)

Tennessee

12. MAIDEN NAME OF MOTHER

Eliza Rose

13. BIRTHPLACE OF MOTHER

(State or Country)

Tennessee

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Marrah Ann Tate(Address) Boise Idaho

15.

Filed 5 - 31913Mrs. Parker

Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

April 30 1913
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from

March 20 1913, to April 29 1913.
that I last saw him alive on 1913and that death occurred on the date stated above, at M.

The CAUSE OF DEATH* was as follows:

Bright's disease

(Duration) yrs. mos. ds.

Contributory
(Secondary)

(Duration) yrs. mos. ds.

(Signed) E. M. D.

19. (Address)

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death yrs. mos. days. In the State yrs. mos. days.

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

Masonic Cem5-4 1913

20. UNDERTAKER

ADDRESS

Schreiber & Langdon Boise Idaho

Form V. S. No. 5 20M.1-16-12

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH.

County of AdaCity of BornerRegistration District No. 1Primary Registration District No. 1(No. 410, States St.)File No. 4956Registered No. 118

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Patrick J. Lynch

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX

Male

4. COLOR OR RACE

White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED.

Married
(Write the word.)

6. DATE OF BIRTH

March 4th 1859
(Month) (Day) (Year)

7. AGE

54 yrs. 1 mos. 24 ds.IF LESS than 1 day
how many hrs. or
..... mins.?

8. OCCUPATION

(a) Trade, profession or particular kind of work

Mine Manager

(b) General nature of industry business, or establishment in which employed (or employer)

9. BIRTHPLACE

(State or Country)

Dingleerry Co. Ireland

10. NAME OF FATHER

Michael Lynch

11. BIRTHPLACE OF FATHER

(State or Country)

Gerry Co Ireland

12. MAIDEN NAME OF MOTHER

Ellen Hursey

13. BIRTHPLACE OF MOTHER

(State or Country)

Gerry Co Ireland

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

Mrs. P. J. Lynch(Address) 1111 - No - 6th St

15.

Filed 5-5 1913M. Parker

Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH

May 1 1913
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from

1913, to 1913,that I last saw him alive on 1913,and that death occurred on the date stated above, at M.

The CAUSE OF DEATH* was as follows:

abscess of brain

(Duration) yrs. mos. ds.

Contributory
(Secondary)

(Duration) yrs. mos. ds.

(Signed) Geo. Callahan M. D.

19..... (Address).....

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death yrs. mos. days. In the State yrs. mos. days.

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL

St. John's Cemetery 5/6 1913

20. UNDERTAKER

Schubert & Sidenfaden Borner

MARGIN RESERVED FOR BINDING
WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Form V. S. No. 5 20M.1-16-12

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

PLACE OF DEATH

Registration District No.

County of Ada

Primary Registrar in District No.

City of Boise

(No. 2111, 2609 St. St.)

File No. 4957

If death occurs away from usual residence, give facts called for under special information. 2. FULL NAME Bert H. Bennett

Registered No. 119

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX Male 4. COLOR OR RACE white American 5. SINGLE, MARRIED, WIDOWED OR DIVORCED. Married
(Write the word.)

6. DATE OF BIRTH July 14 1913
(Month) (Day) (Year)

7. AGE 28 yrs. 9 mos. 20 ds.
IF LESS than 1 day how many hrs. or mins.?

8. OCCUPATION
(a) Trade, profession or particular kind of work Laborer
(b) General nature of industry business, or establishment in which employed (or employer)

9. BIRTHPLACE Indiana
(State or Country)

10. NAME OF FATHER H. W. Bennett

11. BIRTHPLACE OF FATHER Indiana
(State or Country)

12. MAIDEN NAME OF MOTHER Minnie Carlton

13. BIRTHPLACE OF MOTHER Indiana
(State or Country)

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) W. A. Bennett
(Address) 2111 No 9 St.

15. Filed 5-6 1913 W. S. Parker
Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH May 5 1913
(Month) (Day) (Year)

17. I HEREBY CERTIFY That I attended deceased from March 1913 to May 5 1913
that I last saw him alive on May 5 1913
and that death occurred on the date stated above, at 2 A. M.

The CAUSE OF DEATH* was as follows:
Tubercular Bleeding + Hemiplegia

(Duration) 1 yrs. 2 mos. — ds.

Contributory (Secondary)

(Duration) yrs. mos. ds.

(Signed) W. S. Titus M. D.

5-7 1913. (Address) Boise

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death yrs. mos. 5 days. In the State yrs. mos. days.

Where was disease contracted if not at place of death? at home

Former or usual residence Boise

19. PLACE OF BURIAL OR REMOVAL DATE OF BURIAL

Morris Hill Cem. May 6 1913

20. UNDERTAKER ADDRESS

Fry & Summers Boise Ida

Form V. S. No. 5 20M.1-16-12

CERTIFICATE OF DEATH

 State of Idaho
 BOARD OF HEALTH
 Bureau of Vital Statistics
File No. **4958**Registered No. **120**

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PLACE OF DEATH.

Registration District No. _____

County of **Ada**

Primary Registration District No. _____

City of **Boise**(No. **112 E. Bannock** St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME **William Smith**

PERSONAL AND STATISTICAL PARTICULARS

3. SEX **M**4. COLOR OR RACE **W.**5. SINGLE, MARRIED, WIDOWED OR DIVORCED. **Single**
(Write the word.)6. DATE OF BIRTH **not obtainable 1835**
(Month) (Day) (Year)7. AGE **78** yrs. — mos. — ds.
 IF LESS than 1 day
 how many hrs. or mins.?

8. OCCUPATION

(a) Trade, profession or particular kind of work **Inmate of County Farm**

(b) General nature of industry business, or establishment in which employed (or employer)

9. BIRTHPLACE **Virginia**
(State or Country)10. NAME OF FATHER **not obtainable**11. BIRTHPLACE OF FATHER **not obtainable**
(State or Country)12. MAIDEN NAME OF MOTHER **not obtainable**13. BIRTHPLACE OF MOTHER **not obtainable**
(State or Country)

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) **Mrs. Wyatt**(Address) **St. Luke's Hosp. Boise,**

15.

Filed **5 - 7** 1913**M. S. Parker**

Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH **May 6** 1913
(Month) (Day) (Year)
 17. I HEREBY CERTIFY, That I attended deceased from **April 25** 1913, to **May 5** 1913, that I last saw him alive on **3rd May** 1913, and that death occurred on the date stated above, at **4 A.M.**

The CAUSE OF DEATH* was as follows:

Infirmities age(Duration) **3** yrs. — mos. — ds.Contributory (Secondary) **fractured hip**(Duration) **8** yrs. — mos. — ds.(Signed) **R. E. Shurtz** M. D.19. (Address) **Boise**

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.) **St. Luke's Hospital**

At place of death... yrs. ... mos. ... days. State... yrs. ... mos. ... days.

Where was disease contracted if not at place of death?

Former or usual residence **Ada County Poor Farm**19. PLACE OF BURIAL OR REMOVAL **Morris Hill County Plat**DATE OF BURIAL **5/7** 191320. UNDERTAKER **Schreiber & Sidenfaden**ADDRESS **Boise, Idaho**

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Form V. S. No. 5 20M.1-16-12

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1950

PLACE OF DEATH.

Registration District No.

County of Gda

Primary Registration District No.

City of Boise(No. 914 Jeff St.)

File No.

Registered No. 121

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Frederick Weiss

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX Female 4. COLOR OR RACE white 5. SINGLE, MARRIED, WIDOWED OR DIVORCED. married
(Write the word.)

6. DATE OF BIRTH

Mar 16 1893
(Month) (Day) (Year)

7. AGE

70 yrs. 1 mos. 21 ds.IF LESS than 1 day
how many hrs. or
..... mins.?

8. OCCUPATION

(a) Trade, profession or particular kind of work
(b) General nature of industry, business, or establishment in which employed (or employer)House work

9. BIRTHPLACE

(State or Country)

Prussia

10. NAME OF FATHER

Benjamin Shilling

11. BIRTHPLACE OF FATHER

(State or Country)

Prussia

12. MAIDEN NAME OF MOTHER

not obtainable

13. BIRTHPLACE OF MOTHER

(State or Country)

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Henry Otto Weiss(Address) Boise

15.

Filed 5/12 1912M. S. Parker
Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH

May 12 1913
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from

May 10 1913, to May 11 1913,that I last saw him alive on May 11 1913,and that death occurred on the date stated above, at M.

The CAUSE OF DEATH* was as follows:

Apoplexy

(Duration) yrs. mos. ds.

Contributory
(Secondary)

(Duration) yrs. mos. ds.

(Signed) Ed. O. O'Connell M. D.

19..... (Address).....

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death yrs. mos. days. In the State yrs. mos. days.

Where was disease contracted if not at place of death?

Former or usual residence.....

19. PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

Morris Hill Cem.May 13 1913

20. UNDERTAKER

ADDRESS

Fry & SummersBoise.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Form V. S. No. 5 20M.1-16-12

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

4960

PLACE OF DEATH.

Registration District No.

County of Ada

Primary Registration District No.

City of Boise(No. 1703, Warm Springs St.)

File No.

If death occurs away from usual residence, give facts called for under special information. 2. FULL NAME John W. Maynard

Registered No. 122

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX male 4. COLOR OR RACE white 5. SINGLE, MARRIED, WIDOWED OR DIVORCED. married (Write the word.)

6. DATE OF BIRTH

May 6 1891
(Month) (Day) (Year)

7. AGE

82 yrs. 10 mos. 10 ds.

IF LESS than 1 day
how many hrs. or
..... mins.?

8. OCCUPATION

(a) Trade, profession or particular kind of work

Retired

(b) General nature of industry business, or establishment in which employed (or employer)

9. BIRTHPLACE

(State or Country)

Massachusetts

10. NAME OF FATHER

William F. Maynard

11. BIRTHPLACE OF FATHER

(State or Country)

Vermont

12. MAIDEN NAME OF MOTHER

Ruby Gallop

13. BIRTHPLACE OF MOTHER

(State or Country)

Massachusetts

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

Mrs Ruth M. Hunt

(Address)

Boise Idaho

15.

Filed

5-171913McParker

Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH

May 16 1913
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from

Apr 25 1913, to May 4 1913,

that I last saw him alive on May 4 1913,

and that death occurred on the date stated above, at M.

The CAUSE OF DEATH* was as follows:

Bright's disease

..... (Duration) yrs. mos. ds.

Contributory
(Secondary)

..... (Duration) yrs. mos. ds.

(Signed)

Ed. Smith M. D.

19..... (Address)

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death..... yrs. mos. days. In the State..... yrs. mos. days.

Where was disease contracted if not at place of death?

Former or usual residence.....

19. PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

Morris Hill Cemetery May 18 1913

20. UNDERTAKER

ADDRESS

Schreiber & Wideman Boise

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Form V. S. No. 5 20M.1-16-12

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

4967

PLACE OF DEATH.

Registration District No.

County of Ada

Primary Registration District No.

City of Boise

(No. 410 State Idaho St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Henry J. Harnish

File No.

Registered No. 123

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX Male 4. COLOR OR RACE White 5. SINGLE, MARRIED, WIDOWED OR DIVORCED. Married
(Write the word.)

6. DATE OF BIRTH Dec 25th 1847
(Month) (Day) (Year)

7. AGE 65 yrs. 4 mos. 23 ds.
IF LESS than 1 day how many hrs. or mins.?

8. OCCUPATION
(a) Trade, profession or particular kind of work R.R. Construction
(b) General nature of industry business, or establishment in which employed (or employer) O.S.L.

9. BIRTHPLACE York Co. Penn
(State or Country)

10. NAME OF FATHER Michel Harnish

11. BIRTHPLACE OF FATHER Penn
(State or Country)

12. MAIDEN NAME OF MOTHER Rebecca Rahmer

13. BIRTHPLACE OF MOTHER Germany
(State or Country)

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Mrs H. J. Harnish
(Address) Bettavia, Ills.

15. Filed 5 / 19 1913 M.S. Parker
Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH May 17th 1913
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from April 29 1913, to May 17 1913, that I last saw him alive on May 17th 1913, and that death occurred on the date stated above, at 7 P.M.

The CAUSE OF DEATH* was as follows:
Valvular disease of heart
(Duration) 506 yrs. 2 mos. 23 ds.

Contributory Prostatic rheumatism
(Secondary)
(Duration) ? yrs. — mos. — ds.

(Signed) Jos R. Numbers M. D.
Apr 18 1913 (Address) Boise Idaho

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.) Hospital
At place of death yrs. mos. 20 days. In the State yrs. 6 mos. days.

Where was disease contracted if not at place of death?
Former or usual residence Bettavia, Ills.

19. PLACE OF BURIAL OR REMOVAL Bettavia Ills DATE OF BURIAL 5/19 1913

20. UNDERTAKER Schreiber & Schenck ADDRESS Boise

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Form V. S. No. 5 20M.1-16-12

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

4962

PLACE OF DEATH
County of Ada
City of Boise

Registration District No. _____
Primary Registration District No. _____
(No. 1405; East Jefferson St.)

File No. _____

Registered No. 124

If death occurs away from usual residence, give facts called for under special information.

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME

Grace Jane Hopper

PERSONAL AND STATISTICAL PARTICULARS

3. SEX Female 4. COLOR OR RACE White 5. SINGLE, MARRIED, WIDOWED OR DIVORCED. Married
(Write the word:)

6. DATE OF BIRTH

Mar 6 1889
(Month) (Day) (Year)

7. AGE

24 yrs. 2 mos. 12 ds.

IF LESS than 1 day
how many hrs. or
..... mins.?

8. OCCUPATION

(a) Trade, profession or particular kind of work. Housewife
(b) General nature of industry, business, or establishment in which employed (or employer) _____

9. BIRTHPLACE

(State or Country) Kansas

10. NAME OF FATHER

W E Tucker

11. BIRTHPLACE OF FATHER

(State or Country) Kansas

12. MAIDEN NAME OF MOTHER

Harriet Travis

13. BIRTHPLACE OF MOTHER

(State or Country) Kansas

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

W E Hopper

(Address) 1415 E Jeff. St.

15.

Filed 5-19 1913

M. S. Parker

Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH

5 18 1913
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from

July 19 1913, to May 18 1913,

that I last saw her alive on 18 May 1913,

and that death occurred on the date stated above, at 8 P M.

The CAUSE OF DEATH* was as follows:

Cerebral Embolism

(Duration) yrs. mos. ds.

Contributory (Secondary)

Infection of Throat

(Duration) yrs. mos. ds.

(Signed)

W E Hopper

M. D.

19. (Address)

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death yrs. mos. days. In the State yrs. mos. days.

Where was disease contracted if not at place of death? _____

Former or usual residence. _____

19. PLACE OF BURIAL OR REMOVAL DATE OF BURIAL

Morris Hill Cemetery May 20 1913

20. UNDERTAKER

ADDRESS

J. S. Summers Boise Id

Form V. S. No. 5 20M.1-16-12

CERTIFICATE OF DEATH

 State of Idaho
 BOARD OF HEALTH
 Bureau of Vital Statistics

PLACE OF DEATH.

Registration District No.

County of Ada

Primary Registration District No.

City of Boise(No. 1412 E. Jeff. St.)File No. 4963Registered No. 125

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

Electa Rue

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

 3. SEX Female 4. COLOR OR RACE white American 5. SINGLE, MARRIED, WIDOWED OR DIVORCED married
 (Write the word.)

6. DATE OF BIRTH

Sept 12 1845
 (Month) (Day) (Year)

7. AGE

67 yrs. 8 mos. 11 ds.

 IF LESS than 1 day
 how many hrs. or
 mins.?

8. OCCUPATION

(a) Trade, profession or particular kind of work

House work

(b) General nature of industry business, or establishment in which employed (or employer)

9. BIRTHPLACE

(State or Country)

Indiana

10. NAME OF FATHER

Jacob Bailey

11. BIRTHPLACE OF FATHER

(State or Country)

Indiana

12. MAIDEN NAME OF MOTHER

not obtainable

13. BIRTHPLACE OF MOTHER

(State or Country)

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

B. F. Rue

(Address)

1412 East Jeff St. Boise

15.

Filed

5-23

1913

M. B. Parker

Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH

May 23 1913
 (Month) (Day) (Year)

 17. I HEREBY CERTIFY, That I attended deceased from May 1 1913, to May 23 1913,

 that I last saw her alive on May 22 1913,

 and that death occurred on the date stated above, at 7 A.M.

The CAUSE OF DEATH* was as follows:

General Debility(Duration) 2 yrs. 11 mos. 1 ds.

Contributory (Secondary)

Inf. Bil. Duets(Duration) 30 yrs. 0 mos. 0 ds.

(Signed)

S. F. Rue M. D.May 1913 (Address) Meridian Idaho

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death yrs. mos. days. In the State yrs. mos. days.

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

Monistad Ceme. May 25 1913

20. UNDERTAKER

ADDRESS

Frymura & Co Boise.

MARGIN RESERVED FOR BINDING
WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Form V. S. No. 5 20M.1-16-12

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics
File No. **4964**

Registered No. **127**

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PLACE OF DEATH

Registration District No.

County of **Idaho**

Primary Registration District No.

City of **Boise**

(No. **St. Alphonsus Hospital**)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME **Samuel Frederick Moore**

PERSONAL AND STATISTICAL PARTICULARS

3. SEX **Male** 4. COLOR OR RACE **White** 5. SINGLE, MARRIED, WIDOWED OR DIVORCED. **Single**
(Write the word.)

6. DATE OF BIRTH

May 9 1888
(Month) (Day) (Year)

7. AGE

28 yrs. — **14** mos. **14** ds.

IF LESS than 1 day
how many hrs. or
..... mins.?

8. OCCUPATION

(a) Trade, profession or particular kind of work **Hardware Merchant**
(b) General nature of industry, business, or establishment in which employed (or employer)

9. BIRTHPLACE

(State or Country) **Missouri**

10. NAME OF FATHER

Samuel T. Moore

11. BIRTHPLACE OF FATHER

(State or Country) **Pennsylvania**

12. MAIDEN NAME OF MOTHER

Lavinia Jones

13. BIRTHPLACE OF MOTHER

(State or Country) **Missouri**

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) **Harry M. Stand**

(Address) **Boise, Ida**

15.

Filed **5-24** 1913 **M. S. Parker**

Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

May 23 1913
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from

May 13 1913 to **May 23 1913**
that I last saw him alive on **May 23 1913**

and that death occurred on the date stated above, at **6 P. M.**

The CAUSE OF DEATH* was as follows:

Pericarditis

(Duration) **2** yrs. mos. ds.

Contributory
(Secondary)

(Duration) yrs. mos. ds.

(Signed) **Robert F. Allen M. D.**

5/24 1913 (Address) **Boise**

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death yrs. mos. days. In the State yrs. mos. days.

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

Welford Mo. **May 29 1913**

20. UNDERTAKER

ADDRESS

Harry & Summers **Boise Ida**

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Form V. S. No. 5 20M.1-16-12

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics
File No. **4965**

1. PLACE OF DEATH.

Registration District No.

County of Ada

Primary Registration District No.

City of Boise

(No. 2011, N. 13th St.)

Registered No. 128

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

Roselle White

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX

Male

4. COLOR OR RACE

White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED.

Married
(Write the word.)

6. DATE OF BIRTH

April 10th 1894
(Month) (Day) (Year)

7. AGE

36 yrs. 1 mos. 15 ds.

IF LESS than 1 day
how many hrs. or
..... mins.?

8. OCCUPATION

(a) Trade, profession or particular kind of work

Housekeeper

(b) General nature of industry business, or establishment in which employed (or employer)

9. BIRTHPLACE

(State or Country)

Quincy, Ills.

10. NAME OF FATHER

Mr. Townsend

11. BIRTHPLACE OF FATHER

(State or Country)

American

12. MAIDEN NAME OF MOTHER

Mrs. Maundy

13. BIRTHPLACE OF MOTHER

(State or Country)

American

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

G. C. White

(Address)

2011 N. 13th

15.

Filed

5-26

1913

M. S. Parker

Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

May 25th 1913
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from

May 4 1913, to May 25 1913,

that I last saw her alive on May 24 1913,

and that death occurred on the date stated above, at 6 A.M.

The CAUSE OF DEATH* was as follows:

Admission disease

(Duration) 2 yrs. mos. ds.

Contributory
(Secondary)

(Duration) yrs. mos. ds.

(Signed)

W. H. Tallman M. D.

5-26 1913

(Address) Boise, Idaho

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death

..... yrs. mos. days.

In the State

..... yrs. mos. days.

Where was disease contracted if not at place of death?

Former or usual residence.

19. PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

Worship Hill Cemetery

5/26 1913

20. UNDERTAKER

ADDRESS

Schneider & Lidenfaden Boise

Tallman

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Form V. S. No. 5 20M.1-16-12

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

PLACE OF DEATH.

Registration District No.

County of Ada

Primary Registration District No.

City of Boise

(No. 703, North 8th St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME George Gumbert

File No. 4966

Registered No. 129

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX Male 4. COLOR OR RACE White 5. SINGLE, MARRIED, WIDOWED OR DIVORCED. Married
(Write the word.)

6. DATE OF BIRTH June 11 1836
(Month) (Day) (Year)

7. AGE 76 yrs. 11 mos. 16 ds.
IF LESS than 1 day how many hrs. or mins.?

8. OCCUPATION
(a) Trade, profession or particular kind of work Retired
(b) General nature of industry business, or establishment in which employed (or employer) Butcher

9. BIRTHPLACE Pa.
(State or Country)

10. NAME OF FATHER George Gumbert

11. BIRTHPLACE OF FATHER Germany
(State or Country)

12. MAIDEN NAME OF MOTHER Mrs Emilie Gumbert

13. BIRTHPLACE OF MOTHER Germany
(State or Country)

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Mrs Geo. Gumbert
(Address) Boise

15. Filed 5-27 1913 M. S. Parker
Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH May 27 1913
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from May 12 1913, to May 27 1913, that I last saw him alive on May 27 1913, and that death occurred on the date stated above, at M.
The CAUSE OF DEATH* was as follows:
Apoplexy

(Duration) yrs. mos. ds.

Contributory (Secondary)

(Duration) yrs. mos. ds.

(Signed) Geo. Gumbert M. D.

19. (Address)

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death yrs. mos. days. In the State yrs. mos. days.

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL Morris Hill Cemetery DATE OF BURIAL 5/28 1913

20. UNDERTAKER Schreibers Undertaking ADDRESS Boise

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Form V. S. No. 5 20M.1-16-12

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

PLACE OF DEATH

Registration District No.

County of *Ada*

Primary Registration District No.

City of *Boise, Ida*

(No. *410* State *State* St.)

File No.

Registered No. *130*

If death occurs away from usual residence, give facts called for under special information. 2. FULL NAME.

Morris Chas Mc Donald

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX

Male

4. COLOR OR RACE

White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED.

Single
(Write the word.)

6. DATE OF BIRTH

Mar 4th 1913
(Month) (Day) (Year)

7. AGE

2 yrs. 2 mos. 25th ds.

IF LESS than 1 day
how many hrs. or
..... mins.?

8. OCCUPATION

(a) Trade, profession or particular kind of work

none

(b) General nature of industry business, or establishment in which employed (or employer)

9. BIRTHPLACE

(State or Country) *Boise Idaho.*

10. NAME OF FATHER

Chas H Mc Donald

11. BIRTHPLACE OF FATHER

(State or Country) *Iowa*

12. MAIDEN NAME OF MOTHER

Grace J Shawver

13. BIRTHPLACE OF MOTHER

(State or Country) *Idaho.*

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) *C. N. McDonald*

(Address) *Boise, Idaho*

15.

Filed *5-29* 1913 *M. S. Parker*

Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH

May 29th 1913
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from *May 29th 1911*, to *May 29th 1913*, that I last saw him alive on *May 29th 1913*, and that death occurred on the date stated above, at *8 A.M.*

The CAUSE OF DEATH* was as follows:

Syphilis

(Duration) yrs. mos. ds.

Contributory
(Secondary)

(Duration) yrs. mos. ds.

(Signed) *W. H. Hallman M. D.*

5/29 1913 (Address) *Boise, Idaho*

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death yrs. mos. days. In the State yrs. mos. days.

Where was disease contracted if not at place of death?

Former or usual residence *#21. Leg. St*

19. PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

Morris Hill Cemetery *5/30 1913*

20. UNDERTAKER

ADDRESS

Schreiber & Siderfaden Boise, Ida

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Form V. S. No. 5 20M.1-16-12

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH.

County of Ada

City of _____

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

Registration District No. _____

Primary Registration District No. _____

(No. 1 1/2 miles N. W. Rydex station)

(Infant) (not named)
(Preston)

File No. 2 4969

Registered No. 132

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX

Male

4. COLOR OR RACE

white
American

5. SINGLE, MARRIED, WIDOWED OR DIVORCED.

Single
(Write the word.)

6. DATE OF BIRTH

May 13 1913
(Month) (Day) (Year)

7. AGE

_____ yrs. _____ mos. 17 ds.

IF LESS than 1 day
how many _____ hrs. or
_____ mins.?

8. OCCUPATION

(a) Trade, profession or particular kind of work

none Infant.

(b) General nature of industry business, or establishment in which employed (or employer)

9. BIRTHPLACE

(State or Country)

Boise Ada Co.

10. NAME OF FATHER

Nelson Preston

11. BIRTHPLACE OF FATHER

(State or Country)

Canada

12. MAIDEN NAME OF MOTHER

Betisa Clawson

13. BIRTHPLACE OF MOTHER

(State or Country)

Idaho City Road.

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

Miss Lobbie Clawson

(Address)

Boise

15.

Filed

5 / 31

1913

W. B. Baker

Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH

May 30 1913
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from

May 13 1913, to May 30 1913,

that I last saw him alive on May 29 1913,

and that death occurred on the date stated above, at 2 M.

The CAUSE OF DEATH* was as follows:

Malnutrition

(Duration) _____ yrs. _____ mos. _____ ds.

Contributory
(Secondary)

(Duration) _____ yrs. _____ mos. _____ ds.

(Signed)

O. W. Hall, M.D.

5/30 1913 (Address) Stan Idaho

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death _____ yrs. _____ mos. _____ days. In the State _____ yrs. _____ mos. _____ days.

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

Morris Hill Ceme.

June 1, 1913

20. UNDERTAKER

ADDRESS

Frydman

Boise Ida.

Form V. S. No. 5 20M.1-16-12

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

File No. 4979

Registered No. 114

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PLACE OF DEATH

Registration District No.

County of Ada

Primary Registration District No.

City of Boise

(No. Ada County St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME H. J. Richards

PERSONAL AND STATISTICAL PARTICULARS

3. SEX Male 4. COLOR OR RACE White 5. SINGLE, MARRIED, WIDOWED OR DIVORCED. Married (Write the word.)

6. DATE OF BIRTH

Jan 10 1851
(Month) (Day) (Year)

7. AGE

62 yrs. 3 mos. 20 ds.

IF LESS than 1 day
how many hrs. or mins.?

8. OCCUPATION

(a) Trade, profession or particular kind of work
(b) General nature of industry, business, or establishment in which employed (or employer)

Farmer

9. BIRTHPLACE

(State or Country)

Ohio

10. NAME OF FATHER

Mr. Richards

11. BIRTHPLACE OF FATHER

(State or Country)

Am.

12. MAIDEN NAME OF MOTHER

Not obtainable

13. BIRTHPLACE OF MOTHER

(State or Country)

u

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

Mary E. Richards
Boise, Idaho

(Address)

15.

Filed

4/30

1913

M. E. Parker

Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH

1913
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from Jan 10 1913, to Jan 30 1913, that I last saw him alive on Jan 1913,

and that death occurred on the date stated above, at M.

The CAUSE OF DEATH* was as follows:

Enterobacter meningitidis
(Cerebro spinal fever)

(Duration) yrs. mos. ds.

Contributory
(Secondary)

(Duration) yrs. mos. ds.

(Signed) J. E. Smith M. D.

19 (Address)

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death yrs. mos. days. In the State yrs. mos. days.

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL DATE OF BURIAL

Morris Hill Cemetery 4/30 1913

20. UNDERTAKER

ADDRESS

Schmidt & Henderson Boise

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Form V. S. No. 5 20M.1-16-12

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics
File No. 4971

1. PLACE OF DEATH. Registration District No. 23
County of Twin Falls Primary Registration District No. 2083
City of Hausen (No. _____ St.)

Registered No. _____
If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Katherine Bager

PERSONAL AND STATISTICAL PARTICULARS

3. SEX F 4. COLOR OR RACE W. 5. SINGLE, MARRIED, WIDOWED OR DIVORCED. Married

6. DATE OF BIRTH April 2 1
(Month) (Day) (Year)

7. AGE 21 yrs. 18 mos. 18 ds.
IF LESS than 1 day how many _____ hrs. or _____ mins.

8. OCCUPATION
(a) Trade, profession or particular kind of work House Wife
(b) General nature of industry business, or establishment in which employed (or employer)

9. BIRTHPLACE Iowa
(State or Country)

10. NAME OF FATHER Carl Grohmann

11. BIRTHPLACE OF FATHER Germany
(State or Country)

12. MAIDEN NAME OF MOTHER Minnie Eckhart

13. BIRTHPLACE OF MOTHER Germany
(State or Country)

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) R. B. Bager

(Address) Hausen

15. Filed Apr 21 1913 John H. Hughes
Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH April 20 1913
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from April 11 1913, to April 20 1913, that I last saw her alive on April 17 1913 and that death occurred on the date stated above, at 9:20 P.M.

The CAUSE OF DEATH* was as follows:

Acute Cholecystitis

(Duration) _____ yrs. _____ mos. 5 ds.

Contributory (Secondary)

(Duration) _____ yrs. _____ mos. _____ ds.

(Signed) H. Wilson M. D.

April 21 1913 (Address) Twin Falls, Idaho

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death _____ yrs. _____ mos. _____ days. In the State _____ yrs. _____ mos. _____ days.

Where was disease contracted if not at place of death?

Former or usual residence.

19. PLACE OF BURIAL OR REMOVAL Twin Falls DATE OF BURIAL April 22 1913

20. UNDERTAKER J. J. Groseman ADDRESS Twin Falls

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Form V. S. No. 5 20M.1-16-12

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics
File No. **4972**

1. PLACE OF DEATH. Registration District No. **23**
County of **Twin Falls** Primary Registration District No. **2085**
City of **"** (No. **"** St.)

Registered No. _____
If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

Max Wm Peterson

PERSONAL AND STATISTICAL PARTICULARS

3. SEX **Male** 4. COLOR OR RACE **White** 5. SINGLE, MARRIED, WIDOWED OR DIVORCED. **Single**

6. DATE OF BIRTH

May 15 1901
(Month) (Day) (Year)

7. AGE

11 yrs. 11 mos. 10 ds.

IF LESS than 1 day
how many hrs. or
mins.?

8. OCCUPATION

(a) Trade, profession or particular kind of work
(b) General nature of industry, business, or establishment in which employed (or employer)

School boy

9. BIRTHPLACE

(State or Country)

Washington

10. NAME OF FATHER

Rudolph Peterson

11. BIRTHPLACE OF FATHER

(State or Country)

Germany

12. MAIDEN NAME OF MOTHER

Ida Kraft

13. BIRTHPLACE OF MOTHER

(State or Country)

Germany

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

Rudolph Peterson

(Address)

15.

Filed **4-28** 191**3**

John H. Hughes
Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH

April 26 1913
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from **April 20 1913**, to **April 26 1913**, that I last saw him alive on **April 26 1913**, and that death occurred on the date stated above, at **2 p.m.**

The CAUSE OF DEATH* was as follows:

Typhoid Fever

(Duration) yrs. mos. **10** ds.

Contributory
(Secondary)

(Duration) yrs. mos. ds.

(Signed)

April 28 1913 (Address) **2101 2nd Twin Falls Idaho**

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death yrs. mos. days. In the State yrs. mos. days.

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL DATE OF BURIAL

Twin Falls **4/28 1913**

20. UNDERTAKER ADDRESS

P. J. Greenwood **Twin Falls**

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. CLAIMS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exactment of OCCUPATION is very important. See instructions on back of certificate.

State of Idaho DEPARTMENT OF HEALTH Bureau of Vital Statistics	
County of <u>Twin Falls</u>	Primary Registration No. <u>4973</u>
City of _____ (No. _____ St.)	Registered No. _____
If death occurs away from usual residence, give facts called for under special information. 2. FULL NAME <u>Clinton Ault</u>	
If death occurred in a hospital, institution or camp, give its NAME instead of street and number.	
PERSONAL AND STATISTICAL PARTICULARS	
3. SEX <u>Male</u>	4. COLOR OR RACE <u>White</u>
5. SINGLE, MARRIED, WIDOWED OR DIVORCED <u>Married</u>	
6. DATE OF BIRTH <u>May 28th, 1867</u> (Month) (Day)	
7. AGE <u>45</u> yrs. <u>10</u> mos. <u>5</u> ds.	IF LESS than _____ how many _____
8. OCCUPATION (a) Trade, profession or particular kind of work <u>Farmer</u> (b) General nature of industry, business, or establishment in which employed (or employer) _____	
9. BIRTHPLACE (State or Country) <u>Ohio</u>	
10. NAME OF FATHER <u>Andrew C. Ault</u>	
11. BIRTHPLACE OF FATHER (State or Country) <u>Ohio</u>	
12. MAIDEN NAME OF MOTHER <u>Robertson Mary C.</u>	
13. BIRTHPLACE OF MOTHER (State or Country) <u>Ohio</u>	
14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE (Informant) <u>Mrs. C. B. Ault</u> (Address) <u>Twin Falls County</u>	
15. Filed <u>Apr 3</u> 191 <u>3</u> <u>John B. Hughes</u> Local Registrar	
MEDICAL CERTIFICATE OF DEATH	
16. DATE OF DEATH <u>April 2</u> 191 <u>3</u> (Month) (Day) (Year)	
17. I HEREBY CERTIFY, That I attended deceased from <u>July 2nd</u> 191 <u>3</u> , to <u>April 2nd</u> 191 <u>3</u> , that I last saw him alive on <u>April 2</u> 191 <u>3</u> , and that death occurred on the date stated above, at <u>6:30 P.M.</u>	
The CAUSE OF DEATH* was as follows: <u>Acute Dilatation of Heart</u>	
(Duration) _____ yrs. _____ mos. _____ ds.	
Contributory <u>Pericarditis</u> (Secondary)	
(Duration) <u>2</u> yrs. _____ mos. _____ ds.	
(Signed) <u>Dr. C. L. Alexander</u> M. D. <u>Apr 15</u> 191 <u>3</u> (Address) <u>Twin Falls, Id.</u>	
*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.	
18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.) At place of death _____ yrs. _____ mos. _____ days. In the State _____ yrs. _____ mos. _____ days.	
Where was disease contracted if not at place of death? _____	
Former or usual residence _____	
19. PLACE OF BURIAL OR REMOVAL <u>Twin Falls</u>	DATE OF BURIAL <u>Apr 5</u> 191 <u>3</u>
20. UNDERTAKER <u>Charles J. C. C.</u>	ADDRESS <u>Twin Falls</u>

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Form V. S. No. 5 20M.1-16-12

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics
File No. **4974**

1. PLACE OF DEATH.

Registration District No. **23**

County of **Twin Falls**

Primary Registration District No. **2083**

City of

(No. ,

St.)

Registered No.

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME **Henry Smith**

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX

Male

4. COLOR OR RACE

White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED.

Married (the word.)

6. DATE OF BIRTH

May 30, 1844

(Month)

(Day)

1

(Year)

7. AGE

68

yrs.

10

mos.

12

ds.

IF LESS than 1 day
how many hrs. or
mins.

8. OCCUPATION

(a) Trade, profession or particular kind of work

Farmer

(b) General nature of industry business, or establishment in which employed (or employer)

9. BIRTHPLACE

(State or Country)

Ill.

10. NAME OF FATHER

Wm. Smith

11. BIRTHPLACE OF FATHER

(State or Country)

Unknown

12. MAIDEN NAME OF MOTHER

Polly Carugh

13. BIRTHPLACE OF MOTHER

(State or Country)

Unknown

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

H. E. Smith

(Address)

Kansen 2d

15.

Filed

Apr 13 1913

John H. Hughes
Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH

April 11
(Month) (Day)

1913
(Year)

17. I HEREBY CERTIFY, That I attended deceased from

Nov 4 1913 to **Apr 11 1913**

that I last saw him alive on **March 20 1913**

and that death occurred on the date stated above, at **9:30 M.**

The CAUSE OF DEATH* was as follows:

Chronic Interstitial Nephritis

(Duration) **Several years** yrs. mos. ds.

Contributory
(Secondary)

(Duration) yrs. mos. ds.

(Signed)

H. Wilson M. D.

Apr 13 1913 (Address) **Twin Falls, Ida**

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death yrs. mos. days. In the State yrs. mos. days.

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

Twin Falls

4-13 1913

20. UNDERTAKER

ADDRESS

Charles J. Crosby

Twin Falls

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Form V. S. No. 5 20M.1-16-12

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics
File No. **4975**

1. PLACE OF DEATH.

Registration District No. **23**

County of **Twin Falls**

Primary Registration District No. **2085**

City of **" "**

(No. **" "**)

St.)

Registered No. **" "**

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME **James E. King**

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX **M**

4. COLOR OR RACE **White**

5. SINGLE, MARRIED, WIDOWED OR DIVORCED. **Married**

6. DATE OF BIRTH **June 15 1869**

(Month)

(Day)

(Year)

7. AGE **43 yrs. 9 mos. 28 ds.**

IF LESS than 1 day
how many hrs. or
mins.?

8. OCCUPATION **Farmer**

(a) Trade, profession or particular kind of work

(b) General nature of industry business, or establishment in which employed (or employer)

9. BIRTHPLACE **Iowa**

(State or Country)

10. NAME OF FATHER **John King**

11. BIRTHPLACE OF FATHER **Penn.**

(State or Country)

12. MAIDEN NAME OF MOTHER **Eliza Cade**

13. BIRTHPLACE OF MOTHER **Penn.**

(State or Country)

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) **Mrs. Jas. E. King**

(Address) **Twin Falls, Ida.**

15. Filed **Apr 15 1913**

John C. Hughes

Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH **April 13 1913**

(Month)

(Day)

(Year)

17. I HEREBY CERTIFY, That I attended deceased from **April 10 1913**, to **April 13 1913**,

that I last saw him alive on **April 13 1913**,

and that death occurred on the date stated above, at **10:10 A.M.**

The CAUSE OF DEATH* was as follows:

Acute Dilatation of Heart

(Duration) yrs. mos. **1** ds.

Contributory **Pneumonia**
(Secondary)

(Duration) yrs. mos. **5** ds.

(Signed) **Samuel L. Alexander M.D.**

4/10/13 (Address) **Twin Falls**

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death yrs. mos. days. In the State yrs. mos. days.

Where was disease contracted if not at place of death?

Former or usual residence.

19. PLACE OF BURIAL OR REMOVAL **Cotton Wood Iowa**

DATE OF BURIAL **4/19 1913**

20. UNDERTAKER **P. J. Grossman**

ADDRESS **T. Falls**

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Form V. S. No. 5 20M.1-16-12

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics
File No. 4977

1. PLACE OF DEATH.

Registration District No. 23County of Twin FallsPrimary Registration District No. 2085City of Twin Falls

(No. _____, _____ St.)

Registered No. _____

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Peter A. Smith

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX

Male

4. COLOR OR RACE

White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED.

Married (the word.)

6. DATE OF BIRTH

May 24, 1835

(Month)

(Day)

1

(Year)

7. AGE

77

10

mos.

28

ds.

IF LESS than 1 day
how many _____ hrs. or
_____ mins.?

8. OCCUPATION

(a) Trade, profession or particular kind of work

Carpenter

(b) General nature of industry business, or establishment in which employed (or employer)

9. BIRTHPLACE

(State or Country)

Ill.

10. NAME OF FATHER

Unknown

11. BIRTHPLACE OF FATHER

(State or Country)

Ill ?

12. MAIDEN NAME OF MOTHER

Hannah Du Bois

13. BIRTHPLACE OF MOTHER

(State or Country)

Unknown.

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

(Address)

15.

Filed

Apr 21 1913

Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH

April

20

1913

(Month)

(Day)

(Year)

17. I HEREBY CERTIFY, That I attended deceased from

Nov 28 1913, to April 19 1913,

that I last saw him alive on April 17 1913,

and that death occurred on the date stated above, at 11 P. M.

The CAUSE OF DEATH* was as follows:

Sanguine

(Duration) _____ yrs. _____ mos. _____ ds.

Contributory
(Secondary)

(Duration) _____ yrs. _____ mos. _____ ds.

(Signed)

J. H. Boyd

M. D.

April 1, 1913 (Address) Twin Falls Idaho

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death _____ yrs. _____ mos. _____ days. In the State _____ yrs. _____ mos. _____ days.

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

Springville, Utah

4 - 23 1913

20. UNDERTAKER

ADDRESS

Twin Falls

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Form V. S. No. 5 20M.1-16-12

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics
File No. **4978**

1. PLACE OF DEATH.

Registration District No. **123**

County of **Twin Falls**

Primary Registration District No. **2085**

City of **Twin Falls**

(No. _____, _____ St.)

Registered No. _____

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME **Wm. Underburg**

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX

Male

4. COLOR OR RACE

White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED.

Single (Give the word.)

6. DATE OF BIRTH

Dec. 6th, 1892

(Month)

(Day)

(Year)

7. AGE

20 yrs. **4** mos. **19** ds.

IF LESS than 1 day
how many _____ hrs. or
_____ mins.?

8. OCCUPATION

(a) Trade, profession or particular kind of work

Fruit rancher

(b) General nature of industry business, or establishment in which employed (or employer)

9. BIRTHPLACE

(State or Country)

Nebr.

10. NAME OF FATHER

C. W. Underburg

11. BIRTHPLACE OF FATHER

(State or Country)

New York

12. MAIDEN NAME OF MOTHER

Helene Zibler

13. BIRTHPLACE OF MOTHER

(State or Country)

Germany

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) **C. W. Underburg**

(Address) **Palisade Colo.**

15.

Filed **4 26** 191**3**

Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH

April

26

1913

(Month)

(Day)

(Year)

17. I HEREBY CERTIFY, That I attended deceased from

April 23

1913

to

April 25

1913

that I last saw him alive on **April 25** 191**3**

and that death occurred on the date stated above, at **6:30 PM**

The CAUSE OF DEATH* was as follows:

Pericarditis originating in the appendix

(Duration) _____ yrs. _____ mos. **5** ds.

Contributory (Secondary)

(Duration) _____ yrs. _____ mos. _____ ds.

(Signed)

Doc Boyd

M. D.

Apr 26 1913 (Address) **Twin Falls, Idaho**

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death _____ yrs. _____ mos. _____ days. In the State _____ yrs. _____ mos. _____ days.

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

Palisade Colo

1913

20. UNDERTAKER

ADDRESS

Charles J. Conroy **Twin Falls**

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Form V. S. No. 5 20M.1-16-12

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics
File No. 4379

1. PLACE OF DEATH. Registration District No. 23
County of Lincoln Primary Registration District No. 2085
City of Lincoln (No. St.)

Registered No.
If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Elie J. Barnes

PERSONAL AND STATISTICAL PARTICULARS

3. SEX F. 4. COLOR OR RACE white 5. SINGLE, MARRIED, WIDOWED OR DIVORCED Married

6. DATE OF BIRTH Sept 4 1 (Month) (Day) (Year)

7. AGE 25 yrs. 7 mos. 24 ds. IF LESS than 1 day how many hrs. or mins.?

8. OCCUPATION
(a) Trade, profession or particular kind of work Housewife
(b) General nature of industry, business, or establishment in which employed (or employer)

9. BIRTHPLACE (State or Country) Kansas

10. NAME OF FATHER W. H. Jacke

11. BIRTHPLACE OF FATHER (State or Country) Kansas

12. MAIDEN NAME OF MOTHER Hattie Couger

13. BIRTHPLACE OF MOTHER (State or Country) Kan.

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) W. H. Jacke
(Address) Lincoln Falls

15. Filed May 2 1913 J. H. B. Bughler Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH April 30 1913
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from April 30 1913, to 191 , that I last saw her alive on April 30 1913 and that death occurred on the date stated above, at 2 a.m. M.

The CAUSE OF DEATH* was as follows:

Puerperal convulsions
(Duration) 4 hours yrs. mos. ds.

Contributory (Secondary)

(Duration) yrs. mos. ds.
(Signed) H. H. Clouch M. D.

May 2 1913 (Address) Lincoln Falls, Ida

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death yrs. mos. days. In the State yrs. mos. days.

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL Lincoln Falls DATE OF BURIAL May 2 1913

20. UNDERTAKER J. J. Grossman ADDRESS Lincoln Falls

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Form V. S. No. 5 20M.1-16-12

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH. Registration District No. 23
County of Twin Falls Primary Registration District No. 2085
City of " " (No. " St.)

File No. 4980

Registered No. _____
If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Charles E. Gustafson

PERSONAL AND STATISTICAL PARTICULARS

3. SEX Male 4. COLOR OR RACE White 5. SINGLE, MARRIED, WIDOWED OR DIVORCED. Married

6. DATE OF BIRTH Jan 29 1879
Month (Day) (Year)

7. AGE 34 yrs. 2 mos. 27 ds.
IF LESS than 1 day how many hrs. or mins.?

8. OCCUPATION
(a) Trade, profession or particular kind of work Laborer
(b) General nature of industry business, or establishment in which employed (or employer)

9. BIRTHPLACE Minn
(State or Country)

10. NAME OF FATHER Elias Gustafson

11. BIRTHPLACE OF FATHER Sweden
(State or Country)

12. MAIDEN NAME OF MOTHER Minnie Jacobson

13. BIRTHPLACE OF MOTHER Sweden
(State or Country)

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Mrs Carrie Gustafson
(Address)

15. Filed Apr 28 1913 Thos B. Sogler
Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH April 26 1913
(Month) (Day) (Year)

17. I HEREBY CERTIFY That I attended deceased from Chas E Gustafson April 24 1913, to April 26 1913, that I last saw him alive on April 25 1913

and that death occurred on the date stated above, at 1 A.M.
The CAUSE OF DEATH* was as follows:

Seplesmia

(Duration) yrs. mos. 4 ds.

Contributory (Secondary)

(Duration) yrs. mos. ds.

(Signed) Thos B. Sogler M. D.

Apr 28 1913 (Address) 201 1st St

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death. yrs. mos. days. In the State. yrs. mos. days.

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL Twin Falls DATE OF BURIAL 4-28 1913

20. UNDERTAKER Charles J. Crosby ADDRESS Terrebonne

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Form V. S. No. 5 20M.1-16-12

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics
File No. 4981

1. PLACE OF DEATH. Twin Falls Registration District No. 2087
County of Twin Falls Primary Registration District No. 23
City of Buhl (No. _____, St.)

Registered No. _____
If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Franklin Pembroke Johnson

PERSONAL AND STATISTICAL PARTICULARS

3. SEX M. 4. COLOR OR RACE W. 5. SINGLE, MARRIED, WIDOWED OR DIVORCED. Single
(Write the word.)

6. DATE OF BIRTH Dec 30 1911
(Month) (Day) (Year)

7. AGE 1 yrs. 3 mos. 26 ds. IF LESS than 1 day how many _____ hrs. or _____ mins.?

8. OCCUPATION
(a) Trade, profession or particular kind of work Chief
(b) General nature of industry, business, or establishment in which employed (or employer)

9. BIRTHPLACE Buhl
(State or Country)

10. NAME OF FATHER J. P. Johnson

11. BIRTHPLACE OF FATHER Nest Va.
(State or Country)

12. MAIDEN NAME OF MOTHER J. P. Broadfield

13. BIRTHPLACE OF MOTHER Georgia
(State or Country)

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) J. P. Johnson
(Address) Buhl

15. Filed 4-25 1913 J. H. Murphy
Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH April 24 1913
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from April 20 1913, to April 24 1913, that I last saw him alive on April 24 1913, and that death occurred on the date stated above, at 9 P.M.

The CAUSE OF DEATH* was as follows:
Enter Colitis

(Duration) _____ yrs. _____ mos. _____ ds.

Contributory (Secondary) _____

(Duration) _____ yrs. _____ mos. _____ ds.

(Signed) J. H. Murphy M. D.

4-25 1913 (Address) Buhl Ida

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death _____ yrs. _____ mos. _____ days. In the State _____ yrs. _____ mos. _____ days.

Where was disease contracted if not at place of death? _____

Former or usual residence _____

19. PLACE OF BURIAL OR REMOVAL DATE OF BURIAL

Twin Falls 4-26 1913

20. UNDERTAKER ADDRESS

H. B. Evans Buhl

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Form V. S. No. 5. 12½ M. 7-24-11

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics
File No. 4982
Registered No. _____

1. PLACE OF DEATH. Registration District No. 23
County of Twin Falls Primary Registration District No. 2087
City of Buhl (No. _____, St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

Baby Smith

If death occurred in a hospital, institution or camp give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX 4. COLOR OR RACE 5. SINGLE, MARRIED, WIDOWED OR DIVORCED.
F W Single
(Write the word.)

6. DATE OF BIRTH
4 4 1913
(Month) (Day) (Year)

7. AGE IF LESS than 1 day
_____ yrs. _____ mos. _____ ds. how many _____ hrs. or _____ min?

8. OCCUPATION

(a) Trade, profession or particular kind of work. None
(b) General nature of industry business or establishment in which employed (or employer)

9. BIRTHPLACE

(State or Country) Buhl.

10. NAME OF FATHER

Barney Smith.

11. BIRTHPLACE OF FATHER

(State or Country) Colo

12. MAIDEN NAME OF MOTHER

Anna Goodlight

13. BIRTHPLACE OF MOTHER

(State or Country) Colo

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Mrs. F. L. Smith
(Address) _____

15.

Filed 4-6 1913

J. T. Murphy
Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH
April 5 1913
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from 4-4-1913, to 1913

that I last saw her alive on 4-4-1913 and that death occurred on the date stated above, at 11:30 P.M.

The CAUSE OF DEATH* was as follows:

Premature birth

(Duration) _____ yrs. _____ mos. _____ ds.

Contributory Cause (Secondary)

(Duration) _____ yrs. _____ mos. _____ ds.

(Signed) J. T. Murphy M. D.

4-6 1913 (Address) Buhl Ida

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death _____ yrs. _____ mos. _____ ds. In the State _____ yrs. _____ mos. _____ ds.

Where was disease contracted, If not at place of death? Former or usual residence.

19. PLACE OF BURIAL OR REMOVAL DATE OF BURIAL

4-6 1913

20. UNDERTAKER ADDRESS

None

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Form V. S. No. 5. 12½ M. 7-24-11

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics
File No. 4583
Registered No. _____

1. PLACE OF DEATH.
County of Lincoln
City of South Buhl

Registration District No. 2087
Primary Registration District No. 23
(No. _____, St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

Ruth M. Buffington

If death occurred in a hospital, institution or camp give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX Female 4. COLOR OR RACE W. 5. SINGLE, MARRIED, WIDOWED OR DIVORCED. Married
(Write the word.)

6. DATE OF BIRTH May 9th 1885
(Month) (Day) (Year)

7. AGE 28 yrs. 11 mos. 26 ds.
IF LESS than 1 day
how many hrs. or
..... min?

8. OCCUPATION

(a) Trade, profession or particular kind of work.....
(b) General nature of industry business or establishment in which employed (or employer).....

Housewife

9. BIRTHPLACE Madison Co. Winteres Iowa.
(State or Country)

10. NAME OF FATHER A. W. Wilkinson

11. BIRTHPLACE OF FATHER West Virginia
(State or Country)

12. MAIDEN NAME OF MOTHER Helen R. Baker

13. BIRTHPLACE OF MOTHER Ky.
(State or Country)

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) R. M. Buffington
(Address) Buhl Ida.

15. Apr 5 1913 J. Murphy
Filed Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH April 4 1913.
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from Feb. 16 1913, to Mar 4 1913,
that I last saw her alive on Mar 4 1913,
and that death occurred on the date stated above, at 6 P. M.

The CAUSE OF DEATH* was as follows:

Uremia Ed Toxemia.

(Duration) yrs. mos. 4 ds.
Contributory Pregnancy
(Secondary)

(Duration) yrs. 4 mos. ds.
(Signed) J. Murphy M. D.
4 1913 (Address) Buhl Ida.

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place In the
of death yrs. mos. ds. State yrs. mos. ds.
Where was disease contracted,
If not at place of death?
Former or
usual residence.....

19. PLACE OF BURIAL OR REMOVAL DATE OF BURIAL

Winteres Iowa 1913

20. UNDERTAKER

ADDRESS

H. P. Evans

Buhl Ida

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Form V. S. No. 5 20M.1-16-12

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics
File No. 4984

1. PLACE OF DEATH
County of Lincoln
City of Buhl

Registration District No. 2087
Primary Registration District No. 23
(No. _____, St.)

Registered No. _____

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Oliver Rose Staeter

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX Male 4. COLOR OR RACE W 5. SINGLE, MARRIED, WID-
OWED OR DIVORCED. Single
(Write the word.)

6. DATE OF BIRTH Feb 7 1913
(Month) (Day) (Year)

7. AGE 2 yrs. 2 mos. 8 ds.
IF LESS than 1 day
how many _____ hrs. or
_____ mins.?

8. OCCUPATION

- (a) Trade, profession or particular kind of work
(b) General nature of industry, business, or establishment in which employed (or employer)

9. BIRTHPLACE Idaho
(State or Country)

10. NAME OF FATHER Staeter

11. BIRTHPLACE OF FATHER Ontario Canada
(State or Country)

12. MAIDEN NAME OF MOTHER Anna Sworchak

13. BIRTHPLACE OF MOTHER Minnesota
(State or Country)

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Staeter
(Address) mic br Ontario, Can.

15. Filed 4-17 1913 J. V. Murphy
Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH Apr. 15 1913
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from Apr. 15 1913, to Apr. 15 1913,
that I last saw her alive on Apr. 15 1913,
and that death occurred on the date stated above, at 7 P.M.
The CAUSE OF DEATH* was as follows:
Thrombosis pulmonary
about 18 hours
(Duration) _____ yrs. _____ mos. _____ ds.

Contributory (Secondary) _____

(Duration) _____ yrs. _____ mos. _____ ds.

(Signed) Chas. Wetherby M. D.

4-16-13 (Address) Buhl Idaho

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death.....yrs.....mos.....days. In the State.....yrs.....mos.....days.

Where was disease contracted if not at place of death?.....

Former or usual residence.....

19. PLACE OF BURIAL OR REMOVAL DATE OF BURIAL

Buhl Can. 1913

20. UNDERTAKER ADDRESS

H. B. Erwin Buhl

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Form V. S. No. 5. 12½ M. 7-24-11

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH
County of Latah
City of Bozwell
Registration District No. 15
Primary Registration District No. 2067
(No. _____ St.)

File No. 4387
Registered No. 73

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

William Barkman

If death occurred in a hospital, institution or camp give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX Male 4. COLOR OR RACE White 5. SINGLE, MARRIED, WIDOWED OR DIVORCED. Widowed
(Write the word.)

6. DATE OF BIRTH 1882
(Month) (Day) (Year)

7. AGE 30 yrs. 0 mos. 0 ds. IF LESS than 1 day how many _____ hrs. or _____ min?

8. OCCUPATION
(a) Trade, profession or particular kind of work. Labor
(b) General nature of industry business or establishment in which employed (or employer) Pottated Lumber Co.

9. BIRTHPLACE
(State or Country) Finland

10. NAME OF FATHER Not know

11. BIRTHPLACE OF FATHER
(State or Country) Not to Finland

12. MAIDEN NAME OF MOTHER Anne Barkman

13. BIRTHPLACE OF MOTHER
(State or Country) Finland

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Will Young
(Address) Bozwell Ida.

15. Filed Apr. 28 1913 Will Young
Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH April 26 1913
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from Apr 26 1913, to Apr 26 1913 that I last saw him alive on Apr 26 1913 and that death occurred on the date stated above, at 7:30 A.M.
The CAUSE OF DEATH* was as follows:
Internal abdominal hemorrhage

(Duration) _____ yrs. _____ mos. _____ ds.
Contributory Pushing injury to abdomen
(Secondary)

(Duration) _____ yrs. _____ mos. 1 day ds.
(Signed) Will Young M. D.
Apr. 26 1913 (Address) Bozwell Ida.

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death _____ yrs. _____ mos. _____ ds. State _____ yrs. _____ mos. _____ ds.
Where was disease contracted, _____
If not at place of death? _____
Former or usual residence _____

19. PLACE OF BURIAL OR REMOVAL Bozwell, Ida. DATE OF BURIAL Apr 29 1913

20. UNDERTAKER C. L. Scher ADDRESS Palouse Wash.

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Form V. S. No. 5. 12½ M. 7-24-11

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics
File No. 4990
Registered No. 75

1. PLACE OF DEATH. Registration District No. 15
County of Latah Primary Registration District No. 2067
City of Boise (No. , St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

Jos Carlson

If death occurred in a hospital, institution or camp give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX Male 4. COLOR OR RACE White 5. SINGLE, MARRIED, WIDOWED OR DIVORCED. Widowed
(Write the word.)

6. DATE OF BIRTH 1978
(Month) (Day) (Year)

7. AGE 34 yrs. mos. ds. IF LESS than 1 day how many hrs. or min?

8. OCCUPATION
(a) Trade, profession or particular kind of work. Supt Foreman
(b) General nature of industry business or establishment in which employed (or employer). C. M. & P. S. Ry

9. BIRTHPLACE
(State or Country) Norway

10. NAME OF FATHER Carlson

11. BIRTHPLACE OF FATHER
(State or Country) Norway

12. MAIDEN NAME OF MOTHER

13. BIRTHPLACE OF MOTHER
(State or Country)

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) W. Young
(Address) Boise Id

15. Filed Feb 14 1913 W. Young
Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH Feb 13 1913
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from Jan 14th 1913, to Feb 13 1913 that I last saw him alive on Feb 13 1913 and that death occurred on the date stated above, at 3:30 A.M.
The CAUSE OF DEATH* was as follows:

Nephritis
Do not know
(Duration) yrs. mos. ds.
Contributory Exposed
(Secondary) (Duration) yrs. mos. ds.
(Signed) W. Young M. D.
Feb 14 1913 (Address) Boise Id

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place In the
of death yrs. mos. ds. State yrs. mos. ds.
Where was disease contracted,
If not at place of death?
Former or
usual residence.

19. PLACE OF BURIAL OR REMOVAL DATE OF BURIAL
S. T. Marine Id 2/16 1913

20. UNDERTAKER ADDRESS
H. E. Muleady H. Marine

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Form V. S. No. 5. 12½ M. 7-24-11

CERTIFICATE OF DEATH

1. PLACE OF DEATH.
County of Latah
City of Bozelle

Registration District No. 15
Primary Registration District No. 2067
(No. _____, _____ St.)

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics
File No. 4995
Registered No. 80

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

L. E. Anderson

If death occurred in a hospital, institution or camp give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX Male 4. COLOR OR RACE White 5. SINGLE, MARRIED, WIDOWED OR DIVORCED. Single as long as
(Write the word.)

6. DATE OF BIRTH Not known
(Month) (Day) (Year)

7. AGE about 50 years IF LESS than 1 day
yrs. mos. ds. how many _____ hrs. or
_____ min?

8. OCCUPATION
(a) Trade, profession or particular kind of work Labour
(b) General nature of industry business or establishment in which employed (or employer) E. T. Chapin Co

9. BIRTHPLACE
(State or Country)

10. NAME OF FATHER

11. BIRTHPLACE OF FATHER
(State or Country)

12. MAIDEN NAME OF MOTHER

13. BIRTHPLACE OF MOTHER
(State or Country)

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) J. L. Schampine
(Address) Bozelle, Ida.

15. Filed May 6th 1913 W. Young
Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH May 1st 1913
(Month) (Day) (Year)

17. I HEREBY CERTIFY That I attended deceased from Nov. 1911 to May 1st 1913
that I last saw him alive on 1913
and that death occurred on the date stated above, at M.
The CAUSE OF DEATH* was as follows:

Cerebral Hemorrhage

(Duration) yrs. mos. ds.
Contributory Art. Sclerosis
(Secondary)

(Duration) yrs. mos. ds.
(Signed) W. Young M. D.
May 6th 1913 (Address) Bozelle Ida.

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place _____ In the _____
of death _____ yrs. _____ mos. _____ ds. State _____ yrs. _____ mos. _____ ds.
Where was disease contracted, _____
If not at place of death? _____
Former or _____
usual residence _____

19. PLACE OF BURIAL OR REMOVAL Sand Point, Ida. DATE OF BURIAL 1913

20. UNDERTAKER E. L. Schaw ADDRESS Palmer Wash.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Form V. S. No. 5 12½ M. 7-24-11

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics
File No. 4906

1. PLACE OF DEATH.

Registration District No. 15

County of Latah

Primary Registration District No. 2065

City of Troy

(No. , St.)

Registered No. 70

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

Mary Oshund

If death occurred in a hospital, institution or camp give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX

Female

4. COLOR OR RACE

white

5. SINGLE, MARRIED, WIDOWED OR DIVORCED.

Married
(Write the word.)

6. DATE OF BIRTH

March 2

(Month)

1899

(Day)

(Year)

7. AGE

54 yrs.

2 mos.

17 ds.

IF LESS than 1 day

how many.....hrs. or
.....min?

8. OCCUPATION

(a) Trade, profession or particular kind of work

Housewife

(b) General nature of industry business or establishment in which employed (or employer)

Farming

9. BIRTHPLACE

(State or Country)

Sweden

10. NAME OF FATHER

Person

11. BIRTHPLACE OF FATHER

(State or Country)

Sweden

12. MAIDEN NAME OF MOTHER

Don't know

13. BIRTHPLACE OF MOTHER

(State or Country)

Sweden

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

Nathan Oshund

(Address)

Troy Idaho

15.

Filed

May 20 1913

J. W. Olson
Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH

May 19

(Month)

1913

(Day)

(Year)

17. I HEREBY CERTIFY, That I attended deceased from

May 13

1913,

to May 19

1913

that I last saw her alive on May 18 1913

and that death occurred on the date stated above, at 11 A.M.

The CAUSE OF DEATH* was as follows:

Lobar Pneumonia

(Duration) yrs. mos. 6 ds.

Contributory
(Secondary)

(Duration) yrs. mos. ds.

(Signed)

J. W. Olson M. D.
May 20 1913 (Address) Troy Idaho

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place

In the

of death..... yrs. mos. ds. State..... yrs. mos. ds.

Where was disease contracted,

If not at place of death?.....

Former or

usual residence.....

19. PLACE OF BURIAL OR REMOVAL DATE OF BURIAL

Dry Creek Cemetery Troy Idaho May 22 1913

20. UNDERTAKER

ADDRESS

Mrs Soderstrom Troy Idaho

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADE INK—THIS IS A PERMANENT RECORD.
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Form V. S. No. 5. 12½M.7-24-11

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics
File No. 4997
Registered No. 71

1. PLACE OF DEATH.
County of Latah
City of Troy

Registration District No. 15
Primary Registration District No. 2065
(No. _____, _____ St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

Harvey Edward Cady

If death occurred in a hospital, institution or camp give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX Male 4. COLOR OR RACE white 5. SINGLE, MARRIED, WIDOWED OR DIVORCED. Single
(Write the word.)

6. DATE OF BIRTH March 13 1913
(Month) (Day) (Year)

7. AGE 2 yrs. 11 mos. 11 ds. IF LESS than 1 day how many _____ hrs. or _____ min?

8. OCCUPATION
(a) Trade, profession or particular kind of work nour
(b) General nature of industry business or establishment in which employed (or employer)

9. BIRTHPLACE
(State or Country) Troy Idaho

10. NAME OF FATHER Otis W. Cady

11. BIRTHPLACE OF FATHER
(State or Country) Loyal Wis

12. MAIDEN NAME OF MOTHER Sofrona A. McGarvey

13. BIRTHPLACE OF MOTHER
(State or Country) Mich

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Otis W. Cady
(Address) Troy Ida

15. Filed May 24 1913 J.W. Mason
Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH May 24 1913
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from March 13 1913, to May 24 1913
that I last saw him alive on May 24 1913
and that death occurred on the date stated above, at 4 P. M.

The CAUSE OF DEATH* was as follows:

Inanition

(Duration) 2 yrs. 11 mos. 11 ds.
Contributory Obstruction of Bowels
(Secondary)

(Duration) 1 ds.
(Signed) J.W. Mason M. D.
May 24 1913 (Address) Troy Idaho

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; (2) whether ACCIDENTAL, SUICIDAL OR HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place _____ In the _____
of death _____ yrs. _____ mos. _____ ds. State _____ yrs. _____ mos. _____ ds.
Where was disease contracted,
If not at place of death?
Former or
usual residence.

19. PLACE OF BURIAL OR REMOVAL DATE OF BURIAL
Bulah Cemetery, Troy May 26 1913

20. UNDERTAKER ADDRESS
Mrs E. Armstrong Troy Idaho

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. Exact
GIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact
ment of OCCUPATION is very important. See instructions on back of certificate.

County of Butte Primary Registration District No. 1009 Bureau of Vital Statistics
City of Moscow (No. _____, _____ St.) File No. 4998
Registered No. 68
If death occurs away from usual residence, give facts called for under special information. 2. FULL NAME Margaret D. Collins If death occurred in a hospital, institution or camp give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX Female 4. COLOR OR RACE White 5. SINGLE, MARRIED, WIDOWED OR DIVORCED Married
6. DATE OF BIRTH Feb. 8 1892
(Month) (Day) (Year)

7. AGE 61 yrs. 3 mos. 23 ds. IF LESS than 1 day how many _____ hrs. or _____ min?

8. OCCUPATION
(a) Trade, profession or particular kind of work Housewife
(b) General nature of industry business or establishment in which employed (or employer)

9. BIRTHPLACE (State or Country) Wis.

10. NAME OF FATHER J. R. Wood.

11. BIRTHPLACE OF FATHER (State or Country) New York.

12. MAIDEN NAME OF MOTHER Evelyn C. Palmer

13. BIRTHPLACE OF MOTHER (State or Country) New York.

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Ralph M. Hall
(Address) Moscow Idaho.

15. Filed June 2 1913 J. F. Rar
Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH May 31 1913
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from May 28 1913, to May 31 1913 that I last saw her alive on May 31 1913 and that death occurred on the date stated above, at 1:40 P.M.
The CAUSE OF DEATH* was as follows:

Lillian Calcutt
(Duration) 2 yrs. 2 mos. 2 ds.
Contributory (Secondary) Respiration of Gallbladder
(Duration) 2 yrs. 2 mos. 2 ds.
(Signed) J. C. Wiik M. D.
May 31 1913 (Address) Moscow, Idaho.

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; (2) whether ACCIDENTAL, SUICIDAL OR HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death _____ yrs. _____ mos. _____ ds. State _____ yrs. _____ mos. _____ ds.
Where was disease contracted, If not at place of death? _____
Former or usual residence _____

19. PLACE OF BURIAL OR REMOVAL, DATE OF BURIAL
Moscow June 2 1913

20. UNDERTAKER ADDRESS
C. Stultz Moscow

WRITE PLAINLY, WITH UNFADEING INK—THIS IS A PERMANENT RECORD.
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Form V. S. No. 5. 12½ M. 7-24-11

CERTIFICATE OF DEATH

1. PLACE OF DEATH. Registration District No. 15
County of Latah Primary Registration District No. 1008
City of Moscow (No. _____, _____ St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Edison Frank Hall

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

File No. 4999
Registered No. 61

If death occurred in a hospital, institution or camp give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX Male 4. COLOR OR RACE White 5. SINGLE, MARRIED, WIDOWED OR DIVORCED married
(Write the word.)
6. DATE OF BIRTH May 2 1856
(Month) (Day) (Year)

7. AGE 56 yrs. — mos. 23 ds. IF LESS than 1 day
how many _____ hrs. or _____ min?

8. OCCUPATION
(a) Trade, profession or particular kind of work. Carpenter
(b) General nature of industry business or establishment in which employed (or employer)

9. BIRTHPLACE
(State or Country) Michigan

10. NAME OF FATHER Levi Hall

11. BIRTHPLACE OF FATHER
(State or Country) I don't know.

12. MAIDEN NAME OF MOTHER Almina Parks.

13. BIRTHPLACE OF MOTHER
(State or Country) I don't know.

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Mrs. E. F. Hall wife
(Address) Moscow.

15. Filed May 27 1913 O. F. Rae
Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH May 25 1913
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from May 18 1913, to May 25 1913
that I last saw him alive on May 25 1913
and that death occurred on the date stated above, at 3 P. M.

The CAUSE OF DEATH* was as follows:

Pneumonia and Heart disease

(Duration) _____ yrs. _____ mos. _____ ds.

Contributory (Secondary)

(Duration) _____ yrs. _____ mos. _____ ds.

(Signed) W. R. Adams M. D.

May 26 1913 (Address) Moscow, Idaho

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place In the
of death. _____ yrs. _____ mos. _____ ds. State _____ yrs. _____ mos. _____ ds.

Where was disease contracted,

If not at place of death?

Former or

usual residence.

19. PLACE OF BURIAL OR REMOVAL DATE OF BURIAL

Moscow 5/27 1913

20. UNDERTAKER ADDRESS

Geo. Stutz Moscow

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PH CLANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

DEATH

15

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics
File No. 5000
Registered No. 62

County of Idaho Registration District No. 1008
City of Moscow (No. 1008 St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME O. C. Carson

If death occurred in a hospital, institution or camp give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX Male 4. COLOR OR RACE White 5. SINGLE, MARRIED, WIDOWED OR DIVORCED. Married

6. DATE OF BIRTH Jan 2 1873
(Month) (Day) (Year)

7. AGE 40 yrs. 4 mos. 25 ds. IF LESS than 1 day how many.....hrs. or min?

8. OCCUPATION
(a) Trade, profession or particular kind of work Grocery Store
(b) General nature of industry business or establishment in which employed (or employer)

9. BIRTHPLACE (State or Country) Missouri

10. NAME OF FATHER Chas. T. Carson

11. BIRTHPLACE OF FATHER (State or Country) Germany

12. MAIDEN NAME OF MOTHER Amie Schwartz

13. BIRTHPLACE OF MOTHER (State or Country) Missouri

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) E. J. Carson
(Address) Big Sandy, Mont.

15. Filed May 28 1913 S. F. Roe
Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH May 27th 1913
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from May 22 1913, to May 27 1913 that I last saw him alive on May 27 1913 and that death occurred on the date stated above, at 7:15 A.M.

The CAUSE OF DEATH* was as follows:
Chronic Parenchymatous Nephritis

(Duration) Don't Know yrs. mos. ds.

Contributory (Secondary)

(Duration) yrs. mos. ds.

(Signed) J. C. Wick M. D.
May 27 - 1913 (Address) Moscow, Idaho

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place In the
of death.....yrs.....mos.....ds. State.....yrs.....mos.....ds.
Where was disease contracted,
If not at place of death?.....
Former or
usual residence.....

19. PLACE OF BURIAL OR REMOVAL DATE OF BURIAL

Moscow, Ida May 27 1913

20. UNDERTAKER ADDRESS

E. O. Tuttle Moscow

Form V. S. No. 5. 12½M.7-24-11

CERTIFICATE OF DEATH

State of Utah
BOARD OF HEALTH
Bureau of Vital Statistics1. PLACE OF DEATH
County of Garfield
City of Moscow
Registration District No. 15
Primary Registration District No. 1008
(No. _____ St.)File No. 500Registered No. 6

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

Charisa Korman Bartlett

If death occurred in a hospital, institution or camp give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX Female 4. COLOR OR RACE White 5. SINGLE, MARRIED, WIDOWED OR DIVORCED. Widowed
(Write the word.)6. DATE OF BIRTH Dec 14 1838
(Month) (Day) (Year)7. AGE 74 yrs. 11 mos. 11 ds. IF LESS than 1 day
how many _____ hrs. or _____ min?

8. OCCUPATION

(a) Trade, profession or particular kind of work.

Retired

(b) General nature of industry business or establishment in which employed (or employer)

9. BIRTHPLACE

(State or Country)

Moscow

10. NAME OF FATHER

Henry Brooks

11. BIRTHPLACE OF FATHER

(State or Country)

Don't Know

12. MAIDEN NAME OF MOTHER

13. BIRTHPLACE OF MOTHER

(State or Country)

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

W. C. Korman

(Address)

Moscow

15.

Filed May 26 1913J. F. Rasmussen

Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH

May 25 1913
(Month) (Day) (Year)17. I HEREBY CERTIFY, That I attended deceased from May 24 1913, to May 25 1913that I last saw her alive on May 25 1913and that death occurred on the date stated above, at 5 P.M.

The CAUSE OF DEATH* was as follows:

Rheumatism.* (Duration) 4 yrs. _____ mos. _____ ds.Contributory (Secondary) Endocarditis.

(Duration) _____ yrs. _____ mos. _____ ds.

(Signed) W. H. Bartholomew M. D.May 25 1913 (Address) Moscow, Idaho

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place _____ In the _____
of death _____ yrs. _____ mos. _____ ds. State _____ yrs. _____ mos. _____ ds.

Where was disease contracted,

If not at place of death?

Former or

usual residence.

19. PLACE OF BURIAL OR REMOVAL

Moscow

DATE OF BURIAL

May 26 1913

20. UNDERTAKER

Geo. Shelby

ADDRESS

Moscow

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Form V. S. No. 5. 12½ M. 7-24-11

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics
File No. 5002
Registered No. 64

1. PLACE OF DEATH. Registration District No. 15
County of *Blaine* Primary Registration District No. 1008
City of *Moscow* (No. , St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME *Lillian F. Chapman*

If death occurred in a hospital, institution or camp give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX *Female* 4. COLOR OR RACE *White* 5. SINGLE, MARRIED, WIDOWED OR DIVORCED. *Single*
(Write the word.)

6. DATE OF BIRTH *July 2 1895*
(Month) (Day) (Year)

7. AGE *17 yrs. 10 mos. 20 ds.* IF LESS than 1 day how many... hrs. or min?

8. OCCUPATION *None*
(a) Trade, profession or particular kind of work.
(b) General nature of industry business or establishment in which employed (or employer)

9. BIRTHPLACE *North Dakota*
(State or Country)

10. NAME OF FATHER *Wm H Chapman*

11. BIRTHPLACE OF FATHER *Ill*
(State or Country)

12. MAIDEN NAME OF MOTHER *Mina M. Lucas*

13. BIRTHPLACE OF MOTHER *Canada*
(State or Country)

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) *Mrs. Mina Chapman*
(Address) *Moscow Ida.*

15. Filed *May 23 1913* *J. F. Roe*
Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH *May 22 1913*
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from *Sept 1911*, to *May 22 1913*
that I last saw her alive on *May 1 1913*
and that death occurred on the date stated above, at *5 P. M.*

The CAUSE OF DEATH* was as follows:

Tuberculosis
(Duration) *2* yrs. mos. ds.

Contributory (Secondary)
(Duration) yrs. mos. ds.
(Signed) *Joseph Aspray M. D.*
May 23 1913 (Address) *Moscow, Ida.*

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death... yrs... mos... ds. State... yrs... mos... ds.
Where was disease contracted,
If not at place of death?
Former or usual residence.

19. PLACE OF BURIAL OR REMOVAL *Moscow* DATE OF BURIAL *May 24 1913*

20. UNDERTAKER *G. W. Stetz* ADDRESS *Moscow*

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Form V. S. No. 5. 12½ M. 7-24-11

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics
File No. 5003
Registered No. 66

1. PLACE OF DEATH
County of Idaho
City of Moscow
Registration District No. 15
Primary Registration District No. 1008
(No. , St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

Earnest C. Rathbun

If death occurred in a hospital, institution or camp give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX M. 4. COLOR OR RACE white 5. SINGLE, MARRIED, WIDOWED OR DIVORCED. single
(Write the word.)

6. DATE OF BIRTH June 21 1890
(Month) (Day) (Year)

7. AGE 22 yrs. 11 mos. 19 ds.
IF LESS than 1 day how many hrs. or min?

8. OCCUPATION. laborer
(a) Trade, profession or particular kind of work.
(b) General nature of industry business or establishment in which employed (or employer)

9. BIRTHPLACE
(State or Country) Moscow

10. NAME OF FATHER Erastus A Rathbun

11. BIRTHPLACE OF FATHER Wis.
(State or Country)

12. MAIDEN NAME OF MOTHER Julia M. Larrabee

13. BIRTHPLACE OF MOTHER Iowa
(State or Country)

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Julia Rathbun
(Address) Harvard Idaho

15. Filed May 10 1913
D. F. Rau
Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH May 10 1913
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from April 28 1913, to May 10 1913
that I last saw him alive on May 10 1913
and that death occurred on the date stated above, at 1:30 P.M.

The CAUSE OF DEATH* was as follows:
Mitral insufficiency

(Duration) yrs. mos. ds.
Contributory (Secondary)

(Signed) Chas. L. Gutzger M. D.
19 (Address) Moscow, Ida.

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death yrs. mos. ds. In the State yrs. mos. ds.
Where was disease contracted,
If not at place of death?
Former or usual residence.

19. PLACE OF BURIAL OR REMOVAL Moscow DATE OF BURIAL May 11 1913

20. UNDERTAKER Geo. Hitz ADDRESS Moscow

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Form V. S. No. 5. 12½ M. 7-24-11

CERTIFICATE OF DEATH

1. PLACE OF DEATH. Registration District No. 15
County of Latah Primary Registration District No. 2062
City of Moscow (No. _____, _____ St.)

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics
File No. 5004
Registered No. 60

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Naomo Tilden

If death occurred in a hospital, institution or camp give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX M 4. COLOR OR RACE Red (Indian) 5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.)

6. DATE OF BIRTH March 19 1913
(Month) (Day) (Year)

7. AGE 2 yrs. 2 mos. _____ ds. IF LESS than 1 day how many _____ hrs. or _____ min?

8. OCCUPATION

- (a) Trade, profession or particular kind of work _____
(b) General nature of industry business or establishment in which employed (or employer) S

9. BIRTHPLACE Spalding Idaho
(State or Country)

10. NAME OF FATHER Sam Tilden
11. BIRTHPLACE OF FATHER Lapwai
(State or Country)

12. MAIDEN NAME OF MOTHER Ann Robin
13. BIRTHPLACE OF MOTHER Alpawatz
(State or Country)

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Sam Tilden
(Address) Lapwai

15. May 19 1913 D. F. Rae
Filed _____ Local Registrar

MEDICAL CERTIFICATE OF DEATH

Naomo Tilden
16. DATE OF DEATH May 19 1913
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from May 12 1913, to May 19 1913, that I last saw him alive on May 18 1913 and that death occurred on the date stated above, at 2 A. M.

The CAUSE OF DEATH* was as follows:

Tubercular Meningitis

(Duration) _____ yrs. 2 mos. _____ ds.

Contributory (Secondary)

(Duration) _____ yrs. _____ mos. _____ ds.
(Signed) W. H. Caruthers M. D.
May 19 1913 (Address) Moscow

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place _____ In the _____
of death _____ yrs. _____ mos. _____ ds. State _____ yrs. _____ mos. _____ ds.
Where was disease contracted, _____
If not at place of death? _____
Former or _____
usual residence _____

19. PLACE OF BURIAL OR REMOVAL Lapwai DATE OF BURIAL May 20 1913

20. UNDERTAKER Geo. Slitz ADDRESS Moscow

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

1. PLACE OF DEATH
County of Latah
City of Moscow
Registration District No. 15
Primary Registration District No. 2062
(No. St.)

If death occurs away from usual residence, give facts called for under special information.
2. FULL NAME Joseph Reilly
If death occurred in a hospital, institution or camp give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX male 4. COLOR OR RACE white 5. SINGLE, MARRIED, WIDOWED OR DIVORCED. single
(Write the word.)

6. DATE OF BIRTH Don't know
(Month) (Day) (Year)

7. AGE 65 yrs. mos. ds.
IF LESS than 1 day how many hrs. or min?

8. OCCUPATION
(a) Trade, profession or particular kind of work. Farmer
(b) General nature of industry business or establishment in which employed (or employer)

9. BIRTHPLACE Ireland.
(State or Country)

10. NAME OF FATHER Don't know

11. BIRTHPLACE OF FATHER Don't know
(State or Country)

12. MAIDEN NAME OF MOTHER Don't know

13. BIRTHPLACE OF MOTHER Don't know
(State or Country)

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Robert Reilly
(Address) Moscow, Idaho

15. Filed May 13 1913
S. F. Roe
Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH May 11 1913
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from May 11 1913, to May 11 1913, that I last saw him alive on May 11 1913, and that death occurred on the date stated above, at 8:15 A.M.

The CAUSE OF DEATH* was as follows:
Overdose of Formaldehyde taken accidentally.
(Duration) yrs. mos. ds. 1

Contributory (Secondary)
(Duration) yrs. mos. ds.
(Signed) W. F. Caruthers M. D.
May 13 1913. (Address) Moscow, Idaho

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place In the
of death yrs. mos. ds. State yrs. mos. ds.
Where was disease contracted,
If not at place of death?
Former or usual residence

19. PLACE OF BURIAL OR REMOVAL Moscow DATE OF BURIAL May 13 1913

20. UNDERTAKER Geo. Slattery ADDRESS Moscow

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Form V. S. No. 5. 12½M.7-24-11

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics
File No. 5006
Registered No. 67

1. PLACE OF DEATH. Registration District No. 15
County of Latah Primary Registration District No. 2127
City of Juliaetta (No. St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Clarence Veleta McAllister

If death occurred in a hospital, institution or camp give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX Female 4. COLOR OR RACE W. 5. SINGLE, MARRIED, WIDOWED OR DIVORCED. Single
(Write the word.)

6. DATE OF BIRTH Nov. 26, 1909
(Month) (Day) (Year)

7. AGE 3 yrs. 5 mos. 22 ds. IF LESS than 1 day how many hrs. or min?

8. OCCUPATION none
(a) Trade, profession or particular kind of work.
(b) General nature of industry business or establishment in which employed (or employer)

9. BIRTHPLACE Juliaetta, Ida.
(State or Country)

10. NAME OF FATHER Edwin D. McAllister.

11. BIRTHPLACE OF FATHER Kans.
(State or Country)

12. MAIDEN NAME OF MOTHER Ethel Watson.

13. BIRTHPLACE OF MOTHER Kans.
(State or Country)

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Ethel McAllister.
(Address) Juliaetta, Ida.

15. Filed May 19, 1913 S. A. Roe
Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH May 18, 1913.
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from May 15, 1913, to May 18, 1913
that I last saw her alive on May 18, 1913
and that death occurred on the date stated above, at 5:30 P.M.

The CAUSE OF DEATH* was as follows:

Enteritis - Colitis.

(Duration) yrs. 4 mos. ds.
Contributory Probably Arsenic Poisoning
(Secondary)

(Duration) yrs. mos. ds.
(Signed) S. A. Roe M. D.
May 18, 1913 (Address) Juliaetta, Ida.

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place In the
of death yrs. mos. ds. State yrs. mos. ds.
Where was disease contracted,
If not at place of death?
Former or
usual residence.

19. PLACE OF BURIAL OR REMOVAL DATE OF BURIAL
Juliaetta, Ida. May 19, 1913

20. UNDERTAKER ADDRESS
J. C. Groseclose Juliaetta, Ida.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Form V. S. No. 5. 12½ M. 7-24-11

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics
File No. 5007
Registered No. 86

1. PLACE OF DEATH. Registration District No. 15.
County of Latah Primary Registration District No. 2066
City of Pocatello (No. , St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

William Deary

If death occurred in a hospital, institution or camp give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX male 4. COLOR OR RACE white 5. SINGLE, MARRIED, WIDOWED OR DIVORCED. married
(Write the word.)

6. DATE OF BIRTH Oct. 10th 1854
(Month) (Day) (Year)

7. AGE 59 yrs. 10 mos. 14 ds. IF LESS than 1 day how many hrs. or min?

8. OCCUPATION

(a) Trade, profession or particular kind of work. Lumberman
(b) General nature of industry business or establishment in which employed (or employer)

9. BIRTHPLACE

(State or Country) Canada

10. NAME OF FATHER

Andrew Deary

11. BIRTHPLACE OF FATHER

(State or Country) Canada

12. MAIDEN NAME OF MOTHER

Ellen Deary

13. BIRTHPLACE OF MOTHER

(State or Country) Canada

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Mrs M. Deary
(Address) Pocatello Idaho

15.

Filed May 9 1913

J. W. Thompson
Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH

May 7 1913
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from April 27 1913, to May 5 1913 that I last saw him alive on May 5 1913 and that death occurred on the date stated above, at 10 P.M. The CAUSE OF DEATH* was as follows:

Bright Disease

(Duration) — yrs. 6 mos. — ds.

Contributory (Secondary)

(Duration) — yrs. — mos. — ds.

(Signed)

J. W. Thompson M.D.
509 1913 (Address) Pocatello Idaho

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place In the
of death — yrs. — mos. — ds. State — yrs. — mos. — ds.
Where was disease contracted,
If not at place of death?
Former or
usual residence.

19. PLACE OF BURIAL OR REMOVAL DATE OF BURIAL

Spokane

May 10 1913

20. UNDERTAKER

ADDRESS

J. D. Buchanan

Spokane

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Form V. S. No. 5. 12½ M. 7-24-11

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH. Registration District No. 15
County of Blaine Primary Registration District No. 20 66
City of Princeton (No. _____, _____ St.)

File No. 5008
Registered No. 85

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Vivian Louise McMarais
If death occurred in a hospital, institution or camp give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX Female 4. COLOR OR RACE White 5. SINGLE, MARRIED, WIDOWED OR DIVORCED. Married
(Write the word.)
6. DATE OF BIRTH Nov. 18 1892
(Month) (Day) (Year)

7. AGE 20 yrs. 0 mos. 29 ds.
IF LESS than 1 day how many _____ hrs. or _____ min?

8. OCCUPATION
(a) Trade, profession or particular kind of work. House & business
(b) General nature of industry business or establishment in which employed (or employer).

9. BIRTHPLACE
(State or Country) Michigan

10. NAME OF FATHER Geo. H. Grimsbury

11. BIRTHPLACE OF FATHER
(State or Country) W. S.

12. MAIDEN NAME OF MOTHER Sarah McGrimsbury

13. BIRTHPLACE OF MOTHER
(State or Country) W. S.

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Geo. H. Grimsbury
(Address) Princeton Idaho

15. Filed May 20 1913 Dr. J. W. Thompson
Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH May 17 1913
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from May 12 1913, to May 17 1913
that I last saw her alive on May 17 1913
and that death occurred on the date stated above, at 9:30 P.M.
The CAUSE OF DEATH* was as follows:
Bright's Disease

(Duration) _____ yrs. 9 mos. _____ ds.
Contributory (Secondary) _____
(Duration) _____ yrs. _____ mos. _____ ds.
(Signed) W. B. M. D.
May 18 1913 (Address) Princeton Idaho

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place _____ In the _____
of death _____ yrs. _____ mos. _____ ds. State _____ yrs. _____ mos. _____ ds.
Where was disease contracted, _____
If not at place of death? _____
Former or _____
usual residence _____

19. PLACE OF BURIAL OR REMOVAL DATE OF BURIAL
Palouse Mary May 19 1913
20. UNDERTAKER ADDRESS
E. Quclerroy Palouse

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Form V. S. No. 5. 12½ M. 7-24-11

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics
File No. _____
Registered No. 84

1. PLACE OF DEATH. Registration District No. 16
County of Blaine Primary Registration District No. 2066
City of Patlatoh (No. _____, St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME unknown

If death occurred in a hospital, institution or camp give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX Male 4. COLOR OR RACE Stationary 5. SINGLE, MARRIED, WIDOWED OR DIVORCED. not known
(Write the word.)

6. DATE OF BIRTH _____
(Month) (Day) (Year)

7. AGE about 40 yrs IF LESS than 1 day
_____ yrs. _____ mos. _____ ds. how many _____ hrs. or _____ min?

8. OCCUPATION laborer
(a) Trade, profession or particular kind of work.
(b) General nature of industry business or establishment in which employed (or employer)

9. BIRTHPLACE _____
(State or Country)

10. NAME OF FATHER _____

11. BIRTHPLACE OF FATHER _____
(State or Country)

12. MAIDEN NAME OF MOTHER _____

13. BIRTHPLACE OF MOTHER _____
(State or Country)

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Coroner
(Address) Patlatoh

15. Filed May 14 1913 E. J. Thompson
Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH May 14 1913
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from _____ 191____, to _____ 191____

that I last saw h. _____ alive on _____ 191____
and that death occurred on the date stated above, at 11 A.M.

The CAUSE OF DEATH* was as follows:
was sitting on the R.R. Rail and on a crossing and the Engineer was unable to stop train and struck him on right chest killing him instantly.

Contributory (Secondary) _____
(Duration) _____ yrs. _____ mos. _____ ds.

(Signed) E. B. McCarter Coroner M. D.
May 14 1913 (Address) Moreau

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place _____ In the _____
of death _____ yrs. _____ mos. _____ ds. State _____ yrs. _____ mos. _____ ds.
Where was disease contracted, _____
If not at place of death? _____
Former or _____
usual residence _____

19. PLACE OF BURIAL OR REMOVAL Patlatoh Idaho DATE OF BURIAL May 14 1913

20. UNDERTAKER E. J. Thompson ADDRESS Patlatoh

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Form

1. PLACE OF DEATH. Registration District No. 15
 County of Idaho Primary Registration District No. 2066
 City of _____ (No. _____, St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

Mary S. Howell

Idaho
 BOARD OF HEALTH
 Bureau of Vital Statistics
 File No. 5019
 Registered No. 83

If death occurred in a hospital, institution or camp give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX Female 4. COLOR OR RACE White 5. SINGLE, MARRIED, WIDOWED OR DIVORCED. Married
 (Write the word.)
 6. DATE OF BIRTH May 22 1866
 (Month) (Day) (Year)

7. AGE 47 yrs. 0 mos. 15 ds. IF LESS than 1 day how many hrs. or min?

8. OCCUPATION

- (a) Trade, profession or particular kind of work.
 (b) General nature of industry business or establishment in which employed (or employer)

House Wife

9. BIRTHPLACE

(State or Country)

Kansas

10. NAME OF FATHER

Napoleon Sherris

11. BIRTHPLACE OF FATHER

(State or Country)

Not known

12. MAIDEN NAME OF MOTHER

not known

13. BIRTHPLACE OF MOTHER

(State or Country)

not known

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

Bert Howell

(Address)

Poland, Wash

15.

Filed June 8th 1913

Dr. J. W. Thompson
 Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH

June 7 1913
 (Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from 191 to 191

that I last saw h. alive on 191
 and that death occurred on the date stated above, at 5:30 M.

The CAUSE OF DEATH* was as follows:

Instantly killed by lightning

..... (Duration) yrs. mos. ds.

Contributory
 (Secondary)

..... (Duration) yrs. mos. ds.

(Signed) Dr. Harrison M. D.

..... 19..... (Address) Poland, Wash

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place In the
 of death yrs. mos. ds. State yrs. mos. ds.

Where was disease contracted,

If not at place of death?

Former or

usual residence.

19. PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

Poland Wash

June 9th 1913

20. UNDERTAKER

ADDRESS

E. Lindersun

Poland

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH

Registration District No. 15

County of Idaho

Primary Registration District No. 2062

City of Genesee

(No.)

(St.)

File No. 5011

Registered No. 82

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

Frederick Franklin Burdick

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX

male

4. COLOR OR RACE

white5. SINGLE, MARRIED, WID-
OWED OR DIVORCED.married
(Write the word.)

6. DATE OF BIRTH

February 19, 1835
(Month) (Day) (Year)

7. AGE

79 yrs. 3 mos. 15 ds.IF LESS than 1 day
how many hrs. or
..... mins.?

8. OCCUPATION

(a) Trade, profession or
particular kind of work(b) General nature of industry
business, or establishment in
which employed (or employer)retired farmer

9. BIRTHPLACE

(State or Country)

Vermont10. NAME OF
FATHERJ. Burdick11. BIRTHPLACE
OF FATHER

(State or Country)

Vermont12. MAIDEN NAME
OF MOTHERLura Franklin13. BIRTHPLACE
OF MOTHER

(State or Country)

Vermont

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

Mrs. Maude Hasbrouck

(Address)

Cottlatch, Idaho

15.

Filed June 4, 1913W. H. Chen
Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

June 2, 1913
(Month) (Day) (Year)17. I HEREBY CERTIFY, That I attended deceased from
Sept 7, 1912, to June 2, 1913
that I last saw him alive on June 2, 1913and that death occurred on the date stated above, at 4 P. M.

The CAUSE OF DEATH* was as follows:

apoplexy

(Duration) yrs. 9 mos. ds.

Contributory arteriosclerosis
(Secondary)

(Duration) 5 yrs. mos. ds.

(Signed) W. H. Chen M. D.6-4 1913 (Address) Genesee*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1)
MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.18. LENGTH OF RESIDENCE (For Hospitals, Institutions,
Transients or Recent Residents.)

At place of death yrs. mos. days. In the State yrs. mos. days.

Where was disease contracted
if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL DATE OF BURIAL

F.O.B. Cemetery 6-6 1913

20. UNDERTAKER

E. Lambert

ADDRESS

Genesee

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Form V. S. No. 5 20M.1-16-12

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH.

Registration District No. 13County of LatahPrimary Registration District No. 2063City of Genesee

(No. _____)

(St.) _____

File No. 5112Registered No. 87

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

Calvin Ernest Wood

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX

Male

4. COLOR OR RACE

White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED.

married
(Write the word.)

6. DATE OF BIRTH

January 28 1899
(Month) (Day) (Year)

7. AGE

54 yrs. 3 mos. 6 ds.IF LESS than 1 day
how many hrs. or
..... mins.?

8. OCCUPATION

(a) Trade, profession or particular kind of work

Grain Dealer

(b) General nature of industry, business, or establishment in which employed (or employer)

9. BIRTHPLACE

(State or Country)

Ohio

10. NAME OF FATHER

Griffith L. Wood

11. BIRTHPLACE OF FATHER

(State or Country)

Ohio

12. MAIDEN NAME OF MOTHER

Elizabeth Hayes

13. BIRTHPLACE OF MOTHER

(State or Country)

Ohio

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

Mrs. C. E. Wood

(Address)

Genesee Idaho

15.

Filed

May 5 1913W. H. E. H. E.

Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH

May 4 1913
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from

Oct. 10 1912 to May 3 1913that I last saw him alive on May 2 1913and that death occurred on the date stated above, at 1220A

The CAUSE OF DEATH* was as follows:

Chronic Interstitial Nephritis
and arteriosclerosis(Duration) 7 yrs. — mos. — ds.Contributory
(Secondary)Hemiplegia(Duration) — yrs. 2 mos. 4 ds.

(Signed)

May 5, 1913 (Address) Genesee Ida

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place

of death yrs. mos. days.

In the

State yrs. mos. days.

Where was disease contracted if not at place of death?

Former or usual residence.

19. PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

500 S. Genesee5/6 1913

20. UNDERTAKER

ADDRESS

F. E. LambertGenesee Ida

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Form V. S. No. 5 20M.1-16-12

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH. Registration District No. 17
County of Clearwater Primary Registration District No. 2078
City of Burien (No. _____ St.)

File No. 5013
Registered No. 23

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Otille Olson

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX Female 4. COLOR OR RACE White 5. SINGLE, MARRIED, WIDOWED OR DIVORCED. Married
(Write the word.)

6. DATE OF BIRTH Sept 23 1853
(Month) (Day) (Year)

7. AGE 59 yrs. 7 mos. 29 ds.
IF LESS than 1 day how many hrs. or mins.?

8. OCCUPATION
(a) Trade, profession or particular kind of work Housewife
(b) General nature of industry business, or establishment in which employed (or employer)

9. BIRTHPLACE Norway
(State or Country)

10. NAME OF FATHER Unknown

11. BIRTHPLACE OF FATHER Unknown
(State or Country)

12. MAIDEN NAME OF MOTHER Unknown

13. BIRTHPLACE OF MOTHER Unknown
(State or Country)

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Mrs. Theo Pederson
(Address) Chesham, Ida

15. Filed Jan 1 1913 J. M. Fair
Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH May 10 1913
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from March 20 1913 to May 10 1913
that I last saw him alive on May 1 1913
and that death occurred on the date stated above, at 11 A.M.
The CAUSE OF DEATH* was as follows:
Carcinoma of throat
(Duration) yrs. 13 mos. ds.
Contributory (Secondary)
(Duration) yrs. mos. ds.
(Signed) J. M. Fair M. D.
(Address) Proffins, Ida

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death yrs. mos. days. In the State yrs. mos. days.

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL Burien, Ida DATE OF BURIAL May 11 1913

20. UNDERTAKER ✓ ADDRESS _____

MARGIN RESERVED FOR BINDING

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Form V. S. No. 5 20M.1-16-12

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics
File No. 5014

1. PLACE OF DEATH
County of Clearwater
City of Elk River
Registration District No. 17
Primary Registration District No. 2079
(No. St.)

Registered No. 24
If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME John Disco

PERSONAL AND STATISTICAL PARTICULARS

3. SEX Male 4. COLOR OR RACE Russian 5. SINGLE, MARRIED, WIDOWED OR DIVORCED. Single (Write the word.)

6. DATE OF BIRTH Not known
(Month) (Day) (Year)

7. AGE 23 yrs. - mos. - ds.
IF LESS than 1 day how many hrs. or mins.?

8. OCCUPATION

(a) Trade, profession or particular kind of work Lumberman
(b) General nature of industry business, or establishment in which employed (or employer)

9. BIRTHPLACE

(State or Country) Russia

10. NAME OF FATHER Not known

11. BIRTHPLACE OF FATHER Not known
(State or Country)

12. MAIDEN NAME OF MOTHER Not known

13. BIRTHPLACE OF MOTHER Not known
(State or Country)

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) H. T. Seely M. D.
(Address) Elk River, Idaho

15. Filed June 1 1913 J. M. Gentry
Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH May 12 1913
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from April 30 1913, to May 12 1913, that I last saw him alive on May 12 1913, and that death occurred on the date stated above, at 2 A. M.

The CAUSE OF DEATH* was as follows:

Syphilis of the Brain

(Duration) 1 yrs. 4 mos. - ds.

Contributory (Secondary) ✓

(Duration) yrs. mos. ds.

(Signed) H. T. Seely M. D.

19 (Address) Elk River, Idaho

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death... yrs. ... mos. ... days. In the State... yrs. ... mos. ... days.

Where was disease contracted if not at place of death? Not known

Former or usual residence Not known

19. PLACE OF BURIAL OR REMOVAL DATE OF BURIAL

Elk River Idaho May 13 1913

20. UNDERTAKER ADDRESS

C. G. Morris Elk River

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

File No. 5015
Registered No. 25

If death occurred in a hospital, institution or camp give its NAME instead of street and number.

1. PLACE OF DEATH. Registration District No. 17
County of Clearwater Primary Registration District No. 2079
City of Elk River (No. , St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Ernest Runney

PERSONAL AND STATISTICAL PARTICULARS

3. SEX Male 4. COLOR OR RACE White 5. SINGLE, MARRIED, WIDOWED OR DIVORCED. married
(Write the word.)

6. DATE OF BIRTH Not known 1
(Month) (Day) (Year)

7. AGE 48 yrs. mos. ds. IF LESS than 1 day how many hrs. or min?

8. OCCUPATION

(a) Trade, profession or particular kind of work. Lumberman
(b) General nature of industry business or establishment in which employed (or employer)

9. BIRTHPLACE Not known
(State or Country)

10. NAME OF FATHER Not known

11. BIRTHPLACE OF FATHER Not known
(State or Country)

12. MAIDEN NAME OF MOTHER Not known

13. BIRTHPLACE OF MOTHER Not known
(State or Country)

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) M. T. Seely M.D.
(Address) Elk River Ida

15. Filed June 1 1913 J. M. Seely
Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH Jan 26 1913
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from Dec 20 1913, to Jan 26 1913 that I last saw him alive on Jan 25 1913 and that death occurred on the date stated above, at 1 A. M. The CAUSE OF DEATH* was as follows:

Acute Nephritis

(Duration) yrs. 1 mos. 6 ds.
Contributory Carbuncle
(Secondary)

(Duration) yrs. 10 ds.
(Signed) M. T. Seely M. D.
Jan 29 1913 (Address) Elk River Ida

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place In the
of death yrs. mos. ds. State yrs. mos. ds.
Where was disease contracted,
If not at place of death?
Former or
usual residence.

19. PLACE OF BURIAL OR REMOVAL DATE OF BURIAL

Chippewa Falls, Wis. Jan 27 1913

20. UNDERTAKER ADDRESS
C. L. Shaw Palouse Wash.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIAN should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
N. B.—Item of information should be carefully supplied. AGE should be state EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Form V. S. No. 5. 10M. 6-20-11.

CERTIFICATE OF DEATH

1. PLACE OF DEATH. Registration District
County of Cassia Primary Registrant
City of Burley (No. _____, _____ St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Mary E. Tree

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics
File No. 5916
Registered No. 26

If death occurred in a hospital, institution or camp give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX F. 4. COLOR OR RACE white 5. SINGLE, MARRIED, WIDOWED OR DIVORCED Married

6. DATE OF BIRTH Jan. 30
(Month) (Day)

7. AGE 1 yrs. 3 mos. 18 ds. IF LESS how many min.

8. OCCUPATION

- (a) Trade, profession, or particular kind of work
(b) General nature of industry, business, or establishment in which employed (or employer)

9. BIRTHPLACE
(State or Country) Burley, Idaho

10. NAME OF FATHER T. R. Tree

11. BIRTHPLACE OF FATHER
(State or Country) Colorado

12. MAIDEN NAME OF MOTHER Lilly West

13. BIRTHPLACE OF MOTHER
(State or Country) Idaho

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) T. R. Tree
(Address) Burley, Idaho

15. Filed 6-7 1913 L. B. Toole
Local

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH May 15th 1913
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from died before Dr. saw her 1913
that I last saw her alive on 1913
and that death occurred on the date stated above, at 5 a. m.

The CAUSE OF DEATH* was as follows:

Branchio-Pneumonia

(Duration) 3 yrs. 3 mos. 3 ds.

Contributory
(Secondary)

(Duration) 3 yrs. 3 mos. 3 ds.

(Signed) J. C. Patterson M. D.
May 16th 1913 (Address) Burley, Idaho

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL,

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place _____ In the _____
of death _____ yrs. _____ mos. _____ ds. State _____ yrs. _____ mos. _____ ds.
Where was Disease contracted,
If not at place of death? _____
Former or
usual residence _____

19. PLACE OF BURIAL OR REMOVAL Burley, Idaho DATE OF BURIAL May 19 1913

20. UNDERTAKER Home ADDRESS _____

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
 Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Form V. S. No. 5. 10M. 6-20-11.

CERTIFICATE OF DEATH

 State of Idaho
 BOARD OF HEALTH
 Bureau of Vital Statistics

1. PLACE OF DEATH.

Registration District No. 21

County of Blaine

Primary Registration District No. 2022

City of Hailey

(No. _____ St.)

Registered No. 20

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

Mrs. Julia Haupt.

If death occurred in a hospital, institution or camp give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX

Female

4. COLOR OR RACE

Wht.

5. SINGLE, MARRIED, WIDOWED OR DIVORCED.

Widowed.
(Write the word)

6. DATE OF BIRTH

 Nov. 24 1887
 (Month) (Day) (Year)

7. AGE

61 yrs. 5 mos. 28 ds.

 IF LESS than 1 day
 how many hrs. or min.

8. OCCUPATION

(a) Trade, profession or particular kind of work

Housewife

(b) General nature of industry business or establishment in which employed (or employer)

9. BIRTHPLACE

(State or Country)

Germany

10. NAME OF FATHER

C. Hauser

11. BIRTHPLACE OF FATHER

(State or Country)

Germany

12. MAIDEN NAME OF MOTHER

13. BIRTHPLACE OF MOTHER

(State or Country)

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

V. C. Haupt

(Address)

Hailey

15.

May 26 1913

R. Schuchert Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

 May 22 1913
 (Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from

May 15 1913, to May 22 1913

that I last saw her alive on May 21 1913

and that death occurred on the date stated above, at 4

The CAUSE OF DEATH* was as follows:

Anthrax of Skin

(Duration) 21 yrs. — mos.

Contributory (Secondary)

(Duration) — yrs. — mos.

(Signed) R. Schuchert

May 22 1913 (Address) Hailey

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions or Recent Residents.)

At place of death — yrs. — mos. — ds. State — yrs. — mos.

Where was disease contracted.

If not at place of death?

Former or

usual residence.

19. PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

Ralph S. Harris

May 26 1913

20. UNDERTAKER

ADDRESS

Hailey Ida Hailey

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
 B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Form V. S. No. 5. 10M. 6-20-11.

CERTIFICATE OF DEATH

 State of Idaho
 BOARD OF HEALTH
 Bureau of Vital Statistics

1. PLACE OF DEATH.

Registration District No. 21County of HaileyPrimary Registration District No. 2072City of Beauregard(No. St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

Jose RamonaFile No. 5018Registered No. 21

If death occurred in a hospital, institution or camp give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX

Male

4. COLOR OR RACE

White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED.

Widowed
(Write the word.)

6. DATE OF BIRTH

(Month) (Day) (Year)

7. AGE

About 43 yrs. mos. ds.
 IF LESS than 1 day
 how many hrs. or min.

8. OCCUPATION

 (a) Trade, profession or particular kind of work
 (b) General nature of industry business or establishment in which employed (or employer)
Sheep Herding

9. BIRTHPLACE

(State or Country)

Spain

10. NAME OF FATHER

Jose Ramona

11. BIRTHPLACE OF FATHER

(State or Country)

Spain

12. MAIDEN NAME OF MOTHER

Theresa

13. BIRTHPLACE OF MOTHER

(State or Country)

Spain

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

Frank Barrienta

(Address)

Hailey, Idaho

15.

June 26, 1913Dr. J. H. Smith

Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

May 22 1913
 (Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from

May 19 1913, to May 22 1913

 that I last saw him alive on May 22 1913,

 and that death occurred on the date stated above, at 4:30 M.

The CAUSE OF DEATH* was as follows:

Valvular Heart Disease(Duration) yrs. mos. 3 ds.

Contributory (Secondary)

Stroke

(Duration) yrs. mos. ds.

(Signed)

May 22 1913 (Address) Hailey, Idaho

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death. yrs. mos. ds. State. yrs. mos. ds.

Where was disease contracted.

If not at place of death?

Former or

usual residence.

19. PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

Hailey, Ida1913

20. UNDERTAKER

ADDRESS

R. D. 26Hailey, Ida

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Form V. S. No. 5. 10M. 6-20-11.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics
File No. 5019
Registered No. 22

1. PLACE OF DEATH.

Registration District No. 21

County of Blaine

Primary Registration District No. 2029

City of Mamand

(No. , St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME William Sant

If death occurred in a hospital, institution or camp give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX

Male

4. COLOR OR RACE

White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED.

Married
(Write the word.)

6. DATE OF BIRTH

12 11 1850
(Month) (Day) (Year)

7. AGE

62 yrs. 5 mos. ds.

IF LESS than 1 day
how many hrs. or min.?

8. OCCUPATION

- (a) Trade, profession, or particular kind of work
(b) General nature of industry business, or establishment in which employed (or employer)

Farmer

9. BIRTHPLACE

(State or Country)

England

10. NAME OF FATHER

John Sant

11. BIRTHPLACE OF FATHER

(State or Country)

England

12. MAIDEN NAME OF MOTHER

Mary Shaw

13. BIRTHPLACE OF MOTHER

(State or Country)

England

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Mrs. Adah M. Sant

(Address) Mamand Idaho

15.

Filed May 20

John F. Fisher
Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

May 12 1913
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from

May 10 1913, to May 12 1913

that I last saw him alive on May 10 1913

and that death occurred on the date stated above, at 2 A. M.

The CAUSE OF DEATH* was as follows:

Pneumonia

(Duration) yrs. mos. 6 ds.

Contributory
(Secondary)

Asthma, Cardiac

(Duration) 20 yrs. mos. ds.

(Signed) Dr. W. H. Fisher M. D.

5-12 1913 (Address) Soldier's La

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place In the
of death. yrs. mos. ds. State. yrs. mos. ds.

Where was Disease contracted,
If not at place of death?
Former or usual residence.

19. PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

Mamand Ida

3-14 1913

20. UNDERTAKER

ADDRESS

Lewis Adams

Mamand Ida

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Form V. S. No. 5. 10M. 6-20-11.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH.

Registration District No. 21County of BonnePrimary Registration District No. 2099City of Bellevue

(No. _____ St.)

File No. 5020Registered No. 23

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

John Pascoe

If death occurred in a hospital, institution or camp give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX

Male

4. COLOR OR RACE

Wht

5. SINGLE, MARRIED, WIDOWED OR DIVORCED.

married
(Write the word.)

6. DATE OF BIRTH

March15th1863

(Month)

(Day)

(Year)

7. AGE

50

yrs.

2

mos.

4

ds.

IF LESS than 1 day
how many hrs. or
..... min.?

8. OCCUPATION

- (a) Trade, profession or particular kind of work
(b) General nature of industry business or establishment in which employed (or employer)

9. BIRTHPLACE

(State or Country)

England

10. NAME OF FATHER

John Pascoe

11. BIRTHPLACE OF FATHER

(State or Country)

England

12. MAIDEN NAME OF MOTHER

Jenny Rogers

13. BIRTHPLACE OF MOTHER

(State or Country)

England

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

Wm W. Jones

(Address)

Bellevue

15.

Filed

May 30 1913Robert H. Hughes

Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

May
(Month)19
(Day)1913

(Year)

17. I HEREBY CERTIFY, That I attended deceased from

May 161913to May 191913that I last saw him alive on May 181913and that death occurred on the date stated above, at 7:30 am.

The CAUSE OF DEATH* was as follows:

Pneumonia(Duration) yrs. mos. 3 ds.Contributory
(Secondary)

(Duration) yrs. mos. ds.

(Signed)

May 19 1913

(Address)

Hailey Idaho

M. D.

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place yrs. mos. ds. State yrs. mos. ds.

Where was disease contracted.

If not at place of death?

Former or
usual residence.

19. PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

Bellevue IdaMay 21 1913

20. UNDERTAKER

ADDRESS

Ralph D. HarrisHailey Ida

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Form V. S. No. 5. 10M. 6-20-11.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics
File No. 5021

1. PLACE OF DEATH.

Registration District No. 21

County of Blaine

Primary Registration District No. 2072

City of Bellevue

(No. , St.)

Registered No. 24

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

John Mullins

If death occurred in a hospital, institution or camp give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX

Male

4. COLOR OR RACE

White

(Write the word.)

6. DATE OF BIRTH

March

20th

1911

(Month)

(Day)

(Year)

7. AGE

7 yrs. 2 mos. 10 ds.

IF LESS than 1 day

how many hrs. or min.?

8. OCCUPATION

- (a) Trade, profession or particular kind of work
(b) General nature of industry business or establishment in which employed (or employer)

9. BIRTHPLACE

(State or Country)

Idaho

10. NAME OF FATHER

O. R. Mullins

11. BIRTHPLACE OF FATHER

(State or Country)

West Virginia

12. MAIDEN NAME OF MOTHER

Miss White

13. BIRTHPLACE OF MOTHER

(State or Country)

West Virginia

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

O. R. Mullins

(Address)

Fisherie Idaho

15.

Filed

May 30 1913

John H. H. H.
Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

May

20

1913

(Month)

(Day)

(Year)

17. I HEREBY CERTIFY, That I attended deceased from

May 15

1913

to May 20

1913

that I last saw him alive on May 20 1913
and that death occurred on the date stated above, at about 8 P. M.

The CAUSE OF DEATH* was as follows:

Rocky Mountain Spotted fever

(Duration) yrs. mos. 8 ds.

Contributory (Secondary)

(Duration) yrs. mos. ds.

(Signed)

J. J. Pease M. D.

June 7 1913 (Address) Hailey Idaho

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death yrs. mos. ds. State yrs. mos. ds.

Where was disease contracted,

If not at place of death?

Former or

usual residence.

19. PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

Fisherie Ida

May 22 1913

20. UNDERTAKER

ADDRESS

R. D. Harris

Hailey Ida

County of Franklin Primary Registration District No. 100 File No. 5023
City of Cour. D. Alene (No. _____, St.) Registered No. 296

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Fannie J. Poirier

If death occurred in a hospital, institution or camp give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX Female 4. COLOR OR RACE White 5. SINGLE, MARRIED, WIDOWED OR DIVORCED. Married
(Write the word.)

6. DATE OF BIRTH

July 1 1890
(Month) (Day) (Year)

7. AGE

22 yrs. 9 mos. 23 ds. IF LESS than 1 day how many.....hrs. or min?

8. OCCUPATION

(a) Trade, profession or particular kind of work..... Housewife
(b) General nature of industry business or establishment in which employed (or employer)

9. BIRTHPLACE

(State or Country) Washington

10. NAME OF FATHER Wm Mc Donald

11. BIRTHPLACE OF FATHER

(State or Country) ✓

12. MAIDEN NAME OF MOTHER

Garner

13. BIRTHPLACE OF MOTHER

(State or Country) ✓

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) F. Poirier

(Address) Cour. D. Alene Ida.

15.

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH

April 23 1913
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from Feb. 16 1913, to April 20 1913.

that I last saw him alive on April 20 1913.

and that death occurred on the date stated above, at 9 A. M.

The CAUSE OF DEATH* was as follows:

Tuberculosis

(Duration) 2 yrs. - mos. - ds.

Contributory (Secondary)

(Duration) ✓ yrs. - mos. - ds.

(Signed) W. H. Holden M. D.

April 23 1913 (Address) Cour. d. Alene Ida.

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place In the
of death.....yrs.....mos.....ds. State.....yrs.....mos.....ds.

Where was disease contracted,

If not at place of death?.....

Former or

usual residence.....

19. PLACE OF BURIAL OR REMOVAL DATE OF BURIAL

Forest Burial Apr 25 1913

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Form V. S. No. 5 20M.1-16-12

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics
File No. 5024

1. PLACE OF DEATH.

Registration District No. 17County of KootenaiPrimary Registration District No. 2051City of Arhop

(No. _____, _____ St.)

Registered No. 205

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

Vernon Wells

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX

Male

4. COLOR OR RACE

White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED.

(Write the word.)

6. DATE OF BIRTH

June 10th 1908
(Month) (Day) (Year)

7. AGE

4 yrs. 11 mos. 18 ds.

IF LESS than 1 day
how many hrs. or
..... mins.?

8. OCCUPATION

(a) Trade, profession or particular kind of work

(b) General nature of industry business, or establishment in which employed (or employer)

9. BIRTHPLACE

(State or Country)

Alberta, Canada

10. NAME OF FATHER

Charley Wells

11. BIRTHPLACE OF FATHER

(State or Country)

Ohio

12. MAIDEN NAME OF MOTHER

Bertha M. Link

13. BIRTHPLACE OF MOTHER

(State or Country)

Russia

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

Charley Wells

(Address)

Arhop, Ida.

15.

Filed

6/101913W. J. M. Munn

Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

May 28th 1913
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That ~~I attended~~ deceased from

191, to 191,
that I last saw h. alive on 191

and that death occurred on the date stated above, at 4 P. M.

The CAUSE OF DEATH* was as follows:

Saw the child after death
concluded it was R. S. M.
(Heart) with perforation
(Duration) 1 yrs. 1 mos. 1 ds.

Contributory
(Secondary)(Duration) 1 yrs. 1 mos. 1 ds.(Signed) Frank E. Wenz M. D.May 19 1913 (Address) Rathdrum

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death yrs. mos. days. In the State yrs. mos. days.

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

Arhop May 29 1913

20. UNDERTAKER

ADDRESS

Arhop Rathdrum

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Form V. S. No. 5 20M.1-16-12

CERTIFICATE OF DEATH

1. PLACE OF DEATH

Registration District No. 12

County of Boatwin

Primary Registration District No. 2057

City of Boatwin

(No. 1, St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME John R. Rabin

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics
File No. 5025
Registered No. 293

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX M

4. COLOR OR RACE W

5. SINGLE, MARRIED, WIDOWED OR DIVORCED. S. (Write the word.)

6. DATE OF BIRTH 7 1855

(Month)

(Day)

(Year)

7. AGE 75 yrs. 0 mos. 0 ds.

IF LESS than 1 day
how many hrs. or mins.?

8. OCCUPATION

(a) Trade, profession or particular kind of work Miner

(b) General nature of industry business, or establishment in which employed (or employer)

9. BIRTHPLACE

(State or Country)

10. NAME OF FATHER

11. BIRTHPLACE OF FATHER

(State or Country)

12. MAIDEN NAME OF MOTHER

13. BIRTHPLACE OF MOTHER

(State or Country)

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) John R. Rabin

(Address) Boatwin, Ida.

15.

Filed 6/10

1913

Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH 5 26 1913

(Month)

(Day)

(Year)

17. I HEREBY CERTIFY, That I attended deceased from Dec 1 1913 to May 26 1913

that I last saw him alive on 9 4 1913

and that death occurred on the date stated above, at 90

The CAUSE OF DEATH* was as follows:

Tuberculosis of Bowel

(Duration) 6 yrs. 0 mos. 0 ds.

Contributory (Secondary)

(Duration) 0 yrs. 0 mos. 0 ds.

(Signed) J. S. Drayman M. D.

27 1913 (Address) Boatwin

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death 0 yrs. 0 mos. 0 days. In the State 0 yrs. 0 mos. 0 days.

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

Boatwin

5/27 1913

20. UNDERTAKER

ADDRESS

Boatwin

Boatwin

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Form V. S. No. 5. 12½ M. 7-24-11

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics
File No. **5026**
Registered No. **290**

1. PLACE OF DEATH. Registration District No. **2118**
County of **Blaine** Primary Registration District No. **2118**
City of **Drummet Mission** (No., St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME **Squash Peter Whistachan**

If death occurred in a hospital, institution or camp give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX **male** 4. COLOR OR RACE **Indian** 5. SINGLE, MARRIED, WIDOWED OR DIVORCED. **Single**
(Write the word.)

6. DATE OF BIRTH **July 31 1913**
(Month) (Day) (Year)

7. AGE **10 mos. 24 ds.** IF LESS than 1 day how many hrs. or min?

8. OCCUPATION

(a) Trade, profession or particular kind of work. **None**
(b) General nature of industry business or establishment in which employed (or employer)

9. BIRTHPLACE

(State or Country)

Drummet

10. NAME OF FATHER

Anaisa Whistachan

11. BIRTHPLACE OF FATHER

(State or Country)

Reservation

12. MAIDEN NAME OF MOTHER

Mary Phillips

13. BIRTHPLACE OF MOTHER

(State or Country)

Reservation

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) **Anaisa Whistachan**
(Address) **Drummet, Ida**

15. **June 10/14**
Filed **June 21 1913**
Drummet Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH

May 24 1913
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from **Drummet** 1913, to **May 24 1913**

that I last saw him alive on **May 24 1913**

and that death occurred on the date stated above, at **9 P. M.**

The CAUSE OF DEATH* was as follows:

Tuberculosis, Pulmonary

(Duration) **6 mos.** yrs. mos. ds.

Contributory
(Secondary)

(Duration) **6 mos.** yrs. mos. ds.

(Signed) **J. R. Leeland** M. D.

May 25 1913 (Address) **Drummet, Ida**

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institution Transients or Recent Residents.)

At place In the
of death yrs. mos. ds. State yrs. mos. ds.

Where was disease contracted,

If not at place of death?

Former or

usual residence.

19. PLACE OF BURIAL OR REMOVAL DATE OF BURIAL

Drummet Mission **May 26 1913**

20. UNDERTAKER ADDRESS

None

A stillbirth must be registered both as a birth and death. The date of death should be the date of delivery and the death certificate should further state, if known, the cause of the stillbirth and the period of utero gestation in months.

STATEMENT OF OCCUPATION.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer, Physician, Stenographer, Compositor, Architect, Locomotive engineer, Civil engineer, Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner*, (b) *Cotton mill*; (a) *Salesman*, (b) *Grocery*; (a) *Foreman*, (b) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification, as *Day laborer, Farm laborer, Laborer—Coal mine*, etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers*, who receive a definite salary), may be entered as *Housewife, Housework*, or *At home*, and children, not gainfully employed, as *At school* or *At home*. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer (retired, 6 yrs.)*. For persons who have no occupation whatever, write *None*.

STATEMENT OF CAUSE OF DEATH.—Name, first the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebro-*

spinal fever (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid Pneumonia"); *Lobular pneumonia*; *Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritoneum*, etc., *Carcinoma, Sarcoma*, etc., of (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles*; *Whooping cough*; *Chronic valvular heart disease*; *Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent affection need not be stated unless important. Example: *Measles* (disease causing death), 29 ds.; *Bronchopneumonia* (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "Asthenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility, (Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Haemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uraemia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify as "PUERPERAL, septicemia", "PUERPERAL peritonitis," etc., all diseases resulting from childbirth or miscarriage. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning*; *Struck by railway train—accident*; *Revolver wound of head—homicide*; *Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "Contributory."

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MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Form V. S. No. 5 20M.1-16-12

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH.

Registration District No. 12

County of Kootenai

Primary Registration District No. 1063

City of Pilot Butte

(No. _____, St.)

File No. 5027

Registered No. 794

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Mrs. Ann H. Nelson

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX

4. COLOR OR RACE

5. SINGLE, MARRIED, WIDOWED OR DIVORCED.

Female White

Widow
(Write the word.)

6. DATE OF BIRTH

(Month)

(Day)

(Year)

7. AGE

76 yrs. 0 mos. 0 ds.

IF LESS THAN 1 day
how many _____ hrs. or
_____ mins.

8. OCCUPATION

(a) Trade, profession or particular kind of work

(b) General nature of industry business, or establishment in which employed (or employer)

9. BIRTHPLACE

(State or Country)

Norway

10. NAME OF FATHER

11. BIRTHPLACE OF FATHER

(State or Country)

12. MAIDEN NAME OF MOTHER

13. BIRTHPLACE OF MOTHER

(State or Country)

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

Son

(Address)

Pilot Butte

15.

Filed

6/10

1913

J. D. Orndorff
Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH

May

28

1913

(Month)

(Day)

(Year)

I HEREBY CERTIFY, That I attended deceased from May 28 1913, to May 28 1913, that I last saw her alive on May 27 1913, and that death occurred on the date stated above, at 6 A. M.

The CAUSE OF DEATH* was as follows:

Cerebral Hemorrhage

(Duration)

yrs.

mos.

ds.

Contributory (Secondary)

Senility

(Duration)

yrs.

mos.

ds.

(Signed)

May 28 1913

(Address)

Geo. B. Smith, M. D.
Calvin, Idaho City

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place

of death.

yrs.

mos.

days.

In the

State.

yrs.

mos.

days.

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

Grand Meadows min

1913

20. UNDERTAKER

ADDRESS

J. D. Orndorff

Calvin

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Form V. S. No. 5. 12½M.7-24-11

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics
File No. 5029
Registered No. 291

1. PLACE OF DEATH. Registration District No. 12
County of Boyle Primary Registration District No. 1003
City of Idaho (No. _____ St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Charles E Kreiss

If death occurred in a hospital, institution or camp give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX Male 4. COLOR OR RACE White 5. SINGLE, MARRIED, WIDOWED OR DIVORCED. Divorced
(Write the word.)

6. DATE OF BIRTH Oct 20 1873
(Month) (Day) (Year)

7. AGE 69 yrs. 7 mos. 4 ds. IF LESS than 1 day how many _____ hrs. or _____ min?

8. OCCUPATION
(a) Trade, profession or particular kind of work. Miner
(b) General nature of industry business or establishment in which employed (or employer)

9. BIRTHPLACE New York
(State or Country)

10. NAME OF FATHER Kreiss

11. BIRTHPLACE OF FATHER ✓
(State or Country)

12. MAIDEN NAME OF MOTHER ✓

13. BIRTHPLACE OF MOTHER ✓
(State or Country)

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Geo M Kreiss
(Address) C. D. A.

15. Filed 6/10 1913 A. J. Greenman
Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH May 24 1913
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from 1911, to 1913

that I last saw h..... alive on..... 1911

and that death occurred on the date stated above, at..... M.

The CAUSE OF DEATH* was as follows:

Tuberculosis (Statement of son)

(Duration) _____ yrs. _____ mos. _____ ds.

Contributory (Secondary) _____

(Duration) _____ yrs. _____ mos. _____ ds.

(Signed) No Physician M. D.

May 26 1913 (Address) Cour D'Alene Idaho

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place _____ In the _____
of death..... yrs. mos. ds. State..... yrs. mos. ds.

Where was disease contracted,
If not at place of death?.....

Former or
usual residence.....

19. PLACE OF BURIAL OR REMOVAL Forest Cem. DATE OF BURIAL May 26 1913

20. UNDERTAKER Cassidy & Nelson ADDRESS Cour D'Alene

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Form V. S. No. 5. 12½ M. 7-24-11

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics
File No. 5039
Registered No. 289

1. PLACE OF DEATH. Registration District No. 12
County of Boone Primary Registration District No. 1063
City of Coeur D'Alene (No. _____ St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Infant Phillip Litzenberger

If death occurred in a hospital, institution or camp give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX Female 4. COLOR OR RACE White 5. SINGLE, MARRIED, WIDOWED OR DIVORCED. Single
(Write the word.)

6. DATE OF BIRTH _____
(Month) (Day) (Year)

7. AGE _____ yrs. _____ mos. _____ ds.
IF LESS than 1 day how many _____ hrs. or _____ min?

8. OCCUPATION

(a) Trade, profession or particular kind of work
(b) General nature of industry business or establishment in which employed (or employer)

9. BIRTHPLACE (State or Country) Coeur D'Alene

10. NAME OF FATHER Phillip Litzenberger

11. BIRTHPLACE OF FATHER (State or Country) Russia

12. MAIDEN NAME OF MOTHER Mary Ott

13. BIRTHPLACE OF MOTHER (State or Country) Russia

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Phillip Litzenberger
(Address) _____

15. Filed 6/10 1913 A. S. Newman
Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH May 24 1913
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from May 24 1913, to Same 1913
that I last saw h. 24 alive on May 24 1913
and that death occurred on the date stated above, at 11 P. M.
The CAUSE OF DEATH* was as follows:

Asphyxia neonatorum
(Duration) _____ yrs. _____ mos. _____ ds.

Contributory (Secondary) _____
(Duration) _____ yrs. _____ mos. _____ ds.
(Signed) John Ott M. D.
May 24 1913 (Address) Coeur D'Alene, Ida.

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place _____ In the _____
of death _____ yrs. _____ mos. _____ ds. State _____ yrs. _____ mos. _____ ds.
Where was disease contracted,
If not at place of death? _____
Former or
usual residence _____

19. PLACE OF BURIAL OR REMOVAL Forest Cemetery DATE OF BURIAL 5/25 1913

20. UNDERTAKER Ready & Nelson ADDRESS 824

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Form V. S. No. 5 20M.1-16-12

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics
File No. **5031**
Registered No. **288**

1. PLACE OF DEATH. Registration District No. **14**
County of **Idaho** Primary Registration District No. **1003**
City of **Coca** (No. _____, St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME **Mrs. A. W. W. W.**

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX **Female** 4. COLOR OR RACE **W** 5. SINGLE, MARRIED, WIDOWED OR DIVORCED. **Widowed**
(Write the word.)

6. DATE OF BIRTH **1823**
(Month) (Day) (Year)

7. AGE **90** yrs. mos. ds. IF LESS than 1 day how many hrs. or mins.?

8. OCCUPATION

- (a) Trade, profession or particular kind of work
(b) General nature of industry business, or establishment in which employed (or employer)

9. BIRTHPLACE

(State or Country)

10. NAME OF FATHER

11. BIRTHPLACE OF FATHER

(State or Country)

12. MAIDEN NAME OF MOTHER

13. BIRTHPLACE OF MOTHER

(State or Country)

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) **Louis W. W.**

(Address) **Coca**

15. Filed **6/10** 191**8** **S. S. W.** Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH

May **15** 191**3**
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from 191... to 191... that I last saw h... alive on 191... and that death occurred on the date stated above, at M. The CAUSE OF DEATH* was as follows:

Old age

(Duration) yrs. mos. ds.

Contributory (Secondary)

(Duration) yrs. mos. ds.

(Signed)

May 16 191**3**. (Address) **Coca, Idaho**

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death. yrs. mos. days. In the State. yrs. mos. days.

Where was disease contracted if not at place of death?

Former or usual residence.

19. PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

Sound. C. W.

May 16 191**3**

20. UNDERTAKER

ADDRESS

S. S. W.

Coca

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Form V. S. No. 5 20M.1-16-12

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics
File No. 5032
Registered No. 289

1. PLACE OF DEATH. Registration District No. 12
County of Blaine Primary Registration District No. 10 03
City of Idaho (No. _____, St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME B M Allen

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX male 4. COLOR OR RACE white 5. SINGLE, MARRIED, WIDOWED OR DIVORCED. Single
(Write the word.)

6. DATE OF BIRTH 1648
(Month) (Day) (Year)

7. AGE 65 yrs. mos. ds. IF LESS than 1 day how many hrs. or mins.?

8. OCCUPATION
(a) Trade, profession or particular kind of work Logger
(b) General nature of industry business, or establishment in which employed (or employer)

9. BIRTHPLACE (State or Country) Sweden

10. NAME OF FATHER -

11. BIRTHPLACE OF FATHER (State or Country) -

12. MAIDEN NAME OF MOTHER -

13. BIRTHPLACE OF MOTHER (State or Country) -

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Allen
(Address) Wallace

15. Filed 6/10 1913 D J Newman
Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH May 14 1913
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from 1911, to 1911, that I last saw h. alive on 1911, and that death occurred on the date stated above, at M.
The CAUSE OF DEATH* was as follows:

Opium poisoning

(Duration) yrs. mos. ds.
Contributory Habits
(Secondary)

(Duration) yrs. mos. ds.
(Signed) John H. Shepherd M. D.
19 (Address) Corner 1st & 2nd

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death. yrs. mos. days. In the State. yrs. mos. days.

Where was disease contracted if not at place of death?

Former or usual residence.

19. PLACE OF BURIAL OR REMOVAL Funeral home DATE OF BURIAL May 16 1913

20. UNDERTAKER S J Newman ADDRESS Idaho

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Form V. S. No. 5 20M.1-16-12

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH. Registration District No. 12
County of Kootenai Primary Registration District No. 1003
City of Coeur d'Alene (No. 402, W. Foster St.)

File No. 5033
Registered No. 286

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME A. J. Bryant

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX Male 4. COLOR OR RACE White 5. SINGLE, MARRIED, WIDOWED OR DIVORCED. Married
(Write the word.)

6. DATE OF BIRTH _____
(Month) (Day) (Year)

7. AGE 60 yrs. — mos. — ds. IF LESS than 1 day how many _____ hrs. or _____ mins.?

8. OCCUPATION
(a) Trade, profession or particular kind of work Laborer
(b) General nature of industry business, or establishment in which employed (or employer)

9. BIRTHPLACE _____
(State or Country)

10. NAME OF FATHER _____

11. BIRTHPLACE OF FATHER _____
(State or Country)

12. MAIDEN NAME OF MOTHER _____

13. BIRTHPLACE OF MOTHER _____
(State or Country)

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Mrs. Dunn
(Address) Reid St

15. 6/10
Filed May 14/13 1913 A. J. Newman
Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH May 14th 1913
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from May 9th 1913, to May 14th 1913, that I last saw him alive on May 14th 1913, and that death occurred on the date stated above, at 12³⁰ P.M.
The CAUSE OF DEATH* was as follows:

Hemorrhage of the lungs

(Duration) _____ yrs. _____ mos. 5 ds.
Contributory Tuberculosis of the
(Secondary) lungs

(Duration) _____ yrs. 9 mos. — ds.
(Signed) Jno. Remy M. D.

May 14 1913 (Address) Coeur d'Alene 2da

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death 2 yrs. _____ mos. _____ days. In the State 2 yrs. _____ mos. _____ days.

Where was disease contracted if not at place of death? In Coeur d'Alene City.

Former or usual residence Washington State

19. PLACE OF BURIAL OR REMOVAL Forest cem. DATE OF BURIAL 5/15 1913

20. UNDERTAKER S. J. Dunn ADDRESS _____

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Form V. S. No. 5 20M.1-16-12

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics
File No. 5034
Registered No. 285

1. PLACE OF DEATH. Registration District No. 12
County of Lost Primary Registration District No. 1003
City of C. D. A. (No. St.)
If death occurs away from usual residence, give facts called for under special information. 2. FULL NAME Elsie Johnson

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX Female 4. COLOR OR RACE White 5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.)

6. DATE OF BIRTH May 14th 1913 (Month) (Day) (Year)

7. AGE 34 yrs. mos. ds. IF LESS than 1 day how many hrs. or mins.

8. OCCUPATION (a) Trade, profession or particular kind of work Working Woman (b) General nature of industry business, or establishment in which employed (or employer)

9. BIRTHPLACE (State or Country) Sweden.

10. NAME OF FATHER

11. BIRTHPLACE OF FATHER (State or Country)

12. MAIDEN NAME OF MOTHER

13. BIRTHPLACE OF MOTHER (State or Country)

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Hospital (Address) C. D. A.

15. Filed May 14th 1913 J. D. Johnson Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH May 13 1913 (Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from May 1st 1913, to May 13 1913, that I last saw her alive on May 13 1913, and that death occurred on the date stated above, at 6 A.M.

The CAUSE OF DEATH* was as follows:

Tubercular meningitis

(Duration) 4 yrs. — mos. — ds. Contributory Tubercular Lung (Secondary)

(Duration) 4 yrs. — mos. — ds. (Signed) J. D. B. M. D. (Address) Hope, Idaho

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death. yrs. mos. days. In the State. yrs. mos. days.

Where was disease contracted if not at place of death?

Former or usual residence.

19. PLACE OF BURIAL OR REMOVAL Home - Cam DATE OF BURIAL May 13 1913

20. UNDERTAKER J. D. B. ADDRESS

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Form V. S. No. 5 20M.1-16-12

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH. Registration District No. 14
County of Kootenai Primary Registration District No. 1003
City of Coeur d'Alene (No. —, Davidson Ave. St.)
If death occurs away from usual residence, give facts called for under special information. 2. FULL NAME Fred J. Wall

File No. 5035
Registered No. 284

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX Male 4. COLOR OR RACE White 5. SINGLE, MARRIED, WIDOWED OR DIVORCED. Single
(Write the word.)

6. DATE OF BIRTH Oct. 1 1893
(Month) (Day) (Year)

7. AGE 19 yrs. 8 mos. — ds. —
IF LESS than 1 day how many hrs. or mins.?

8. OCCUPATION
(a) Trade, profession or particular kind of work
(b) General nature of industry business, or establishment in which employed (or employer)

9. BIRTHPLACE Blackfoot
(State or Country)

10. NAME OF FATHER George Wall

11. BIRTHPLACE OF FATHER On the Ocean
(State or Country)

12. MAIDEN NAME OF MOTHER Mary A. McCabe

13. BIRTHPLACE OF MOTHER —
(State or Country)

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) George Wall
(Address) C. D. Alene

15. Filed May 12th 1913 at Coeur d'Alene
Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH May 12th 1913
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from 191 to 191,
that I last saw him alive on 191,
and that death occurred on the date stated above, at M.

The CAUSE OF DEATH* was as follows:

Burned - Accidental

(Duration) yrs. mos. ds.

Contributory (Secondary)

(Duration) yrs. mos. ds.

(Signed) John H. Warner M. D.

19 (Address)

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death yrs. mos. days. In the State yrs. mos. days.

Where was disease contracted if not at place of death?

Former or usual residence.

19. PLACE OF BURIAL OR REMOVAL DATE OF BURIAL

Longview May 16 1913

20. UNDERTAKER ADDRESS

S. J. Luca Coeur d'Alene

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Form V. S. No. 5 20M.1-16-12

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH. Registration District No. 14
County of Kootenai Primary Registration District No. 1003
City of Coeur d'Alene (No. 1045 415 St.)

File No. 5035
Registered No. 283

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Grace Saltschneider

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX Female 4. COLOR OR RACE White 5. SINGLE, MARRIED, WIDOWED OR DIVORCED. Married

6. DATE OF BIRTH May 8th 1913
(Month) (Day) (Year)

7. AGE 25 yrs. 2 mos. 2 ds. IF LESS than 1 day how many 2 hrs. or 2 mins.

8. OCCUPATION

- (a) Trade, profession or particular kind of work
(b) General nature of industry business, or establishment in which employed (or employer)

9. BIRTHPLACE Appleton Wis
(State or Country)

10. NAME OF FATHER Fred G. Reed

11. BIRTHPLACE OF FATHER Appleton Wis
(State or Country)

12. MAIDEN NAME OF MOTHER Sofia Duffy

13. BIRTHPLACE OF MOTHER Chilton Wis
(State or Country)

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) H. P. Saltschneider(Address) 1045 4th St Coeur d'Alene

15. Filed 7 1913 S. J. Luce
Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH May 8th 1913
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from Apr. 28 1913, to May 9th 1913, that I last saw him alive on Apr. 28 1913, and that death occurred on the date stated above, at 11 P.M.

The CAUSE OF DEATH* was as follows:

Tuberculosis

(Duration) 4 yrs. 0 mos. 0 ds.

Contributory
(Secondary)

(Duration) 0 yrs. 0 mos. 0 ds.

(Signed)

A. Hunter M. D.
5-10-1913 (Address) Coeur d'Alene Ida

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death 0 yrs. 0 mos. 0 days. In the State 0 yrs. 0 mos. 0 days.

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL Coeur d'Alene DATE OF BURIAL 5-11-1913

20. UNDERTAKER S. J. Luce ADDRESS Coeur d'Alene

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Form V. S. No. 5 20M.1-16-12

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH. Registration District No. 12
County of Adair Primary Registration District No. 1003
City of Corn Valley (No. _____) St. _____

File No. 5037
Registered No. 282

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME John H. Hume

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX male 4. COLOR OR RACE white 5. SINGLE, MARRIED, WIDOWED OR DIVORCED. married
(Write the word.)

6. DATE OF BIRTH 1833
(Month) (Day) (Year)

7. AGE 80 yrs. mos. ds. IF LESS than 1 day how many hrs. or mins.?

8. OCCUPATION

(a) Trade, profession or particular kind of work _____

(b) General nature of industry business, or establishment in which employed (or employer) _____

9. BIRTHPLACE

(State or Country) Pen

10. NAME OF FATHER Jacob Hume

11. BIRTHPLACE OF FATHER Germany

(State or Country)

12. MAIDEN NAME OF MOTHER _____

13. BIRTHPLACE OF MOTHER _____

(State or Country)

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) J. W. Taylor

(Address) _____

15.

Filed 6/10

1910

J. W. Taylor
Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH

5 6 1913
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from April 15th 1913, to May 7th 1913, that I last saw him alive on May 1st 1913, and that death occurred on the date stated above, at _____ M.

The CAUSE OF DEATH* was as follows:

Cerebral Hemorrhage

(Duration) _____ yrs. mos. ds.

Contributory (Secondary) Senility

(Duration) _____ yrs. mos. ds.

(Signed) John B. Burby M. D.

19 _____ (Address) Corn Valley Adair

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death _____ yrs. mos. days. In the State _____ yrs. mos. days.

Where was disease contracted if not at place of death? _____

Former or usual residence _____

19. PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

St Thomas

May 8 1913

20. UNDERTAKER

ADDRESS

J. W. Taylor

C. W. A.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Form V. S. No. 5 20M.1-16-12

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH.

Registration District No. 12

County of Kootenai

Primary Registration District No. 1003

City of Coeur d'Alene (No. , St.)

File No. 5038

Registered No. 281

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

Louis La Verne

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX

male

4. COLOR OR RACE

white

5. SINGLE, MARRIED, WIDOWED OR DIVORCED.

(Write the word.)

6. DATE OF BIRTH

— (Month) — (Day) 1 (Year)

7. AGE

About

55 yrs. mos. ds.

IF LESS than 1 day
how many hrs. or
mins.?

8. OCCUPATION

(a) Trade, profession or particular kind of work
(b) General nature of industry, business, or establishment in which employed (or employer)

Laborer

9. BIRTHPLACE

(State or Country)

Canada

10. NAME OF FATHER

11. BIRTHPLACE OF FATHER

(State or Country)

Canada

12. MAIDEN NAME OF MOTHER

13. BIRTHPLACE OF MOTHER

(State or Country)

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

Dr. B. B. B.

(Address)

Coeur d'Alene

15.

Filed

6/10

1913

J. J. Newman

Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH

May 6th 1913
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from

May 5th 1913, to May 6th 1913,

that I last saw him alive on May 5th 1913,

and that death occurred on the date stated above, at 8:45 P.M.

The CAUSE OF DEATH* was as follows:

Pneumonia (chronic)

(Duration) yrs. mos. ds.

Contributory
(Secondary)

Pneumonia

(Duration) yrs. mos. ds.

(Signed)

Geo. B. B. M. D.

May 6, 1913

(Address)

Coeur d'Alene City

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death yrs. mos. days. In the State yrs. mos. days.

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

St. Thomas am

5/8 1913

20. UNDERTAKER

ADDRESS

J. J. Newman

Chas. B.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Form V. S. No. 5. 12½ M. 7-24-11

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics
File No. 5039
Registered No. 91

1. PLACE OF DEATH. Registration District No. 22
County of Canyon Primary Registration District No. 2008
City of Fruitland (No. , St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME R D Stegner

If death occurred in a hospital, institution or camp give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX Male 4. COLOR OR RACE White 5. SINGLE, MARRIED, WIDOWED OR DIVORCED. Married
(Write the word.)

6. DATE OF BIRTH June 9 1846
(Month) (Day) (Year)

7. AGE 66 yrs. 11 mos. 17 ds. IF LESS than 1 day how many hrs. or min?

8. OCCUPATION Farmer
(a) Trade, profession or particular kind of work.
(b) General nature of industry business or establishment in which employed (or employer)

9. BIRTHPLACE Indiana
(State or Country)

10. NAME OF FATHER Robert Stegner

11. BIRTHPLACE OF FATHER Germany
(State or Country)

12. MAIDEN NAME OF MOTHER Elizabeth

13. BIRTHPLACE OF MOTHER Penn
(State or Country)

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) E Stegner
(Address) Fruitland

15. Filed May 27 1913 J C Woodward
Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH May 26 1913
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from May 10 - 1913, to May 26 1913
that I last saw him alive on May 25 - 1913
and that death occurred on the date stated above, at 4 P. M.

The CAUSE OF DEATH* was as follows:

Heart Failure

(Duration) yrs. mos. ds.

Contributory Dropsy & Cancer
(Secondary)

(Duration) yrs. mos. 15 ds.

(Signed) J. E. Crouch M. D.
5-27-1913 (Address) Payette Ida

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place In the
of death yrs. mos. ds. State yrs. mos. ds.
Where was disease contracted,
If not at place of death?
Former or
usual residence.

19. PLACE OF BURIAL OR REMOVAL DATE OF BURIAL

Payette Ida May 28 1913

20. UNDERTAKER ADDRESS

J. H. Adair Payette Ida

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Form V. S. No. 5. 10M. 6-20-11.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH.

Registration District No. 22County of CanyonPrimary Registration District No. 2010City of Emmett

(No. _____, St.)

File No. 5041
Registered No. 89

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

Irving Washington Foglesong

If death occurred in a hospital, institution or camp give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX

Male

4. COLOR OR RACE

white

5. SINGLE, MARRIED, WIDOWED OR DIVORCED.

widowed
(Write the word.)

6. DATE OF BIRTH

June 17 1845
(Month) (Day) (Year)

7. AGE

67 yrs. 9 mos. 5 ds.IF LESS than 1 day
how many _____ hrs. or
_____ min.?

8. OCCUPATION

(a) Trade, profession, or particular kind of work

(b) General nature of industry, business, or establishment in which employed (or employer)

News Stand

9. BIRTHPLACE

(State or Country)

Ohio

10. NAME OF FATHER

Foglesong

11. BIRTHPLACE OF FATHER

(State or Country)

Don't know

12. MAIDEN NAME OF MOTHER

""

13. BIRTHPLACE OF MOTHER

(State or Country)

""

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

F. H. Spotts

(Address)

Emmett, Idaho

15.

Filed

May 1 1913
May 24 1913

Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

Apr. 22 1913
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from

Apr 21 1913, to Apr 22 1913that I last saw him alive on Apr 22 1913,and that death occurred on the date stated above, at 6 P. M.

The CAUSE OF DEATH* was as follows:

Probably acute gastritis(Duration) _____ yrs. _____ mos. 2 ds.Contributory
(Secondary)

(Duration) _____ yrs. _____ mos. _____ ds.

(Signed) J. L. Reynolds M. D.May 1, 1913 (Address) Emmett

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL,

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place

In the

of death _____ yrs. _____ mos. _____ ds. State _____ yrs. _____ mos. _____ ds.

Where was Disease contracted,

If not at place of death?

Former or

usual residence.

19. PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

Emmett Cemetery Apr 24 1913

20. UNDERTAKER

ADDRESS

C. L. Bucknum EmmettJ. L. Reynolds
Local Registrar
R. W. Woodward

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Form V. S. No. 5. 10M. 6-20-11.

CERTIFICATE OF DEATH

 State of Idaho
 BOARD OF HEALTH
 Bureau of Vital Statistics
File No. **5042**Registered No. **58**

If death occurred in a hospital, institution or camp give its NAME instead of street and number.

1. PLACE OF DEATH.

 County of *Canyon*
 City of *Emmett*
Registration District No. *2-2*Primary Registration District No. *2010*

(No. _____, St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

Margaret John Bray

PERSONAL AND STATISTICAL PARTICULARS

3. SEX

Female

4. COLOR OR RACE

white

5. SINGLE, MARRIED, WIDOWED OR DIVORCED.

Widow
(Write the word.)

6. DATE OF BIRTH

Oct 15 1833
 (Month) (Day) (Year)

7. AGE

79 yrs. 5 mos. 19 ds.

 IF LESS than 1 day
 how many hrs. or
 min.?

8. OCCUPATION

(a) Trade, profession, or particular kind of work

(b) General nature of industry, business, or establishment in which employed (or employer)

Housewife

9. BIRTHPLACE

(State or Country)

Wales

10. NAME OF FATHER

John Jones

11. BIRTHPLACE OF FATHER

(State or Country)

Wales

12. MAIDEN NAME OF MOTHER

Don't Know

13. BIRTHPLACE OF MOTHER

(State or Country)

Wales

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

D. M. John

(Address)

Emmett Idaho

15.

Filed *24-18* 191*3**May 23 1913**J. D. Reynolds*

Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

April 13 1913
 (Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from

Apr 5 1913 to *Apr 13 1913*
that I last saw him alive on *Apr 13 1913*,and that death occurred on the date stated above, at *2 P. M.*

The CAUSE OF DEATH* was as follows:

Influenza followed with Pneumonia(Duration) yrs. mos. *10* ds.

Contributory (Secondary)

Influenza(Duration) yrs. mos. *10* ds.

(Signed)

J. D. Reynolds M. D.
Apr 18 1913 (Address) *Emmett Ida*

State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL,

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place

In the

of death yrs. mos. ds. State yrs. mos. ds.

Where was Disease contracted,

If not at place of death?

Former or

usual residence.

19. PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

*Emmett Cemetery**Apr 16 1913*

20. UNDERTAKER

ADDRESS

*C. T. Bucknum**Emmett*

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Form V. S. No. 5. 12½ M. 7-24-11

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics
File No. 5043

1. PLACE OF DEATH. Registration District No. 22
County of Canyon Primary Registration District No. 2008
City of Payette (No. , St.)

Registered No. 92

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

Jesse E Richardson

If death occurred in a hospital, institution or camp give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX 4. COLOR OR RACE 5. SINGLE, MARRIED, WIDOWED OR DIVORCED.

Male White Married
(Write the word.)

6. DATE OF BIRTH

Jan 31 1873
(Month) (Day) (Year)

7. AGE

40 yrs. 5 mos. ds.

IF LESS than 1 day
how many hrs. or min?

8. OCCUPATION

(a) Trade, profession or particular kind of work
(b) General nature of industry business or establishment in which employed (or employer)

Farmer

9. BIRTHPLACE

(State or Country)

Missouri

10. NAME OF FATHER

Wm H Richardson

11. BIRTHPLACE OF FATHER

(State or Country)

Not Known

12. MAIDEN NAME OF MOTHER

Barbara A Griffin

13. BIRTHPLACE OF MOTHER

(State or Country)

Not Known

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

(Address)

C. F. Draper
Payette Idaho

15.

Filed May 20 1913

Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH

3:00 p.m. May 30 1913
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from

191 to 191

that I last saw him alive on 191

and that death occurred on the date stated above, at M.

The CAUSE OF DEATH was as follows:

(Duration) yrs. mos. ds.

Contributory
(Secondary)

(Duration) yrs. mos. ds.

(Signed) M. D.

19 (Address)

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place In the

of death yrs. mos. ds. State yrs. mos. ds.

Where was disease contracted,

If not at place of death?

Former or

usual residence.

19. PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

Payette Ida 6-1 1913

20. UNDERTAKER

ADDRESS

J. H. Aldair Payette Ida

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Form V. S. No. 5 20M.1-16-12

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics
File No. 5044

1. PLACE OF DEATH.
County of Canyon
City of Payette

Registration District No. 22
Primary Registration District No. 2005
(No. St.)

Registered No. 93

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Sophronia Hutchinson
If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX Female 4. COLOR OR RACE White 5. SINGLE, MARRIED, WIDOWED OR DIVORCED Married
(Write the word.)

6. DATE OF BIRTH Feb 2 1881
(Month) (Day) (Year)

7. AGE 82 yrs 4 mos 5 ds.
IF LESS than 1 day how many hrs. or mins.?

8. OCCUPATION
(a) Trade, profession or particular kind of work Housewife
(b) General nature of industry business, or establishment in which employed (or employer)

9. BIRTHPLACE Michigan
(State or Country)

10. NAME OF FATHER A. A. Davis

11. BIRTHPLACE OF FATHER Vermont
(State or Country)

12. MAIDEN NAME OF MOTHER Sophia Scott

13. BIRTHPLACE OF MOTHER Canada
(State or Country)

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) S. A. Hutchinson
(Address) Payette

15. Filed June 8 1913 S. R. Woodward Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH June 7 1913
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from June 4 1913 to June 7 1913
that I last saw her alive on June 6 1913
and that death occurred on the date stated above, at 10 M.
The CAUSE OF DEATH* was as follows:
Carcinoma uteri

(Duration) yrs. mos. ds.
Contributory (Secondary)

(Duration) yrs. mos. ds.
(Signed) J. C. Woodward M. D.
June 7 1913 (Address) Payette, Idaho

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death yrs. mos. days. In the State yrs. mos. days.

Where was disease contracted if not at place of death?
Former or usual residence

19. PLACE OF BURIAL OR REMOVAL Payette Idaho DATE OF BURIAL June 8 1913

20. UNDERTAKER A. C. Lair ADDRESS Payette Idaho

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

1. PLACE OF DEATH. Registration District No. 27
 County of Minidoka Primary Registration District No. 2015
 City of Acquia (No. _____ St.)
 If death occurs away from usual residence, give facts called for under special information. 2. FULL NAME Felita C Vanderpool
 State of Idaho
 BOARD OF HEALTH
 Bureau of Vital Statistics
 File No. 5046
 Registered No. 12
 If death occurred in a hospital, institution or camp give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX Male 4. COLOR OR RACE White 5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.)

6. DATE OF BIRTH Dec 22 1896
 (Month) (Day) (Year)

7. AGE 17 yrs. 2 mos. 21 ds. IF LESS than 1 day how many hrs. or min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work Farmer
 (b) General nature of industry business or establishment in which employed (or employer)

9. BIRTHPLACE (State or Country) Nebraska

10. NAME OF FATHER Felix Vanderpool
 11. BIRTHPLACE OF FATHER (State or Country) Missouri

12. MAIDEN NAME OF MOTHER Melvina Weddell

13. BIRTHPLACE OF MOTHER (State or Country) Indiana

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Felix Vanderpool
 (Address) Acquia Idaho

15. Filed June 10 1913 V. P. Killeen
 Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH Mar 13 1913
 (Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from Mar 12 1913, to Mar 13 1913
 that I last saw him alive on Mar 13 1913
 and that death occurred on the date stated above, at 2 P. M.

The CAUSE OF DEATH* was as follows:

Double pneumonia

(Duration) yrs. mos. 2 ds.

Contributory (Secondary)

(Duration) yrs. mos. ds.

(Signed) R. H. Scott M. D.
Mar 13 1913 (Address) Rupert Idaho

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted,

If not at place of death?

Former or usual residence.

19. PLACE OF BURIAL OR REMOVAL DATE OF BURIAL

Rupert Cemetery Mar 16 1913

20. UNDERTAKER ADDRESS

W. A. Goodman Rupert

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Form V. S. No. 5 20M

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH. Registration District No. 27
County of Minidoka Primary Registration District No. 2015
City of Acquia (No. _____ St.) Registered No. 11
If death occurs away from usual residence, give facts called for under special information. 2. FULL NAME Hattie L Ennis
If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX Female 4. COLOR OR RACE White 5. SINGLE, MARRIED, WID-OWED OR DIVORCED. (Write the word.)

6. DATE OF BIRTH Feb 23 1913
(Month) (Day) (Year)

7. AGE 18 yrs. 18 mos. 18 ds.
IF LESS than 1 day how many hrs. or mins.?

8. OCCUPATION

(a) Trade, profession or particular kind of work
(b) General nature of industry, business, or establishment in which employed (or employer)

Infant

9. BIRTHPLACE

(State or Country)

Idaho

10. NAME OF FATHER

Wm Ennis

11. BIRTHPLACE OF FATHER

(State or Country)

Canada

12. MAIDEN NAME OF MOTHER

Hattie Larson

13. BIRTHPLACE OF MOTHER

(State or Country)

Utah

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

Wm Ennis

(Address)

Acquia Idaho

15.

Filed

June 10 1913 V.P. Miller
Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH

Mar 13 1913
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from

Mar 11 1913, to Mar 11 1913,
that I last saw her alive on Mar 11 1913,
and that death occurred on the date stated above, at 9 A.M.

The CAUSE OF DEATH* was as follows:

Pneumonia

(Duration) yrs. mos. 2 ds.

Contributory
(Secondary)

(Duration) yrs. mos. ds.

(Signed) O. H. Scott M. D.

Mar 13 1913 (Address) Acquia Idaho

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death yrs. mos. days. In the State yrs. mos. days.

Where was disease contracted if not at place of death?

Former or usual residence.

19. PLACE OF BURIAL OR REMOVAL DATE OF BURIAL

Rupert Cemetery Mar 14 1913

20. UNDERTAKER ADDRESS

W.G. Grockman Rupert

Form V. S. No. 5 20M.1-16-12

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH

Registration District No. 26

County of

Primary Registration District No. 1010

City of

(No. 5th Street West, St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

Alexander Kesler

File No. 5048

Registered No. 35

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX

Male

4. COLOR OR RACE

White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED.

Married
(Write the word.)

6. DATE OF BIRTH

Dec. - 1828
(Month) (Day) (Year)

7. AGE

85 yrs. 4 mos. ds.

IF LESS than 1 day
how many hrs. or
mins.?

8. OCCUPATION

(a) Trade, profession or particular kind of work

Farmer

(b) General nature of industry business, or establishment in which employed (or employer)

9. BIRTHPLACE

(State or Country)

State of Virginia

10. NAME OF FATHER

Bedrick Kesler

11. BIRTHPLACE OF FATHER

(State or Country)

Unknown to the support to the
Germany

12. MAIDEN NAME OF MOTHER

Unknown

13. BIRTHPLACE OF MOTHER

(State or Country)

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

Robberson

(Address)

Council; Idaho.

15.

Filed

May 3-2

1913

D. R. Hamel

Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH

May - 3 - 1913
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from

May 2 1913, to May 2 1913,

that I last saw him alive on May 2 1913,

and that death occurred on the date stated above, at 6:20 A.M.

The CAUSE OF DEATH* was as follows:

Senility

(Duration) yrs. mos. ds.

Contributory
(Secondary)

(Duration) yrs. mos. ds.

(Signed)

J. M. Hatcher, M. D.

(Address) Kiser Idaho

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death yrs. mos. days. In the State yrs. mos. days.

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

Council; Idaho

May 5 - 1913

20. UNDERTAKER

ADDRESS

R. H. Bowen

Kiser; Idaho.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Form V, S. No. 5. 12½M. 7-24-11

CERTIFICATE OF DEATH

1. PLACE OF DEATH
County of Wash
City of Weiser
Registration District No. 26
Primary Registrar 1010
(No. 1010 St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

Mrs. M. A. Wolf

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics
File No. 5049
Registered No. 26

If death occurred in a hospital, institution or camp give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX Female 4. COLOR OR RACE White 5. SINGLE, MARRIED OR DIVORCED
Married
(Write the word)

6. DATE OF BIRTH August - 14 -
(Month) (Day)

7. AGE 46 yrs. 8 mos. 20 ds. IF LESS THAN ONE YEAR, HOW MANY MONTHS AND DAYS

8. OCCUPATION

(a) Trade, profession or particular kind of work.
(b) General nature of industry, business or establishment in which employed (or employer)

Housewife

9. BIRTHPLACE (State or Country) Greencastle, Ind.

10. NAME OF FATHER R. S. Risk

11. BIRTHPLACE OF FATHER (State or Country) State of Ind.

12. MAIDEN NAME OF MOTHER Mary Woods

13. BIRTHPLACE OF MOTHER (State or Country) State Ind.

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) W. R. Hamilton
(Address) Weiser, Idaho

15. Filed May 6th 1913 W. R. Hamilton
Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH May - 4 - 1913
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from Nov 1 1912, to May 4 1913.
that I last saw him alive on May 3 1913
and that death occurred on the date stated above, at 5 P. M.

The CAUSE OF DEATH* was as follows:

Exophthalmic Goiter

(Duration) 2 yrs. — mos. — ds.

Contributory
(Secondary)

(Duration) — yrs. — mos. — ds.

(Signed) James A. Young M. D.
May 5 1913 (Address) Weiser Idaho

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death — yrs. — mos. — ds. In the State — yrs. — mos. — ds.
Where was disease contracted,
If not at place of death?
Former or usual residence —

19. PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

Attoma, Kansas May 13 1913

20. UNDERTAKER

ADDRESS

R. W. Bowen Weiser Idaho

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Form V. S. No. 5 20M.1-16-12

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics
File No. 5050
Registered No. 37

1. PLACE OF DEATH.

Registration District No. 26

County of Wash.

Primary Registration District No. 2112

City of Wiser

(No. Wiser River St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Jessie L. Wells

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX Male

4. COLOR OR RACE White

5. SINGLE/MARRIED, WIDOWED OR DIVORCED
Married
(Write the word.)

6. DATE OF BIRTH Oct - 6 - 1863

(Month) (Day) (Year)

7. AGE 49 yrs. 7 mos. 7 ds.

IF LESS than 1 day
how many hrs. or
..... mins.?

8. OCCUPATION

(a) Trade, profession or particular kind of work Farmer

(b) General nature of industry business, or establishment in which employed (or employer)

9. BIRTHPLACE

(State or Country) Clark Co. Missouri

10. NAME OF FATHER T. J. Wells

11. BIRTHPLACE OF FATHER

(State or Country) State Ky.

12. MAIDEN NAME OF MOTHER Elizabeth Laswell

13. BIRTHPLACE OF MOTHER

(State or Country)

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Mrs Lucy Wells

(Address) Wiser, Ida.

15.

Filed May 14th

1913

W. B. Haverhill
Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH May - 13 - 1913

(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from

191... to 191...

that I last saw him alive on about May 6th 1913.

and that death occurred on the date stated above, at 9 P. M.

The CAUSE OF DEATH* was as follows:

Chronic Interstitial Nephritis

(Duration) yrs. mos. ds.

Contributory (Secondary)

(Duration) yrs. mos. ds.

(Signed) C. C. Conant

M. D.

19 (Address) Wiser, Idaho

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death yrs. mos. days. In the State yrs. mos. days.

Where was disease contracted if not at place of death?.....

Former or usual residence.....

19. PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

Wiser, Idaho

May - 15 - 1913

20. UNDERTAKER

ADDRESS

R. G. Ordell

Wiser, Ida.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Form V. S. No. 5. 12½M.7-24-11

CERTIFICATE OF DEATH

1. PLACE OF DEATH
County of Washington
City of Idaho

Registration District No. 26
Primary Registration District No. 2112
(No. _____ St.)

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics
File No. 5052
Registered No. 39

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

William Wayne Harris

If death occurred in a hospital, institution or camp give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX Male 4. COLOR OR RACE Wht 5. SINGLE, MARRIED, WIDOWED OR DIVORCED.
Single
(Write the word.)

6. DATE OF BIRTH

(Month) (Day) (Year)

7. AGE 56 yrs. — mos. — ds.
IF LESS than 1 day
how many _____ hrs. or _____ min?

8. OCCUPATION

- (a) Trade, profession or particular kind of work
(b) General nature of industry business or establishment in which employed (or employer)

Farmer

9. BIRTHPLACE

(State or Country)

Missouri

10. NAME OF FATHER

Noah W. Harris

11. BIRTHPLACE OF FATHER

(State or Country)

Missouri

12. MAIDEN NAME OF MOTHER

Nancy Porter

13. BIRTHPLACE OF MOTHER

(State or Country)

Virginia

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

Thomas Harris

(Address)

Weiser Ida

15.

Filed May 20 1913

D. R. Haudt
Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH
5 21 1913
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from
4 2 1913, to 5 21 1913
that I last saw him alive on 20th. of May 1913
and that death occurred on the date stated above, at 11 a.m.

The CAUSE OF DEATH* was as follows:

Diabetes mellitus of
possible duration of 20-3 yrs

(Duration) _____ yrs. _____ mos. _____ ds.
Contributory Myocarditis cum emboli
(Secondary)

(Duration) 2 yrs. _____ mos. _____ ds.
(Signed) Ernest O. Finney M. D.
522 1913 (Address) Weiser Ida

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place _____ In the _____
of death _____ yrs. _____ mos. _____ ds. State _____ yrs. _____ mos. _____ ds.
Where was disease contracted,
If not at place of death?
Former or
usual residence.

19. PLACE OF BURIAL OR REMOVAL DATE OF BURIAL

Monroe Creek Ida 722 1913

20. UNDERTAKER

ADDRESS

L. C. Northam

Weiser Ida

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics
File No. 5053
Registered No. 40

1. PLACE OF DEATH. Registration District No. 26
County of Washington Primary Registration District No. 2112
City of _____ (No. _____ St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

Unknown

If death occurred in a hospital, institution or camp give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX Male 4. COLOR OR RACE white 5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.)

6. DATE OF BIRTH

(Month) (Day) (Year)

7. AGE

50 yrs. — mos. — ds.

IF LESS than 1 day
how many.....hrs. or
.....min?

8. OCCUPATION

(a) Trade, profession or particular kind of work.....
(b) General nature of industry business or establishment in which employed (or employer).....

9. BIRTHPLACE

(State or Country) _____

10. NAME OF FATHER

11. BIRTHPLACE OF FATHER

(State or Country) _____

12. MAIDEN NAME OF MOTHER

13. BIRTHPLACE OF MOTHER

(State or Country) _____

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) _____
(Address) _____

15.

May 25 1913 D. R. Haurb
Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH

Unknown 191_____
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from _____ 191_____, to _____ 191_____
that I last saw h_____ alive on _____ 191_____
and that death occurred on the date stated above, at _____ M.

The CAUSE OF DEATH* was as follows:

Unknown. Found floating in river on Dr Sanders ranch. no evidence of foul play.

(Duration) _____ yrs. _____ mos. _____ ds.

Contributory
(Secondary)

(Duration) _____ yrs. _____ mos. _____ ds.

(Signed) James I. McCann, Coroner

19____ (Address)

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place _____ In the _____
of death..... yrs..... mos..... ds. State..... yrs..... mos..... ds.

Where was disease contracted,

If not at place of death?

Former or

usual residence.

19. PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

Dr Bent Marlett Ranch May 29 1913

20. UNDERTAKER

ADDRESS

L. B. North

MARGIN RESERVED FOR BINDING

ONLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Form V. S. No. 5. 10M. 6-20-11. **CERTIFICATE OF DEATH**

1. **PLACE OF DEATH.** Registration District No. 26
 County of Washington Primary Registration District No. 2113
 City of Midvale (No. _____, St.)
 If death occurs away from usual residence, give facts called for under special information. **2. FULL NAME** William Benj. Shaw

State of Idaho
 BOARD OF HEALTH
 Bureau of Vital Statistics
 File No. 5054
 Registered No. 49
 If death occurred in a hospital, institution or camp give its name instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX Male 4. COLOR OR RACE White 5. SINGLE, MARRIED, WIDOWED OR DIVORCED. Married
 (Write the word.)

6. DATE OF BIRTH _____
 (Month) (Day) (Year)

7. AGE 65 yrs. 3 mos. 19 ds. IF LESS than 1 day how many _____ hrs. or _____ min.

8. OCCUPATION Farmer
 (a) Trade, profession or particular kind of work
 (b) General nature of industry business or establishment in which employed (or employer)

9. BIRTHPLACE England
 (State or Country)

10. NAME OF FATHER John Shaw

11. BIRTHPLACE OF FATHER Don't know
 (State or Country)

12. MAIDEN NAME OF MOTHER Don't know

13. BIRTHPLACE OF MOTHER Don't know
 (State or Country)

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
 (Informant) Arthur Shaw
 (Address) Midvale, Ida

15. Filed June 14 1913 W. R. Hummel
 Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH 5-7
 (Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from dead before 1913, to saw him 1913, that I last saw him alive on 1913, and that death occurred on the date stated above, at 12 M.
 The CAUSE OF DEATH* was as follows: supposed to be paralysis of heart or possibly rupture of blood vessel
 (Duration) _____ yrs. _____ mos. _____ ds.
 Contributory only sick 40 min
 (Secondary) (Duration) _____ yrs. _____ mos. _____ ds.
 (Signed) D. R. G. Parker M. D.
5-7 193 (Address) Midvale, Ida

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES MEANS OF INJURY; and 2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions or Recent Residents.)
 At place of death _____ yrs. _____ mos. _____ ds. State _____ yrs. _____ mos. _____ ds.
 Where was disease contracted, _____
 If not at place of death? _____
 Former or usual residence _____

19. PLACE OF BURIAL OR REMOVAL Midvale DATE OF BURIAL 5-9

20. UNDERTAKER Dowen ADDRESS Weid

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Form V. S. No. 5. 10M. 6-20-11.

CERTIFICATE OF DEATH

5055
State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics
File No. 5055
Registered No. 42
If death occurred in a hospital or institution or camp give it instead of street and number

1. PLACE OF DEATH. Registration District No. 26
County of Washington Primary Registration District No. 2113
City of Midvale (No. St.)
If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME John Evans

PERSONAL AND STATISTICAL PARTICULARS

3. SEX male 4. COLOR OR RACE white 5. SINGLE, MARRIED, WIDOWED OR DIVORCED. widowed (Write the word.)
6. DATE OF BIRTH (Month) (Day) (Year)
7. AGE 80 yrs. 2 mos. 16 ds. IF LESS than 1 day how many hrs. or min.?

8. OCCUPATION (a) Trade, profession or particular kind of work Farmer (b) General nature of industry business or establishment in which employed (or employer)

9. BIRTHPLACE Greensburg Indiana (State or Country)

10. NAME OF FATHER Sam Evans

11. BIRTHPLACE OF FATHER Dont Know (State or Country)

12. MAIDEN NAME OF MOTHER Dont Know

13. BIRTHPLACE OF MOTHER Dont Know (State or Country)

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE (Informant) John T. Evans (Address)

15. Filed June 14 1913 W. R. Hamblin Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH May 11 (Month) (Day)

17. I HEREBY CERTIFY, That I attended deceased May 9 1913, to May 10 that I last saw him alive on May 9 and that death occurred on the date stated above, at

The CAUSE OF DEATH* was as follows: aortic regurgitation and paralysis right arm + leg + etc. (Duration) yrs. mos. 3
Contributory rheumatism (Secondary) (Duration) yrs. mos. 5
(Signed) Dr. R. A. Parker 5-12-1913 (Address) Midvale

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES MEANS OF INJURY; and :2) whether ACCIDENTAL, SUICIDAL OR HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions or Recent Residents.) At place of death yrs. mos. ds. State yrs. mos. Where was disease contracted, If not at place of death? Former or usual residence.

19. PLACE OF BURIAL OR REMOVAL Midvale DATE OF BURIAL 5-12

20. UNDERTAKER L. H. May ADDRESS

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Form V. S. No. 5 20M.1-16-12

CERTIFICATE OF DEATH

1. PLACE OF DEATH
County of Washington
City of Cambridge
Registration District No. 26
Primary Registration District No. 2114
(No. _____, _____ St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Frances E. Nicholas

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics
File No. 5056
Registered No. 43

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX Female 4. COLOR OR RACE White 5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.)

6. DATE OF BIRTH July 15 17 1884
(Month) (Day) (Year)

7. AGE 28 yrs. 10 mos. 28 ds.

IF LESS than 1 day
how many _____ hrs. or
_____ mins.?

8. OCCUPATION

(a) Trade, profession or particular kind of work
(b) General nature of industry business, or establishment in which employed (or employer)

House Wife

9. BIRTHPLACE

(State or Country)

New York St

10. NAME OF FATHER

Friedrich H. Hunt

11. BIRTHPLACE OF FATHER

(State or Country)

New York St

12. MAIDEN NAME OF MOTHER

Hanna Hall

13. BIRTHPLACE OF MOTHER

(State or Country)

New York St

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

Louis Hunt

(Address)

Brownlee Cda

15.

Filed

May 23 1913 C. E. Schmitz
Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH May 21 1913
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from May 13 1913, to May 21 1913, that I last saw her alive on May 20 1913, and that death occurred on the date stated above, at 2 M.

The CAUSE OF DEATH* was as follows:

Brain Poisoning

(Duration) _____ yrs. _____ mos. 8 ds.

Contributory slight spinal disorder
(Secondary)

(Duration) _____ yrs. _____ mos. _____ ds.

(Signed) C. E. Schmitz M. D.

May 21 1913 (Address) Richland Ave.

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death _____ yrs. _____ mos. _____ days. In the State _____ yrs. _____ mos. _____ days.

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

Cambridge

May 22 1913

20. UNDERTAKER

ADDRESS

Garfieldson

Cambridge

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Form V. S. No. 5 20M.1-16-12

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH. Registration District No. _____
County of Washington Primary Registration District No. 2114
City of Salubria (No. 2 St.)

File No. 5057
Registered No. 44

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Ephraim Hanes

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX Male 4. COLOR OR RACE White 5. SINGLE, MARRIED, WIDOWED OR DIVORCED. Widowed
(Write the word.)

6. DATE OF BIRTH

Jan 26 1885
(Month) (Day) (Year)

7. AGE

35 yrs. 3 mos. 7 ds.

IF LESS than 1 day
how many hrs. or
..... mins.?

8. OCCUPATION

(a) Trade, profession or particular kind of work
(b) General nature of industry, business, or establishment in which employed (or employer)

Farmer

9. BIRTHPLACE

(State or Country)

Ohio New York

10. NAME OF FATHER

Unknown

11. BIRTHPLACE OF FATHER

(State or Country)

12. MAIDEN NAME OF MOTHER

13. BIRTHPLACE OF MOTHER

(State or Country)

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

(Address)

E. F. Hanes

Salubria

Idaho

15.

Filed

May 29 1913

C. C. Schmitt

Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH

(Month) (Day) (Year)
May 20 1913

17. I HEREBY CERTIFY, That I attended deceased from May 20 1913, to May 29 1913, that I last saw him alive on May 25 1913, and that death occurred on the date stated above, at 2 P. M.

The CAUSE OF DEATH* was as follows:

Nephritis

(Duration) 3 yrs. mos. ds.

Contributory Gen. Debility
(Secondary)

(Duration) 3 yrs. mos. ds.

(Signed)

May 29 1913

(Address)

C. C. Schmitt

M. D.

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death yrs. mos. days. In the State yrs. mos. days.

Where was disease contracted if not at place of death?

Former or usual residence.

19. PLACE OF BURIAL OR REMOVAL DATE OF BURIAL

Salubria Id.

May 29 1913

20. UNDERTAKER

Jos. H. Nelson

ADDRESS

Cambridge Id.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Form V. S. No. 5 20M.1-16-12

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics
File No. 5058
Registered No. 209

1. PLACE OF DEATH.

Registration District No. 8County of BonnerPrimary Registration District No. 2033City of Sandpoint

(No. _____ St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

Goldie Garrison

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX

4. COLOR OR RACE

5. SINGLE, MARRIED, WIDOWED OR DIVORCED.

FemaleWhiteSingle
(Write the word)

6. DATE OF BIRTH

July91913

(Month)

(Day)

(Year)

7. AGE

.....yrs.....mos.....ds.

IF LESS than 1 day
how manyhrs. or
.....mins.?

8. OCCUPATION

(a) Trade, profession or particular kind of work

None

(b) General nature of industry business, or establishment in which employed (or employer)

9. BIRTHPLACE

(State or Country)

Idaho

10. NAME OF FATHER

J. H. Garrison

11. BIRTHPLACE OF FATHER

(State or Country)

Mo.

12. MAIDEN NAME OF MOTHER

Martha Pierce

13. BIRTHPLACE OF MOTHER

(State or Country)

Mo.

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

(Address)

J. H. Garrison
Sandpoint, Ida

15.

Filed April, 29th 1913M. McKinnon
Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH

April,30291913

(Month)

(Day)

(Year)

17. I HEREBY CERTIFY, That I attended deceased from

April 21 1913, to April 30 1913that I last saw her alive on April 29 1913,and that death occurred on the date stated above, at 5 A.M.

The CAUSE OF DEATH* was as follows:

Whooping CoughPneumonia(Duration) 2 yrs. 2 mos. 2 ds.Contributory
(Secondary)(Duration) 2 yrs. 2 mos. 2 ds.(Signed) C. P. Seachouse M. D.4/30 1913 (Address) Sandpoint

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death.....yrs.....mos.....days. In the State.....yrs.....mos.....days.

Where was disease contracted if not at place of death?

Former or usual residence.....

19. PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

Sandpoint, Idaho.April, 30 1913

20. UNDERTAKER

ADDRESS

C. P. Seachouse Sandpoint, Id

A stillbirth must be registered both as a birth and death. The date of death should be the date of delivery and the death certificate should further state, if known, the cause of the stillbirth and the period of utero gestation in months.

STATEMENT OF OCCUPATION.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer, Physician, Stenographer, Compositor, Architect, Locomotive engineer, Civil engineer, Stationary fireman, etc.* But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner*, (b) *Cotton mill*; (a) *Salesman*, (b) *Grocery*; (a) *Foreman*, (b) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification, as *Day laborer, Farm laborer, Laborer—Coal mine*, etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers*, who receive a definite salary), may be entered as *Housewife, Housework*, or *At home*, and children, not gainfully employed, as *At school* or *At home*. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer (retired, 6 yrs.)* For persons who have no occupation whatever, write *None*.

STATEMENT OF CAUSE OF DEATH.—Name, first the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebro-*

spinal fever (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid Pneumonia") *Lobar pneumonia; Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritoneum, etc., Carcinoma, Sarcoma, etc.*, of (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis, etc.* The contributory (secondary or intercurrent affection need not be stated unless important. Example: *Measles* (disease causing death), 29 ds.; *Bronchopneumonia* (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "Asthenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility," "Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Haemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uraemia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify as "PUERPERAL, septicemia", "PUERPERAL peritonitis," etc., all diseases resulting from childbirth or miscarriage. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning; Struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid—probably suicide.* The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "Contributory."

9 # 2

MARGIN RESERVED FOR BINDING
WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Form V. S. No. 5. 10M. 6-20-11.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

File No. 5059

Registered No. 207

If death occurred in a hospital, institution or camp give its NAME instead of street and number.

1. PLACE OF DEATH.

Registration District No. 8

County of Bonner

Primary Registration District No. 2436

City of Priest River

(No. , St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

Ruth E Danforth

PERSONAL AND STATISTICAL PARTICULARS

3. SEX

Female

4. COLOR OR RACE

White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED.

Single
(Write the word.)

6. DATE OF BIRTH

Sept 19

1894

(Month)

(Day)

(Year)

7. AGE

18 yrs.

7 mos.

11 ds.

IF LESS than 1 day
how many hrs. or
..... min.?

8. OCCUPATION

(a) Trade, profession, or particular kind of work
(b) General nature of industry, business, or establishment in which employed (or employer)

None

9. BIRTHPLACE

(State or Country)

Michigan

10. NAME OF FATHER

Chas E Danforth

11. BIRTHPLACE OF FATHER

(State or Country)

Michigan

12. MAIDEN NAME OF MOTHER

Jessie E Scott

13. BIRTHPLACE OF MOTHER

(State or Country)

Canada

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

C E Hadley
Miss Thelma

(Address)

15.

Filed

May 6

1913

W. McKinnis

Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

April

29

1913
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from

March 1913, to April 29th 1913

that I last saw him alive on April 29 1913

and that death occurred on the date stated above, at 10:45 P. M.

The CAUSE OF DEATH* was as follows:

Pulmonary Tuberculosis

(Duration) 1 yrs. 4 mos. — ds.

Contributory
(Secondary)

(Duration) yrs. mos. ds.

(Signed)

esbury

M. D.

April 3, 1913 (Address) Priest River

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place In the
of death yrs. mos. ds. State yrs. mos. ds.

Where was Disease contracted,

If not at place of death?

Former or

usual residence.

19. PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

191

20. UNDERTAKER

ADDRESS

W. C. Cope
Ketchikan

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Form V. S. No. 5 20M.1-16-12

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics
File No. **5060**

1. PLACE OF DEATH.

Registration District No. **8**County of **Bonner**Primary Registration District No. **2533**

City of _____

(No. _____)

St.) _____

Registered No. **213**

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME **Cora M. Gray**

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX **Female**4. COLOR OR RACE **White**5. SINGLE, MARRIED, WIDOWED OR DIVORCED. **Married**6. DATE OF BIRTH **June 30 1864**

(Month)

(Day)

(Year)

7. AGE **48 yrs. 9 mos. 29 ds.**

IF LESS than 1 day
how many _____ hrs. or
_____ mins.?

8. OCCUPATION

(a) Trade, profession or particular kind of work **Housewife**

(b) General nature of industry business, or establishment in which employed (or employer)

9. BIRTHPLACE

(State or Country) **Mich**10. NAME OF FATHER **Brown**11. BIRTHPLACE OF FATHER **U. S.**

(State or Country)

12. MAIDEN NAME OF MOTHER **Poe**13. BIRTHPLACE OF MOTHER **U. S.**

(State or Country)

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) **Jas M. Gray**(Address) **Sunder Idaho**

15.

Filed **4/29**

1913

Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH **April 29 1913**

(Month)

(Day)

(Year)

17. I HEREBY CERTIFY, That I attended deceased from **April 28 1913**, to **April 29 1913**,that I last saw her alive on **April 28 1913**, and that death occurred on the date stated above, at **1-9 P. M.**The CAUSE OF DEATH* was as follows: **Tuberculosis of Bowels**(Duration) _____ yrs. **3** mos. _____ ds.

Contributory (Secondary)

(Duration) _____ yrs. _____ mos. _____ ds.

(Signed) **Dr. W. W. Brown** M. D.19. (Address) **Rathbone Idaho**

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death _____ yrs. _____ mos. _____ days. In the State _____ yrs. _____ mos. _____ days.

Where was disease contracted if not at place of death? _____

Former or usual residence _____

19. PLACE OF BURIAL OR REMOVAL **Rathbone Idaho**DATE OF BURIAL **May 2 1913**20. UNDERTAKER **Edw. Brown**ADDRESS **Sunder Idaho**

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics
File No. 5061

1. PLACE OF DEATH. Registration District No. 8
County of Bonner Primary Registration District No. 2033
City of Sandpoint (No. St.)

Registered No. 211

If death occurs away from usual residence, give facts called for under special information. 2. FULL NAME Baby Grasso
If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX Male 4. COLOR OR RACE white 5. SINGLE, MARRIED, WIDOWED OR DIVORCED.
(Write the word.)

6. DATE OF BIRTH April 28 1913
(Month) (Day) (Year)

7. AGE yrs. mos. ds. IF LESS than 1 day how many hrs. or mins.?

8. OCCUPATION
(a) Trade, profession or particular kind of work none
(b) General nature of industry business, or establishment in which employed (or employer)

9. BIRTHPLACE Colburn
(State or Country)

10. NAME OF FATHER Alex Grasso

11. BIRTHPLACE OF FATHER This.
(State or Country)

12. MAIDEN NAME OF MOTHER Adelia Helbur

13. BIRTHPLACE OF MOTHER This
(State or Country)

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Alex Grasso
(Address) Colburn Idaho

15. Filed April, 29th 1913 M. M. M. Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH April 28 1913
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from April 28 1913, to April 28 1913, that I last saw him alive on April 28 1913, and that death occurred on the date stated above, at 10 P.M.

The CAUSE OF DEATH* was as follows:
Premature birth six mos

(Duration) yrs. mos. ds.
Contributory Premature birth
(Secondary)

(Duration) yrs. mos. ds.
(Signed) M. M. M. M. D.
19 (Address) Sandpoint

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death... yrs. mos. days. In the State... yrs. mos. days.
Where was disease contracted if not at place of death?
Former or usual residence...

19. PLACE OF BURIAL OR REMOVAL Colburn, Idaho DATE OF BURIAL April 29 1913

20. UNDERTAKER E. M. Brown ADDRESS Sandpoint, Ida

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Form V. S. No. 5 20M.1-16-12

CERTIFICATE OF DEATH

1. PLACE OF DEATH.

County of BonnerCity of SandpointRegistration District No. 8Primary Registration District No. 2033

(No. _____, _____ St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Jennie Irene YawState of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics
File No. 5062Registered No. 210

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX

Female

4. COLOR OR RACE

White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED.

Married
(Write the word.)

6. DATE OF BIRTH

March 12 1884
(Month) (Day) (Year)

7. AGE

29 yrs. 1 mos. 13 ds.IF LESS than 1 day
how many _____ hrs. or
_____ mins.?

8. OCCUPATION

- (a) Trade, profession or particular kind of work Housewife
(b) General nature of industry, business, or establishment in which employed (or employer) _____

9. BIRTHPLACE

(State or Country) Penn

10. NAME OF FATHER

Burton K. Luther

11. BIRTHPLACE OF FATHER

(State or Country) Ill

12. MAIDEN NAME OF MOTHER

Mary Burdek

13. BIRTHPLACE OF MOTHER

(State or Country) Ill

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) E. M. Brown(Address) Sandpoint, Idaho.

15.

Filed April 25 1913M. McKinn
Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH

April 25 1913
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from

Oct 1 1912, to April 14 1913,
that I last saw her alive on April 14 1913.and that death occurred on the date stated above, at 7 P.M.

The CAUSE OF DEATH* was as follows:

Pulmonary Tuberculosis
Intestinal Tuberculosis(Duration) _____ yrs. 8 mos. _____ ds.Contributory Pleurisy
(Secondary)

(Duration) _____ yrs. _____ mos. _____ ds.

(Signed) M. McKinn19 (Address) Sandpoint

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death _____ yrs. _____ mos. _____ days. In the State _____ yrs. _____ mos. _____ days.

Where was disease contracted if not at place of death? _____

Former or usual residence _____

19. PLACE OF BURIAL OR REMOVAL

Sandpoint, Idaho

DATE OF BURIAL

April 27 1913

20. UNDERTAKER

E. M. Brown

ADDRESS

Sandpoint, Ida

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Form V. S. No. 5. 12½ M. 7-24-11

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics
File No. **5063**
Registered No. **212**

1. PLACE OF DEATH. Registration District No. **8**
County of **Bonner** Primary Registration District No. **2033**
City of **Sandpoint** (No. _____, _____ St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

Edwin Bowen

If death occurred in a hospital, institution or camp give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX **M.** 4. COLOR OR RACE **white** 5. SINGLE, MARRIED, WIDOWED OR DIVORCED. **Single**
(Write the word.)

6. DATE OF BIRTH **Apr. 11 - 1913**
(Month) (Day) (Year)

7. AGE _____ yrs. _____ mos. **14** ds. IF LESS than 1 day how many _____ hrs. or _____ min?

8. OCCUPATION

(a) Trade, profession or particular kind of work
(b) General nature of industry business or establishment in which employed (or employer)

Infant

9. BIRTHPLACE

(State or Country)

Sandpoint Idaho

10. NAME OF FATHER

Edwin Bowen

11. BIRTHPLACE OF FATHER

(State or Country)

Missouri

12. MAIDEN NAME OF MOTHER

Clara Grate

13. BIRTHPLACE OF MOTHER

(State or Country)

Minn.

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

(Address)

Rep Jackson
Sandpoint

15.

Filed **April 25th 1913**

M. McKeen
Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH

April 26 - 1913
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I ~~attended~~ deceased from _____ 191____, to _____ 191____

that I last saw h _____ alive on **Apr 26 - 1913** and that death occurred on the date stated above, at **8 A.M.**

The CAUSE OF DEATH* was as follows:

Infantile Debility, Less than 4 pounds at birth -

_____ (Duration) _____ yrs. _____ mos. **14** ds.

Contributory (Secondary)

_____ (Duration) _____ yrs. _____ mos. _____ ds.

(Signed) **W. H. Jackson** M. D.

_____ 19____ (Address) _____

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death _____ yrs. _____ mos. _____ ds. In the State _____ yrs. _____ mos. _____ ds.
Where was disease contracted,
If not at place of death?
Former or usual residence _____

19. PLACE OF BURIAL OR REMOVAL DATE OF BURIAL

Sandpoint, Idaho **Apr 26 1913**

20. UNDERTAKER

ADDRESS

Edwin Bowen **Sandpoint**

MARGIN RESERVED FOR BINDING
WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Form V. S. No. 5. 10M. 6-20-11.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics
File No. 5064

1. PLACE OF DEATH.
County of Bonner
City of Priest River

Registration District No. 8
Primary Registration District No. 2036
(No., St.)

Registered No. 206

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

Unnamed

If death occurred in a hospital, institution or camp give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX Male 4. COLOR OR RACE white 5. SINGLE, MARRIED, WIDOWED OR DIVORCED.

(Write the word.)

6. DATE OF BIRTH

Apr 20 1913
(Month) (Day) (Year)

7. AGE

IF LESS than 1 day
how many 3 hrs. or
..... min.?

..... yrs. mos. ds.

8. OCCUPATION

(a) Trade, profession, or particular kind of work
(b) General nature of industry, business, or establishment in which employed (or employer)

None

9. BIRTHPLACE

(State or Country)

Bonner County

10. NAME OF FATHER

C. A. Campbell

11. BIRTHPLACE OF FATHER

(State or Country)

Ohio

12. MAIDEN NAME OF MOTHER

Vinnie H. Binkley

13. BIRTHPLACE OF MOTHER

(State or Country)

Ohio

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

C. D. Busey

(Address)

Priest River

15.

Filed May 5 1913

M. McKinnon

Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

Apr 20 1913
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from

Apr 20 1913, to Apr 20 1913

that I last saw him alive on Apr 20 1913

and that death occurred on the date stated above, at 11³⁰ A.M.

The CAUSE OF DEATH* was as follows:

Injury to brain from
pressure of ototoxic forces
in debility, deceased child

(Duration) yrs. mos. ds.

Contributory (Secondary)

(Duration) yrs. mos. ds.

(Signed)

C. D. Busey M. D.
Apr 24 1913 (Address) Priest River

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place In the
of death yrs. mos. ds. State yrs. mos. ds.

Where was Disease contracted,

If not at place of death?

Former or

usual residence.

19. PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

Priest River

Apr 21 1913

20. UNDERTAKER

ADDRESS

None

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Form V. S. No. 5 20M.1-16-12

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics
File No. **5065**
Registered No. **208**

1. PLACE OF DEATH
County of Bonner
City of Sandpoint
Registration District No. 8
Primary Registration District No. 2033
(No. _____, _____ St.)

If death occurs away from usual residence, give facts called for under special information. 2. FULL NAME Nicolena Wells

PERSONAL AND STATISTICAL PARTICULARS
3. SEX Female 4. COLOR OR RACE White 5. SINGLE, MARRIED, WIDOWED OR DIVORCED. Married (the word.)

6. DATE OF BIRTH
July 3 1 1884
(Month) (Day) (Year)

7. AGE
28 yrs. 9 mos. 12 ds.
IF LESS than 1 day
how many _____ hrs. or
_____ mins.

8. OCCUPATION
(a) Trade, profession or particular kind of work Housewife
(b) General nature of industry, business, or establishment in which employed (or employer) _____

9. BIRTHPLACE
(State or Country) Wis

10. NAME OF FATHER
Deceased- Unknown

11. BIRTHPLACE OF FATHER
(State or Country) Norway.

12. MAIDEN NAME OF MOTHER
Unknown

13. BIRTHPLACE OF MOTHER
(State or Country) ''

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) _____
(Address) Clarks Fork Idaho.

15.
Filed April 16th 1913 M. M. Kinnear
Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH
April 15 17 1913
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from 191, to April 16 1913
that I last saw her alive on April 16 1913,
and that death occurred on the date stated above, at 4A. M.
The CAUSE OF DEATH* was as follows:
Subdiaphragmatic abscess

(Duration) _____ yrs. 3 mos. _____ ds.
Contributory (Secondary) _____
(Duration) _____ yrs. _____ mos. _____ ds.
(Signed) C. P. [Signature] M. D.
4/17/1913 (Address) Sandpoint

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death. _____ yrs. _____ mos. _____ days. In the State. _____ yrs. _____ mos. _____ days.
Where was disease contracted if not at place of death? _____
Former or usual residence. _____

19. PLACE OF BURIAL OR REMOVAL Sandpoint, Idaho DATE OF BURIAL April 17

20. UNDERTAKER E. M. Brower ADDRESS Sandpoint

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Form V. S. No. 5. 10M. 6-20-11. N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics
File No. 5066
Registered No. 285

Form V. S. No. 5. 10M. 6-20-11.

1. PLACE OF DEATH.
County of Bonner
City of Clarkfork

Registration District No. 8
Primary Registration District No. 2035
(No. St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Capt. Geo. A. Moody

If death occurred in a hospital, institution or camp give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX M. 4. COLOR OR RACE White 5. SINGLE, MARRIED, WIDOWED OR DIVORCED. Widower (Write the word.)

6. DATE OF BIRTH (Month) (Day) (Year)

7. AGE 75 yrs. mos. ds. IF LESS than 1 day how many hrs. or min.?

8. OCCUPATION (a) Trade, profession or particular kind of work Hotel Clerk (b) General nature of industry business or establishment in which employed (or employer)

9. BIRTHPLACE (State or Country) Maine

10. NAME OF FATHER Unknown

11. BIRTHPLACE OF FATHER (State or Country) Unknown

12. MAIDEN NAME OF MOTHER Unknown

13. BIRTHPLACE OF MOTHER

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) James Casey (Address) Clarkfork

15. Filed May 6 1913 M. McKinnon Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH Feb 7 1913 (Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from Feb 5 1913, to Feb 7 1913, that I last saw him alive on Feb 6 1913, and that death occurred on the date stated above, at 6 A.M. The CAUSE OF DEATH* was as follows:

Acute Pneumonia (Duration) yrs. mos. ds. Contributory (Secondary) Bright's Disease (Duration) 3 or 4 yrs. mos. ds. (Signed) W. M. Knapp M. D. Feb. 10 1913 (Address) Hope, Ida

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death yrs. mos. ds. In the State yrs. mos. ds. Where was disease contracted. If not at place of death? Former or usual residence.

19. PLACE OF BURIAL OR REMOVAL Clarkfork DATE OF BURIAL 10 1913

20. UNDERTAKER E. M. Brewer ADDRESS Sandpoint

Form V. S. No. 5 20M.1-16-12

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH

Registration District No. 18

County of Franklin

Primary Registration District No. 2119

City of Burdon

(No. St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

John E. Olsen

Registered No. 57

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX

4. COLOR OR RACE

5. SINGLE, MARRIED, WID-
OWED OR DIVORCED.

6. DATE OF BIRTH

7. AGE

IF LESS than 1 day
how many hrs. or
..... mins.?

8. OCCUPATION

(a) Trade, profession or
particular kind of work(b) General nature of industry
business, or establishment in
which employed (or employer)

9. BIRTHPLACE

(State or Country)

10. NAME OF
FATHER11. BIRTHPLACE
OF FATHER

(State or Country)

12. MAIDEN NAME
OF MOTHER13. BIRTHPLACE
OF MOTHER

(State or Country)

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

(Address)

15.

Filed

1913

1913

W. S. Packard
Sub Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

May 30 1913
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from

Nov. 1912, to May 30 1913

that I last saw him alive on May 20 1913

and that death occurred on the date stated above, at 2:30 P. M.

The CAUSE OF DEATH* was as follows:

Tuberculosis of
lungs

(Duration) 5 yrs. 4 mos. 4 ds.

Contributory
(Secondary)

(Duration) yrs. mos. ds.

(Signed)

June 2, 1913 (Address) Burdon, Idaho

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions,
Transients or Recent Residents.)

At place of death yrs. mos. days. In the State yrs. mos. days.

Where was disease contracted
if not at place of death?Former or
usual residence

19. PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

Mapleton, Idaho

June 2, 1913

20. UNDERTAKER

ADDRESS

S. J. Hansen

Burdon, Idaho

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Form V. S. No. 5 20M.1-16-12

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH

Registration District No. 18

County of

Primary Registration District No. 2119

City of

(No. , St.)

File No. 5068

Registered No. 58

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

Weigh Nelson

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX

4. COLOR OR RACE

5. SINGLE, MARRIED, WIDOWED OR DIVORCED.

Male

White

Single
(Write the word.)

6. DATE OF BIRTH

Apr 14 1913

(Month)

(Day)

(Year)

7. AGE

6 yrs. 1 mos. 15 ds.

IF LESS than 1 day
how many hrs. or mins.

8. OCCUPATION

(a) Trade, profession or particular kind of work

(b) General nature of industry business, or establishment in which employed (or employer)

9. BIRTHPLACE

(State or Country)

Lumpton, Mass

10. NAME OF FATHER

Pete E. Nelson

11. BIRTHPLACE OF FATHER

(State or Country)

Mass

12. MAIDEN NAME OF MOTHER

Nelson

13. BIRTHPLACE OF MOTHER

(State or Country)

Mass

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

P. E. Hirsman

(Address)

Preston, Ida

15.

Filed

May 30 1913

C. H. Hirsman
Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH

May 29 1913

(Month)

(Day)

(Year)

17. I HEREBY CERTIFY, That I attended deceased from May 11 1913, to May 29 1913, that I last saw him alive on May 29 1913, and that death occurred on the date stated above, at 10 A.M.

The CAUSE OF DEATH* was as follows:

Cerebro - spinal Meningitis

(Duration) yrs. 2 mos. 18 ds.

Contributory (Secondary)

(Duration) yrs. mos. ds.

(Signed)

G. W. State M. D.

May 1913 (Address) Preston, Ida

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death yrs. mos. days. In the State yrs. mos. days.

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

Preston, Ida

May 30 1913

20. UNDERTAKER

ADDRESS

J. H. Hirsman

Preston, Ida

Form V. S. No. 5 20M.1-16-12

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics
File No. 5069

1. PLACE OF DEATH. Registration District No. 18
County of Franklin Primary Registration District No. 2119
City of Preston (No. St.)

Registered No. 59
If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME David T. Linn

PERSONAL AND STATISTICAL PARTICULARS

3. SEX Male 4. COLOR OR RACE White 5. SINGLE, MARRIED, WIDOWED OR DIVORCED. Married
(Write the word.)

6. DATE OF BIRTH Jan 13 1847
(Month) (Day) (Year)

7. AGE 66 yrs. 4 mos. ds. IF LESS than 1 day how many hrs. or mins.?

8. OCCUPATION (a) Trade, profession or particular kind of work Farmer (b) General nature of industry business, or establishment in which employed (or employer)

9. BIRTHPLACE (State or Country) Wales

10. NAME OF FATHER Henry Linn

11. BIRTHPLACE OF FATHER (State or Country) Wales

12. MAIDEN NAME OF MOTHER Jane Powell

13. BIRTHPLACE OF MOTHER (State or Country) Wales

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE (Informant) Mrs. Edith Rose (Address) San Diego, Cal

15. Filed May 27 1913 Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH May 26 1913
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from May 19 1913, to May 25 1913, that I last saw him alive on May 25 1913, and that death occurred on the date stated above, at 7 A. M.

The CAUSE OF DEATH was as follows: Cerebral hemorrhage

(Duration) yrs. mos. 7 ds.

Contributory (Secondary)

(Duration) yrs. mos. ds.

(Signed) G. W. States M. D.

May 27/13 (Address) Preston, Idaho

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death yrs. mos. days. In the State yrs. mos. days.

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL Date of Burial
Preston, Idaho May 28 1913

20. UNDERTAKER ADDRESS
G. W. States
Preston, Idaho

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Form V. S. No. 5 20M.1-16-12.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH

Registration District No. 18

County of

Primary Registration District No. 2119

City of

(No.

St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

Noah Winger

Registered No. 60

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX

4. COLOR OR RACE

5. SINGLE, MARRIED, WIDOWED OR DIVORCED.

Male

White

Married
(Write the word.)

6. DATE OF BIRTH

Apr

6

1

(Month)

(Day)

(Year)

7. AGE

77

yrs.

mos.

ds.

IF LESS than 1 day
how many hrs. or
..... mins.?

8. OCCUPATION

(a) Trade, profession or particular kind of work

Farmer

(b) General nature of industry business, or establishment in which employed (or employer)

9. BIRTHPLACE

(State or Country)

Penn

10. NAME OF FATHER

Joseph Winger

11. BIRTHPLACE OF FATHER

(State or Country)

Penn

12. MAIDEN NAME OF MOTHER

Not known

13. BIRTHPLACE OF MOTHER

(State or Country)

Not known

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

N. W. Winger

(Address)

Preston Idaho

15.

Filed

May 13

1913

J. H. Parkison

Int. Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH

May

12

1913

(Month)

(Day)

(Year)

17. I HEREBY CERTIFY, That I attended deceased from

May 11 1913, to May 12 1913,

that I last saw him alive on May 12 1913,

and that death occurred on the date stated above, at 8 A.M.

The CAUSE OF DEATH* was as follows:

Rheumatism of heart
with general articular
rheumatism.

(Duration)

yrs.

X mos.

X ds.

Contributory

(Secondary)

General debility

(Duration)

yrs.

mos.

ds.

(Signed)

May 13 1913

(Address) W. E. Stiles M. D.

Preston Idaho

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place

of death yrs. mos. days.

In the

State yrs. mos. days.

Where was disease contracted if not at place of death?

Former or usual residence.

19. PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

Preston Idaho

May 14 1913

20. UNDERTAKER

ADDRESS

G. L. Hansen

Preston

June 10 1913

D. C. Ray for Reg

Form V. S. No. 5 20M.1-16-12

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH

Registration District No. 18

County of Franklin

Primary Registration District No. 2119

City of Coeur d'Alene

(No. 1)

St.)

File No. 5071

Registered No. 61

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

Earl G. Gooch

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX

4. COLOR OR RACE

5. SINGLE, MARRIED, WIDOWED OR DIVORCED.

Male

White

(Write the word.)

6. DATE OF BIRTH

Aug

17

1902

(Month)

(Day)

(Year)

7. AGE

11 yrs. 10 mos. ds.

IF LESS than 1 day
how many hrs. or
mins.?

8. OCCUPATION

(a) Trade, profession or particular kind of work

(b) General nature of industry business, or establishment in which employed (or employer)

9. BIRTHPLACE

(State or Country)

Coeur d'Alene

10. NAME OF FATHER

Louis Gooch

11. BIRTHPLACE OF FATHER

(State or Country)

Richmond, Wash

12. MAIDEN NAME OF MOTHER

Willcox

13. BIRTHPLACE OF MOTHER

(State or Country)

Coeur d'Alene

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

John D. Gooch

(Address)

Coeur d'Alene, Idaho

15.

Filed May 16 1913

W. P. Parkinson
Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH

May

24

1913

(Month)

(Day)

(Year)

17. I HEREBY CERTIFY, That I attended deceased from

May 1 1913, to May 24 1913,

that I last saw him alive on May 24 1913,

and that death occurred on the date stated above, at 8 A.M.

The CAUSE OF DEATH* was as follows:

General Sepsis

(Duration) yrs. mos. 14 ds.

Contributory Puncture wound of foot
(Secondary) by a nail

(Duration) yrs. mos. 1 ds.

(Signed) Allen R. Gooch M. D.

May 16 1913 (Address) Coeur d'Alene, Idaho

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death. yrs. mos. days. In the State. yrs. mos. days.

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL DATE OF BURIAL

Coeur d'Alene, Idaho May 17 1913

20. UNDERTAKER

ADDRESS

P. J. Hanson Coeur d'Alene, Idaho

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Form V. S. No. 5 20M.1-16-12

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH.

Registration District No. 18

County of Oneida

Primary Registration District No. 2069

City of Malad

(No. _____ St.)

File No. 5473

Registered No. 83

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME William Albert Smith

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX

4. COLOR OR RACE

5. SINGLE, MARRIED, WID-
OWED OR DIVORCED.

Male

White

Single (word.)

6. DATE OF BIRTH

July

16

1913

7. AGE

7 yrs. 18 mos. 18 ds.

IF LESS than 1 day
how many _____ hrs. or
_____ mins.?

8. OCCUPATION

(a) Trade, profession or particular kind of work
(b) General nature of industry business, or establishment in which employed (or employer)

None

9. BIRTHPLACE

(State or Country)

Salt Lake City Ut.

10. NAME OF FATHER

William H. Smith

11. BIRTHPLACE OF FATHER

(State or Country)

Salt Lake City Ut.

12. MAIDEN NAME OF MOTHER

Effie J. Evans

13. BIRTHPLACE OF MOTHER

(State or Country)

Malad Idaho

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

W. H. Smith

(Address)

Malad Idaho

15.

Filed

10

1913

W. C. Ray

Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH

March

7

1913

17. I HEREBY CERTIFY, That I attended deceased from

March 1st 1913, to March 7 1913

that I last saw him alive on March 5 1913

and that death occurred on the date stated above, at 9 a. m.

The CAUSE OF DEATH* was as follows:

Spinal Dilitation Complicating
Influenza

Duration) yrs. mos. ds.

Contributory

(Secondary)

(Duration) yrs. mos. ds.

(Signed)

3/8 1913 (Address) Malad

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death.....yrs.....mos.....days. In the State.....yrs.....mos.....days.

Where was disease contracted if not at place of death?.....

Former or usual residence.....

19. PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

Malad Idaho

Mar. 9 1913

20. UNDERTAKER

ADDRESS

W. S. Johnson

Malad

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Form V. S. No. 5. 10M. 6-20-11.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics
File No. 5073

1. PLACE OF DEATH.

Registration District No. 3

County of Canyon

Primary Registration District No.

City of

(No. St.)

Registered No.

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Laura J. Rubins

If death occurred in a hospital, institution or camp give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX

4. COLOR OR RACE 5. SINGLE, MARRIED, WIDOWED OR DIVORCED.

6. DATE OF BIRTH

12th (Month) 1981 (Year)

7. AGE

32 yrs. 2 mos. ds. IF LESS than 1 day how many hrs. or min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work
(b) General nature of industry business or establishment in which employed (or employer)

9. BIRTHPLACE

(State or Country)

10. NAME OF FATHER

11. BIRTHPLACE OF FATHER

(State or Country)

12. MAIDEN NAME OF MOTHER

13. BIRTHPLACE OF MOTHER

(State or Country)

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

(Address)

15.

Filed

1913

Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

May 27 1913 (Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from

May 27 1913, to May 27 1913

that I last saw her alive on May 27 1913

and that death occurred on the date stated above, at, 3 AM

The CAUSE OF DEATH* was as follows:

hemorrhage

(Duration) yrs. mos. 2 1/2 ds.

Contributory (Secondary)

(Duration) yrs. mos. ds.

(Signed) William J. Mulder M. D.

May 27 1913 (Address) Parma, Ida

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL OR HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, If not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

Idaho Falls 7/31 1913

20. UNDERTAKER

ADDRESS

Shelton & Sons Parma

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Form V. S. No. 5. 10M. 6-20-11.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics
File No. **5074**

1. PLACE OF DEATH.

Registration District No. **3**

County of _____

Primary Registrar _____

District No. _____

City of _____

(No. _____)

St. _____

Registered No. _____

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

Bell I Hastie

If death occurred in a hospital, institution or camp give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX

M

4. COLOR OR RACE

W

5. SINGLE, MARRIED, WIDOWED OR DIVORCED.

(Write the word.) **M**

6. DATE OF BIRTH

Oct

7

1862

(Month)

(Day)

(Year)

7. AGE

51

7

18

ds.

30

IF LESS than 1 day how many **16** hrs. or **30** min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work
(b) General nature of industry business or establishment in which employed (or employer)

Housewife

9. BIRTHPLACE

(State or Country)

Polk County Iowa

10. NAME OF FATHER

Major L. Britton

11. BIRTHPLACE OF FATHER

(State or Country)

Lowell Mass.

12. MAIDEN NAME OF MOTHER

Martha Brasher

13. BIRTHPLACE OF MOTHER

(State or Country)

Deubugue Iowa

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

Phos L. Hastie

(Address)

Parma Idaho

15.

Filed

5/30

1913

R. J. Pluen

Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

May

26

1913

(Month)

(Day)

(Year)

17. I HEREBY CERTIFY, That I attended deceased from

May 18

1913

to **May 26**

1913

that I last saw her alive on **May 26** **1913**

and that death occurred on the date stated above, at **5 P.** M.

The CAUSE OF DEATH* was as follows:

Myelogenous Leukemia

(Duration)

several

yrs.

mos.

ds.

Contributory (Secondary)

(Duration)

yrs.

mos.

ds.

(Signed)

Chas. B. Allen

M. D.

5-28

1913

(Address)

Parma, Ida.

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place

of death

yrs.

mos.

20

ds.

State

yrs.

mos.

same

ds.

Where was disease contracted.

If not at place of death?

Former or usual residence.

Portland Ore.

19. PLACE OF BURIAL OR REMOVAL

Parma Idaho

DATE OF BURIAL

5/30

1913

20. UNDERTAKER

Chas. B. Allen

ADDRESS

Parma

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Form V. S. No. 5 20M.1-16-12

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH.

Registration District No.

County of

Primary Registration District No.

City of

(No., St.)

File No. 5075

Registered No.

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

George McIntyre Sharp

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX

M

4. COLOR OR RACE

W.

5. SINGLE, MARRIED, WIDOWED OR DIVORCED.

Single (Write the word.)

6. DATE OF BIRTH

4 16 1913
(Month) (Day) (Year)

7. AGE

0 yrs. 0 mos. 15 ds.

IF LESS than 1 day
how many hrs. or
..... mins.?

8. OCCUPATION

(a) Trade, profession or particular kind of work

(b) General nature of industry business, or establishment in which employed (or employer)

9. BIRTHPLACE

(State or Country)

Roswell Canyon Co

10. NAME OF FATHER

Geo W Sharp

11. BIRTHPLACE OF FATHER

(State or Country)

Wisconsin

12. MAIDEN NAME OF MOTHER

Martie McIntyre

13. BIRTHPLACE OF MOTHER

(State or Country)

Wisconsin

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

Geo W Sharp

(Address)

Parma Ida

15.

Filed

5/2

1913

R. R. R. R.

Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH

May 1 1913
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from

Apr - 16 1913 to May - 1 1913

that I last saw him alive on Apr - 30 1913

and that death occurred on the date stated above, at 12 M.

The CAUSE OF DEATH* was as follows:

Congenital deformity

(Duration) yrs. mos. 15 ds.

Contributory
(Secondary)

(Duration) yrs. mos. ds.

(Signed)

D. R. R. R. M. D.

5/2 1913 (Address) Parma

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death yrs. mos. days. In the State yrs. mos. days.

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

Raswell

5/2 1913

20. UNDERTAKER

ADDRESS

R. R. R. R. Co

Parma

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Form V. S. No. 5 20M.1-16-12

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics
File No. **5076**

1. PLACE OF DEATH

Registration District No. **28**County of **Shoshone**Primary Registration District No. **111**City of **Wallace**(No. **Wallace**, Providence Hosp. St.)Registered No. **31**

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME **William R. Thomas**

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX

male

4. COLOR OR RACE

white

5. SINGLE, MARRIED, WIDOWED OR DIVORCED.

married
(Write the word.)

6. DATE OF BIRTH

Nov. **16** **1889**
(Month) (Day) (Year)

7. AGE

23 yrs. **5** mos. **16** ds.

IF LESS than 1 day
how many hrs. or
..... mins.?

8. OCCUPATION

(a) Trade, profession or particular kind of work **miner**
(b) General nature of industry, business, or establishment in which employed (or employer)

9. BIRTHPLACE

(State or Country) **Kansas**

10. NAME OF FATHER

P. J. Thomas

11. BIRTHPLACE OF FATHER

(State or Country) **Ohio**

12. MAIDEN NAME OF MOTHER

Ella M. Holcomb

13. BIRTHPLACE OF MOTHER

(State or Country) **Ohio**

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) **P. J. Thomas**(Address) **Caldwell, Idaho.**

15.

Filed **May 2****1913**

F. Leo Dwyer
Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

5 **2** **1913**
(Month) (Day) (Year)

17. WHEREBY CERTIFY, That I attended deceased from

Apr 23 **1913** to **May 2** **1913**that I last saw him alive on **May 1** **1913**and that death occurred on the date stated above, at **2 A.M.**

The CAUSE OF DEATH was as follows:

Double Lobar Pneumonia

.....

.....

.....

.....

.....

.....

.....

.....

.....

.....

.....

.....

.....

.....

.....

.....

.....

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Form V. S. No. 5 20M.1-16-12

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH

Registration District No. 78County of ShoshonePrimary Registration District No. 1011-City of Wallace

(No. _____)

St.)

Registered No. 72

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

Anna C. O'Connor

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX

4. COLOR OR RACE

5. SINGLE, MARRIED, WID-
OWED OR DIVORCEDFemalewhitemarried
(Write the word.)

6. DATE OF BIRTH

Nov.241873

(Month)

(Day)

(Year)

7. AGE

40 yrs. 5 mos. 17 ds.

IF LESS than 1 day
how many _____ hrs. or
_____ mins.?

8. OCCUPATION

(a) Trade, profession or particular kind of work

Housewife

(b) General nature of industry business, or establishment in which employed (or employer)

9. BIRTHPLACE

(State or Country)

Canada

10. NAME OF FATHER

Hugh M. C. Glynn

11. BIRTHPLACE OF FATHER

(State or Country)

Canada

12. MAIDEN NAME OF MOTHER

Margaret Beolin

13. BIRTHPLACE OF MOTHER

(State or Country)

Canada

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

Chas. H. Wilson

(Address)

Wallace Ida

15.

Filed

May 111913F. Leo Zinger

Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

May9th1913

(Month)

(Day)

(Year)

17. I HEREBY CERTIFY, That I attended deceased from

May 81913

to

May 91913that I last saw her alive on May 9 1913and that death occurred on the date stated above, at 3:30 P.M.

The CAUSE OF DEATH* was as follows:

Cerebro-spinal meningitis

(Duration)

yrs.

mos.

For 6 ds.

Contributory

(Secondary)

(Duration)

yrs.

mos.

ds.

(Signed)

Dr. H. H. H. H. H.

(Address)

Wallace, Ida

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death

_____ yrs. _____ mos. _____ days.

In the State

_____ yrs. _____ mos. _____ days.

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

Wallace IdaMay 12 1913

20. UNDERTAKER

ADDRESS

Wards Undertaking Co Wallace Ida

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Form V. S. No. 5 20M.1-16-12

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH

Registration District No. 28

County of Shoshone

Primary Registration District No. 1011-

City of Wallace

(No. , St.)

File No. 5078

Registered No. 83

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

John Conway

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX

Male

4. COLOR OR RACE

White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED.

Divorced.
(Write the word.)

6. DATE OF BIRTH

April 5 1882
(Month) (Day) (Year)

7. AGE

61 yrs. 1 mos. 8 ds.

IF LESS than 1 day
how many hrs. or mins.?

8. OCCUPATION

(a) Trade, profession or particular kind of work

Janitor

(b) General nature of industry, business, or establishment in which employed (or employer)

Wallace Hospital.

9. BIRTHPLACE

(State or Country)

Unknown

10. NAME OF FATHER

Unknown

11. BIRTHPLACE OF FATHER

(State or Country)

Unknown

12. MAIDEN NAME OF MOTHER

Unknown

13. BIRTHPLACE OF MOTHER

(State or Country)

Unknown

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

Mrs John Selland

(Address)

Spokane Wash

15.

Filed

5/13

191

H. L. Simpson

Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

May 13 1913
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from

May 4 1913 to May 13 1913
that I last saw him alive on May 13 1913

and that death occurred on the date stated above, at 1:30 P.

The CAUSE OF DEATH* was as follows:

Pneumonia

(Duration) yrs. mos. 9 ds.

Contributory (Secondary)

Exposure

(Duration) yrs. mos. ds.

(Signed)

J. H. Jones M. D.

19

(Address)

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death 6 yrs. 10 mos. 3 days In the State 10 yrs. mos. days.

Where was disease contracted if not at place of death?

Former or usual residence Spokane Wash.

19. PLACE OF BURIAL OR REMOVAL DATE OF BURIAL

Spokane Wash 191

20. UNDERTAKER

ADDRESS

Wall Undertaking Co. Wallace Idaho

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Form V. S. No. 5 20M.1-16-12

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH

Registration District No. 28

County of Shoshone

Primary Registration District No. 1011-

City of Wallace

(No. Near Strope Ranch, Wallace St.)

File No. 5079

Registered No. 37

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Frank Berry

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX

male

4. COLOR OR RACE

white

5. SINGLE, MARRIED, WIDOWED OR DIVORCED.

single
(Write the word.)

6. DATE OF BIRTH

1 (Month) 1 (Day) 1913 (Year)

7. AGE

45 yrs. mos. ds.

IF LESS than 1 day
how many hrs. or mins.

8. OCCUPATION

(a) Trade, profession or particular kind of work

Cook's Helper

(b) General nature of industry, business, or establishment in which employed (or employer)

9. BIRTHPLACE

(State or Country)

California

10. NAME OF FATHER

11. BIRTHPLACE OF FATHER

(State or Country)

12. MAIDEN NAME OF MOTHER

13. BIRTHPLACE OF MOTHER

(State or Country)

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) O. J. Ernest

(Address) Wallace, Idaho.

15.

Filed 5/10

1913

G. Leo Jones
Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

May 10 1913
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from

191, to 191,

that I last saw h alive on 191,

and that death occurred on the date stated above, at M.

The CAUSE OF DEATH* was as follows:

Strawing

(Duration) yrs. mos. ds.

Contributory
(Secondary)

(Duration) yrs. mos. ds.

(Signed) Dr. Mowery

M. D.

5/15 1913 (Address) Wallace, Ida.

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death yrs. mos. days. In the State yrs. mos. days.

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

Wallace, Idaho.

May 16 1913

20. UNDERTAKER

ADDRESS

Brucal Mowery Wallace.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Form V. S. No. 5 20M.1-16-12

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH

Registration District No. 28

County of Shoshone

Primary Registration District No. 1011-

City of Wallace,

(No. Hope Hospital St.)

File No. 5080

Registered No. 35-

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Henry Parks.

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX

male

4. COLOR OR RACE

white

5. SINGLE, MARRIED, WIDOWED OR DIVORCED.

married
(Write the word.)

6. DATE OF BIRTH

Nov.

4

1855

(Month)

(Day)

(Year)

7. AGE

56

yrs.

6

mos.

8

ds.

IF LESS than 1 day
how many hrs. or
mins.?

8. OCCUPATION

(a) Trade, profession or
particular kind of work

miner

(b) General nature of industry
business, or establishment in
which employed (or employer)

9. BIRTHPLACE

(State or Country)

Illinois

10. NAME OF
FATHER

Meridan Parks,

11. BIRTHPLACE
OF FATHER

(State or Country)

Illinois,

12. MAIDEN NAME
OF MOTHER13. BIRTHPLACE
OF MOTHER

(State or Country)

Illinois

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

Blarene Parks

(Address)

Wace Idaho

15.

Filed

May 14

1913

H. S. Gooding

Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

May

12

1913

(Month)

(Day)

(Year)

17. I HEREBY CERTIFY, That I attended deceased from

April 30

1913

to May 12

1913

that I last saw him alive on May 12 1913

and that death occurred on the date stated above, at 11:45 P.

The CAUSE OF DEATH* was as follows:

(Duration)

yrs.

29

mos.

29

Contributory
(Secondary)

(Duration)

yrs.

7

mos.

ds.

(Signed)

M. D.

19

(Address)

Wace, Idaho

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents)

At place Hope Hospital

of death

yrs.

mos.

days

State

yrs.

mos.

days

Where was disease contracted
if not at place of death?

Grupe

Former or
usual residence

Wace, Idaho

19. PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

Spokane Wash

May 15 1913

20. UNDERTAKER

ADDRESS

Bruce G. Voster Wallace

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Form V. S. No. 5 20M.1-16-12

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics
File No. **5081**

1. PLACE OF DEATH Registration District No. **28**
County of **Shoshone** Primary Registration District No. **1011**
City of **Wallace** (No. _____ St.)

Registered No. **36**
If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

If death occurs away from usual residence, give facts called for under special information. 2. FULL NAME **Lulu Bromaghin**

PERSONAL AND STATISTICAL PARTICULARS

3. SEX **Female** 4. COLOR OR RACE **white** 5. SINGLE, MARRIED, WIDOWED OR DIVORCED **married**
(Write the word.)

6. DATE OF BIRTH _____
(Month) (Day) (Year)

7. AGE **28** yrs. **4** mos. **4** ds.
IF LESS than 1 day how many _____ hrs. or _____ mins.

8. OCCUPATION
(a) Trade, profession or particular kind of work **housewife**
(b) General nature of industry business, or establishment in which employed (or employer)

9. BIRTHPLACE
(State or Country) **Missouri**

10. NAME OF FATHER **Fred Gudd**

11. BIRTHPLACE OF FATHER
(State or Country) **Idaho**

12. MAIDEN NAME OF MOTHER **Martha Feeley**

13. BIRTHPLACE OF MOTHER
(State or Country) **Missouri**

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) **L. L. Bromaghin**
(Address) **Gen.**

15. Filed **5/20** 191**3** **H. Leo Jumper**
Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH **May 18** 191**3**
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from **May 12** 191**3**, to **May 18** 191**3**
that I last saw her alive on **May 18** 191**3**
and that death occurred on the date stated above, at **7:30 A.M.**

The CAUSE OF DEATH* was as follows:
General peritonitis
(Duration) _____ yrs. _____ mos. _____ ds.

Contributory (Secondary) _____
(Duration) _____ yrs. _____ mos. _____ ds.

(Signed) **D. H. Mowery** M. D.
5/19 191**3** (Address) **Wallace, Ida.**

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death _____ yrs. _____ mos. _____ days. In the State _____ yrs. _____ mos. _____ days.

Where was disease contracted if not at place of death? _____

Former or usual residence _____

19. PLACE OF BURIAL OR REMOVAL **Spokane** DATE OF BURIAL **5/20** 191**3**

20. UNDERTAKER **Ward Undertaking** ADDRESS **Wallace**

MARGIN RESERVED FOR BINDING
WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Form V. S. No. 5 20M.1-16-12

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH

Registration District No. 28

County of Shoshone

Primary Registration District No. 1011

City of Wallace

(No. Providence Hospital St.)

File No. 5082

Registered No. 17

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Olof Sundberg

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX

male

4. COLOR OR RACE

white

5. SINGLE, MARRIED, WIDOWED OR DIVORCED.

widowed
(Write the word.)

6. DATE OF BIRTH

Feb. 11 1852
(Month) (Day) (Year)

7. AGE

61 yrs. 3 mos. 10 ds.

IF LESS than 1 day
how many hrs. or
mins.?

8. OCCUPATION

(a) Trade, profession or particular kind of work

miner

(b) General nature of industry business, or establishment in which employed (or employer)

9. BIRTHPLACE

(State or Country)

Sweeden

10. NAME OF FATHER

Olof Olson

11. BIRTHPLACE OF FATHER

(State or Country)

Sweeden,

12. MAIDEN NAME OF MOTHER

Anna Granlund

13. BIRTHPLACE OF MOTHER

(State or Country)

Sweeden

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

Jas. W. Sundberg

(Address)

Phillipsburg, Mont,

15.

Filed

May 23

1913

F. Leo Jumper
Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

May 21 1913
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from

May 18 1913, to May 21 1913,
that I last saw him alive on May 18 1913,

and that death occurred on the date stated above, at 7 P. M.

The CAUSE OF DEATH* was as follows:

Cirrhosis of liver

(Duration) 4 yrs. 2 mos. 10 ds.

Contributory
(Secondary)

Alcoholism

(Duration) 6-5 yrs. 2 mos. 10 ds.

(Signed)

Mrs. Mowery M. D.

5/22/13. (Address) Wallace, Idaho.

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

Providence Hosp. In the
At place of death yrs. 4 mos. 4 days State yrs. 4 mos. 4 days

Where was disease contracted if not at place of death?

Former or usual residence

Mullan, Idaho

19. PLACE OF BURIAL OR REMOVAL

Mullan, Idaho.

DATE OF BURIAL

May 23 1913

20. UNDERTAKER

James J. Mott

ADDRESS

Wallace

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Form V. S. No. 5 20M.1-16-12

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics
File No. 5083
Registered No. 98

1. PLACE OF DEATH. Registration District No. 28
County of shoshone Primary Registration District No. 1811
City of Malace (No. _____ St.)
If death occurs away from usual residence, give facts called for under special information. 2. FULL NAME John O. Fosse

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX male 4. COLOR OR RACE white 5. SINGLE, MARRIED, WIDOWED OR DIVORCED. married
(Write the word.)

6. DATE OF BIRTH _____
(Month) (Day) (Year)

7. AGE 45 yrs. — mos. — ds. IF LESS than 1 day how many hrs. or mins.?

8. OCCUPATION
(a) Trade, profession or particular kind of work mill man
(b) General nature of industry, business, or establishment in which employed (or employer)

9. BIRTHPLACE
(State or Country) Norway.

10. NAME OF FATHER Ole Fosse

11. BIRTHPLACE OF FATHER
(State or Country) Norway

12. MAIDEN NAME OF MOTHER unmarried

13. BIRTHPLACE OF MOTHER
(State or Country)

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Mrs John O Fosse
(Address) Malace Ida.

15. Filed 5/25 1913 L. Leo Zimney
Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH May 22 1913
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from _____ 1913, to _____ 1913,
that I last saw him alive on May 23 1913,
and that death occurred on the date stated above, at 10:30 M.
The CAUSE OF DEATH* was as follows: acute Alcoholism

(Duration) yrs. mos. ds.
Contributory (Secondary) Chronic Alcoholism
(Signed) Ward Underlaking M. D.
Date May 26 1913 (Address) Malace Ida

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death. yrs. mos. days. In the State. yrs. mos. days.

Where was disease contracted if not at place of death? _____

Former or usual residence. _____

19. PLACE OF BURIAL OR REMOVAL Malace Ida DATE OF BURIAL 5/25 1913

20. UNDERTAKER Ward Underlaking ADDRESS Malace Ida

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Form V. S. No. 5 20M.1-16-12

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics
File No. 5084
Registered No. 99

1. PLACE OF DEATH
County of Shoshone Registration District No. 28
City of Wallace (No. _____ St.)
Primary Registration District No. 107

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME John A. Jones

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX male 4. COLOR OR RACE white 5. SINGLE, MARRIED, WIDOWED OR DIVORCED. married
(Write the word.)

6. DATE OF BIRTH
(Month) _____ (Day) 1 (Year) _____

7. AGE 36 yrs. — mos. — ds. IF LESS than 1 day how many _____ hrs. or _____ mins.

8. OCCUPATION
(a) Trade, profession or particular kind of work nurse
(b) General nature of industry, business, or establishment in which employed (or employer) _____

9. BIRTHPLACE
(State or Country) Penn.

10. NAME OF FATHER John Jones

11. BIRTHPLACE OF FATHER England
(State or Country)

12. MAIDEN NAME OF MOTHER Ema Perrell

13. BIRTHPLACE OF MOTHER England
(State or Country)

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Mrs. Sarah Jane Jones
(Address) Burke Ida

15. Filed 5/25/1913 F. L. Jones Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH
May 23 1913
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from May 22 1913 to May 23 1913 that I last saw him alive on May 23 1913 and that death occurred on the date stated above, at 8:15 A.

The CAUSE OF DEATH* was as follows:

Wrenia
(Duration) — yrs. — mos. 3 ds.

Contributory (Secondary) _____

(Duration) — yrs. — mos. — ds.
(Signed) May 25/1913 M. D.
(Address) Wallace Ida

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death. _____ yrs. _____ mos. _____ days. In the State. _____ yrs. _____ mos. _____ days.

Where was disease contracted if not at place of death? _____

Former or usual residence. _____

19. PLACE OF BURIAL OR REMOVAL Wallace Idaho DATE OF BURIAL May 26 1913

20. UNDERTAKER Wards Undertaking Co. ADDRESS Wallace Ida

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Form V. S. No. 5 20M.1-16-12

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH. Registration District No. 28
County of Shoshone Primary Registration District No. 104
City of Wallace (No. _____ St.)

File No. 5095
Registered No. 40

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Charles Henry Culver

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX male 4. COLOR OR RACE white 5. SINGLE, MARRIED, WIDOWED OR DIVORCED. married
(Write the word.)

6. DATE OF BIRTH _____
(Month) (Day) (Year)

7. AGE 74 yrs. — mos. — ds. IF LESS than 1 day how many hrs. or mins.?

8. OCCUPATION
(a) Trade, profession or particular kind of work laborer
(b) General nature of industry, business, or establishment in which employed (or employer)

9. BIRTHPLACE
(State or Country) Wisconsin

10. NAME OF FATHER Henry Culver

11. BIRTHPLACE OF FATHER
(State or Country) Maine

12. MAIDEN NAME OF MOTHER Ballard

13. BIRTHPLACE OF MOTHER
(State or Country) Vermont

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Sarah A Culver
(Address) Wallace Ida

15. Filed 5/25 1913 F. Leo Dwyer
Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH May 24 1913
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from _____ 1913, to _____ 1913,
that I last saw him alive on May 24 1913,
and that death occurred on the date stated above, at _____ M.
The CAUSE OF DEATH* was as follows:

Cerebral Hemorrhage

(Duration) _____ yrs. _____ mos. _____ ds.
Contributory (Secondary) arteriosclerosis
(Signed) Dr. Snowsdy M. D.
5/25/13 (Address) Wallace Ida

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death _____ yrs. _____ mos. _____ days. In the State _____ yrs. _____ mos. _____ days.
Where was disease contracted if not at place of death? _____
Former or usual residence _____

19. PLACE OF BURIAL OR REMOVAL Wallace DATE OF BURIAL 5/25 1913

20. UNDERTAKER Wards Undertaking Co ADDRESS Wallace Ida

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Form V. S. No. 5 20M.1-16-12

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH

Registration District No. 28

County of Shoshone

Primary Registration District No. 1071

City of Wallace

(No. 424, Bank St., St.)

File No. 5086

Registered No. 41

If death occurs away from usual residence, give facts called for under special information.

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME John B. Fenstermaker,

PERSONAL AND STATISTICAL PARTICULARS

3. SEX

male

4. COLOR OR RACE

white

5. SINGLE, MARRIED, WIDOWED OR DIVORCED.

married

(Write the word.)

6. DATE OF BIRTH

Nov.

(Month)

1862.

(Day)

(Year)

7. AGE

50 yrs. 6 mos. ds.

IF LESS than 1 day
how many hrs. or
mins.?

8. OCCUPATION

(a) Trade, profession or particular kind of work

farmer

(b) General nature of industry business, or establishment in which employed (or employer)

9. BIRTHPLACE

(State or Country)

Illinois

10. NAME OF FATHER

John Fenstermaker

11. BIRTHPLACE OF FATHER

(State or Country)

Pennsylvania,

12. MAIDEN NAME OF MOTHER

M. J. Sykes

13. BIRTHPLACE OF MOTHER

(State or Country)

Ohio

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

(Address) Opportunity, Washington.

15.

Filed

5/30

1913

F. Leo Murphy
Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

May

28

1913

(Month)

(Day)

(Year)

17. I HEREBY CERTIFY, That I attended deceased from

May 24, 1913, to May 28, 1913

that I last saw him alive on May 28, 1913

and that death occurred on the date stated above, at 12:45 P.M.

The CAUSE OF DEATH* was as follows:

Hypertrophy of
the Stomach

(Duration)

yrs.

mos.

ds.

Contributory
(Secondary)

(Duration)

yrs.

mos.

ds.

(Signed)

Mrs. Mowbray M. D.

5/30 1913. (Address) Wallace, Idaho,

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place

of death

yrs.

mos.

In the

State

yrs.

mos.

days.

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

Wallace, Idaho

May 31, 1913

20. UNDERTAKER

ADDRESS

Bruce & Norton Wallace, Ida.

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Form V. S. No. 5 20M.1-16-12

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics
File No. **5087**

1. PLACE OF DEATH. Registration District No. **28**
County of **Shoshone** Primary Registration District No. **171**
City of **Wallace** (No. _____ St.)

Registered No. **42**
If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME **Philip Goggin**

PERSONAL AND STATISTICAL PARTICULARS

3. SEX **male** 4. COLOR OR RACE **white** 5. SINGLE, MARRIED, WIDOWED OR DIVORCED. **single**
(Write the word.)

6. DATE OF BIRTH _____
(Month) (Day) (Year)

7. AGE **5** yrs. _____ mos. _____ ds.
IF LESS than 1 day how many _____ hrs. or _____ mins.?

8. OCCUPATION
(a) Trade, profession or particular kind of work **none**
(b) General nature of industry, business, or establishment in which employed (or employer)

9. BIRTHPLACE
(State or Country) **Idaho**

10. NAME OF FATHER **Michael Goggin**

11. BIRTHPLACE OF FATHER **Michigan**
(State or Country)

12. MAIDEN NAME OF MOTHER **Mary Kelly**

13. BIRTHPLACE OF MOTHER **Ireland**
(State or Country)

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) **Michael Goggin**
(Address) **Black Bear Idaho**

15. Filed **57 31/** 191**3** **H. Leo Zimble**
Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH **May 29** 191**3**
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from **May 26** 191**3** to **May 29** 191**3**, that I last saw him alive on **May 29** 191**3**, and that death occurred on the date stated above, at **7 P.** M. The CAUSE OF DEATH* was as follows:
Broncho Pneumonia

(Duration) _____ yrs. _____ mos. **10** ds.
Contributory **Measles**
(Secondary)

(Duration) _____ yrs. _____ mos. _____ ds.
(Signed) **W. T. Dink** M. D.
5-31-13 (Address) **Wallace Idaho**

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death _____ yrs. _____ mos. _____ days. In the State _____ yrs. _____ mos. _____ days.

Where was disease contracted if not at place of death? _____

Former or usual residence _____

19. PLACE OF BURIAL OR REMOVAL **Wards Undertaking Co** DATE OF BURIAL **5/31-** 191**3**

20. UNDERTAKER **Wallace**
ADDRESS

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Form V. S. No. 5. 12½M.7-24-11

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics
File No. 5088
Registered No. 38

1. PLACE OF DEATH.
County of Bingham
City of Blackfoot

Registration District No. 13
Primary Registration District No. 2053
(No. Country St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

Golden Benson Wright

If death occurred in a hospital, institution or camp give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX Male 4. COLOR OR RACE White 5. SINGLE, MARRIED, WIDOWED OR DIVORCED.
(Write the word.)

6. DATE OF BIRTH March 1 1913
(Month) (Day) (Year)

7. AGE me 1 yrs. 1 mos. 7 ds. IF LESS than 1 day how many 1 hrs. or 1 min?

8. OCCUPATION
(a) Trade, profession or particular kind of work
(b) General nature of industry business or establishment in which employed (or employer)

9. BIRTHPLACE Blackfoot Bingham Co Ida
(State or Country)

10. NAME OF FATHER Joseph Smith Wright

11. BIRTHPLACE OF FATHER Franklin Ida
(State or Country)

12. MAIDEN NAME OF MOTHER Mauda Monson

13. BIRTHPLACE OF MOTHER Richmond Utah
(State or Country)

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) J. S. Wright
(Address) Blackfoot

15. M. E. Patric
Filed Apr 2 3 1913 Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH Apr 2 1913
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from Mar 31 1913, to Apr 2 1913, that I last saw him alive on Apr 2 1913, and that death occurred on the date stated above, at 9 30 AM

The CAUSE OF DEATH* was as follows:

infantile Rubeolosis

(Duration) 3 yrs. 3 mos. 3 ds.

Contributory (Secondary)

(Duration) 3 yrs. 3 mos. 3 ds.
(Signed) John B. Chapin M. D.
Apr 2 1913 (Address) Blackfoot

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death 3 yrs. 3 mos. 3 ds. In the State 3 yrs. 3 mos. 3 ds.
Where was disease contracted, If not at place of death?
Former or usual residence.

19. PLACE OF BURIAL OR REMOVAL DATE OF BURIAL

Grum City Cem. Apr 2 1913
20. UNDERTAKER ADDRESS
E. J. Burk Blackfoot

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Form V. S. No. 5. 12½ M. 7-24-11

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics
File No. 5089
Registered No. 279

1. PLACE OF DEATH. Registration District No. 13
County of Bingham Primary Registration District No. 2053
City of Moreland Ward (No. , St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Nora May Roy

If death occurred in a hospital, institution or camp give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX Female 4. COLOR OR RACE White 5. SINGLE, MARRIED, WIDOWED OR DIVORCED. 5
(Write the word.)

6. DATE OF BIRTH Mch 6 1913
(Month) (Day) (Year)

7. AGE yrs. 24 ds. IF LESS than 1 day how many hrs. or min?

8. OCCUPATION
(a) Trade, profession or particular kind of work.
(b) General nature of industry business or establishment in which employed (or employer)

9. BIRTHPLACE (State or Country) Bingham Co. Ida

10. NAME OF FATHER

11. BIRTHPLACE OF FATHER Frank Edwin Roy Okla
(State or Country)

12. MAIDEN NAME OF MOTHER Clara Elsie Parbath

13. BIRTHPLACE OF MOTHER Ida.
(State or Country)

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Frank Roy
(Address)

15. Apr 3 1913 M. E. Petrie
Filed Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH 17 April 3 1913
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from 191 to 191

that I last saw him alive on 191 and that death occurred on the date stated above, at 5 M.

The CAUSE OF DEATH* was as follows:
Broncho-pneumonia

(Duration) yrs. 3 mos. ds.

Contributory (Secondary)

(Signed) M. E. Petrie M. D.
4-3 1913 (Address) Blackfoot

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place In the
of death yrs. mos. ds. State yrs. mos. ds.
Where was disease contracted,
If not at place of death?
Former or
usual residence.

19. PLACE OF BURIAL OR REMOVAL DATE OF BURIAL
Moreland Ida. 4-3 1913

20. UNDERTAKER ADDRESS
Frank Roy Blackfoot

R. F. D. No 4

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Form V. S. No. 5. 12½ M. 7-24-11

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics
File No. 5090
Registered No. 40

1. PLACE OF DEATH. Registration District No. 13
County of Bingham Primary Registration District No. 2053
City of Montland (No. _____, _____ St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

Millie May Anderson

If death occurred in a hospital, institution or camp give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX Female 4. COLOR OR RACE White 5. SINGLE, MARRIED, WIDOWED OR DIVORCED. Married
(Write the word.)

6. DATE OF BIRTH Feb 20 1874
(Month) (Day) (Year)

7. AGE 39 yrs. 1 mos. 13 ds. IF LESS than 1 day how many hrs. or min?

8. OCCUPATION

(a) Trade, profession or particular kind of work
(b) General nature of industry business or establishment in which employed (or employer)

Housewife

9. BIRTHPLACE

(State or Country)

Kansas

10. NAME OF FATHER

Josiah Neal

11. BIRTHPLACE OF FATHER

(State or Country)

?

12. MAIDEN NAME OF MOTHER

Mary Ann Baird

13. BIRTHPLACE OF MOTHER

(State or Country)

?

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Ernest Anderson
(Address) _____

15. Filed Apr 4 1913
Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH April 3 1913
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from Mar 27 1913, to Apr 3 1913 that I last saw her alive on Apr 3 1913 and that death occurred on the date stated above, at 11:30 M.

The CAUSE OF DEATH* was as follows:

Puerperal Pyrexia
Hemorrhage

(Duration) yrs. 23 mos. ds.
Contributory (Secondary) Pregnancy (labor)

(Duration) yrs. 9 mos. ds.
(Signed) M. E. Purdie M. D.
Apr 4 1913 (Address) Blackfoot

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place In the
of death yrs. mos. ds. State yrs. mos. ds.
Where was disease contracted,
If not at place of death?
Former or
usual residence.....

19. PLACE OF BURIAL OR REMOVAL DATE OF BURIAL
Montland, Idaho Apr 6 1913

20. UNDERTAKER ADDRESS
Ernest Anderson Blackfoot, Idaho

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. N. B.—Every item of information should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Form V. S. No. 5. 12½M.7-24-11

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics
File No. 5091
Registered No. 41

1. PLACE OF DEATH. Registration District No. 13
County of Blaine Primary Registration District No. 2053
City of Moulton (No. _____ St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

Freda Charlotte Williams
If death occurred in a hospital, institution or camp give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX Female 4. COLOR OR RACE White 5. SINGLE, MARRIED, WIDOWED OR DIVORCED Married
(Write the word.)

6. DATE OF BIRTH Feb. 12 1874
(Month) (Day) (Year)

7. AGE 39 yrs. 1 mos. 27 ds.
IF LESS than 1 day how many hrs. or min?

8. OCCUPATION

(a) Trade, profession or particular kind of work.

(b) General nature of industry business or establishment in which employed (or employer)

Housewife

9. BIRTHPLACE

(State or Country)

Sweden

10. NAME OF FATHER

Carl A. Anderson

11. BIRTHPLACE OF FATHER

(State or Country)

Sweden

12. MAIDEN NAME OF MOTHER

Charlotte Anderson

13. BIRTHPLACE OF MOTHER

(State or Country)

Sweden

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

Joseph Williams

(Address)

Blaine R.F.D. #4

15.

Filed

Apr 10 1913

W.E. Patric

Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH

April 9 1913
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from April 7 1913, to April 9 1913

that I last saw her alive on April 7 1913 and that death occurred on the date stated above, at 6:30 PM

The CAUSE OF DEATH* was as follows:

Pneumo-Pneumonia

..... (Duration) yrs. mos. ds.

Contributory (Secondary)

Valvular disease heart
mitral

..... (Duration) yrs. mos. ds.

(Signed) W.E. Patric M. D.

..... 19..... (Address)

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place yrs. mos. ds. In the

of death yrs. mos. ds. State yrs. mos. ds.

Where was disease contracted, If not at place of death?

Former or usual residence yrs. mos. ds.

19. PLACE OF BURIAL OR REMOVAL DATE OF BURIAL

Moulton Idaho Apr 12 1913

20. UNDERTAKER ADDRESS

Joseph Williams

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Form V. S. No. 5. 10M. 6-20-11.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

File No. 5092

Registered No. 42

If death occurred in a hospital, institution or camp give its NAME instead of street and number.

1. PLACE OF DEATH.

County of *Bingham*City of *Blackfoot*

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

Registration District No. *13*Primary Registration District No. *2053*(No. *Blackfoot Bingham* St.)*Anna W. C. Harrison*

PERSONAL AND STATISTICAL PARTICULARS

3. SEX

Female

4. COLOR OR RACE

White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED.

Married
(Write the word.)

6. DATE OF BIRTH

1872
(Month) (Day) (Year)

7. AGE

48 yrs. *4* mos. *4* ds.

IF LESS than 1 day
how many hrs. or
..... min.?

8. OCCUPATION

(a) Trade, profession, or particular kind of work

(b) General nature of industry business, or establishment in which employed (or employer)

Housewife

9. BIRTHPLACE

(State or Country)

Idaho

10. NAME OF FATHER

J. M. Brunzell

11. BIRTHPLACE OF FATHER

(State or Country)

12. MAIDEN NAME OF MOTHER

13. BIRTHPLACE OF MOTHER

(State or Country)

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

Francis H. Poole
(Address) *Blackfoot, Idaho.*

15.

Filed *Apr 12 1913**W. E. Putz*

Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

April *11* *1913*
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from

Sept. 27 *1912*, to *Apr. 11* *1913*

that I last saw her alive on *Apr. 11* *1913*,

and that death occurred on the date stated above, at *5 P.* M.

The CAUSE OF DEATH* was as follows:

Peritonitis

(Duration) yrs. mos. *5* ds.

Contributory (Secondary)

Ruptured appendix

(Duration) yrs. mos. ds.

(Signed) *Francis H. Poole* M. D.

Apr. 12 1913 (Address) *Blackfoot*

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL,

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death yrs. *6* mos. *15* ds. State *40* yrs. mos. ds.

Where was Disease contracted, If not at place of death? *Nampa, Idaho*

Former or usual residence *Nampa, Idaho*

19. PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

*Nampa Idaho**1913*

20. UNDERTAKER

ADDRESS

*E. J. Ruck**Blackfoot*

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Form V. S. No. 5. 12½ M. 7-24-11

CERTIFICATE OF DEATH

1. PLACE OF DEATH. Registration District No. 13
 County of Bingham Primary Registration District No. 1007
 City of Blackfoot (No. 530, E. Bridge St.)

State of Idaho
 BOARD OF HEALTH
 Bureau of Vital Statistics
 File No. 5093
 Registered No. 43

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Herbert Whitcomb

If death occurred in a hospital, institution or camp give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX Male 4. COLOR OR RACE White 5. SINGLE, MARRIED, WIDOWED OR DIVORCED. Married
 (Write the word.)

6. DATE OF BIRTH June 17 1880
 (Month) (Day) (Year)

7. AGE 62 yrs. 9 mos. 26 ds. IF LESS than 1 day how many hrs. or min?

8. OCCUPATION
 (a) Trade, profession or particular kind of work. Laborer
 (b) General nature of industry business or establishment in which employed (or employer)

9. BIRTHPLACE (State or Country) Main

10. NAME OF FATHER Herbert Whitcomb

11. BIRTHPLACE OF FATHER (State or Country) ?

12. MAIDEN NAME OF MOTHER ?

13. BIRTHPLACE OF MOTHER (State or Country) ?

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Jesse Whitcomb
 (Address) 117 So. 1st Blackfoot

15. Filed Apr 14 1913 M. E. Purie
 Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH 4 13 1913
 (Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from Feb 3 1913 to Apr 13 1913
 that I last saw him alive on Apr 12 1913
 and that death occurred on the date stated above, at 6:30 PM.

The CAUSE OF DEATH* was as follows:

General Septicaemia
 (Duration) yrs. 14 mos. 14 ds.
 Contributory (Secondary) Arterial Sclerosis with Senile Gangrene
 (Duration) yrs. 3 mos. 3 ds.
 (Signed) Dr. H. H. Rogers M. D.
Apr 14 1913 (Address) Blackfoot, Ida

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place In the
 of death.....yrs.....mos.....ds. State.....yrs.....mos.....ds.
 Where was disease contracted,
 If not at place of death?
 Former or usual residence.....

19. PLACE OF BURIAL OR REMOVAL DATE OF BURIAL
Union City Cem. Blackfoot Apr 14 1913
 20. UNDERTAKER ADDRESS
E. J. Puck Blackfoot

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Form V. S. No. 5. 12½ M. 7-24-11

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics
File No. 5094
Registered No. 44

1. PLACE OF DEATH. Registration District No. 13
County of Blaine Primary Registration District No. 1007
City of Blackfoot (No. No. E. Main & Monroe St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Helma Celeste Watson

If death occurred in a hospital, institution or camp give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX Female 4. COLOR OR RACE White 5. SINGLE, MARRIED, WIDOWED OR DIVORCED. Single
(Write the word.)

6. DATE OF BIRTH Sept 28 1913
(Month) (Day) (Year)

7. AGE 1 yrs. 6 mos. 18 ds. IF LESS than 1 day how many.....hrs. or min?

8. OCCUPATION
(a) Trade, profession or particular kind of work.
(b) General nature of industry business or establishment in which employed (or employer)

9. BIRTHPLACE Idaho
(State or Country)

10. NAME OF FATHER Francis J. Watson

11. BIRTHPLACE OF FATHER Utah
(State or Country)

12. MAIDEN NAME OF MOTHER Rose A. Lundquist

13. BIRTHPLACE OF MOTHER Utah
(State or Country)

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Francis J. Watson
(Address) Blackfoot Idaho

15. File Apr 16 1913 M. E. Patric Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH April 16 1913
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from April 16 1913, to April 16 1913 that I last saw her alive on Apr 16 1913 and that death occurred on the date stated above, at 3 P. M.

The CAUSE OF DEATH* was as follows:

Pneumonia
(Duration) yrs. mos. 20 ds.

Contributory (Secondary)
(Duration) yrs. mos. ds.
(Signed) M. E. Patric M. D.
Apr 16 1913 (Address) Blackfoot

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place In the
of death..... yrs. mos. ds. State..... yrs. mos. ds.
Where was disease contracted,
If not at place of death?
Former or
usual residence.....

19. PLACE OF BURIAL OR REMOVAL DATE OF BURIAL
Long City Cem Blackfoot Apr 18 1913

20. UNDERTAKER ADDRESS
Francis J. Watson Blackfoot

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Form V. S. No. 5. 12½ M. 7-24-11

CE

1. PLACE OF DEATH Registration District No. 13
County of Buchanan Primary Registration District No. 1007
City of Blackfoot (No. 210 N. Bridge St.)
Bureau of Vital Statistics
File No. 5095
Registered No. 45

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

Montgomery (unnamed)

If death occurred in a hospital, institution or camp give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX F 4. COLOR OR RACE W 5. SINGLE, MARRIED, WIDOWED OR DIVORCED Single
6. DATE OF BIRTH April 5 1913
(Month) (Day) (Year)

7. AGE 11 yrs. 11 mos. 11 ds. IF LESS than 1 day how many 7 hrs. or 7 min?

8. OCCUPATION

- (a) Trade, profession or particular kind of work.
(b) General nature of industry business or establishment in which employed (or employer)

9. BIRTHPLACE Blackfoot Ida
(State or Country)

10. NAME OF FATHER Harry Montgomery

11. BIRTHPLACE OF FATHER Kansas
(State or Country)

12. MAIDEN NAME OF MOTHER Jillie Hilliard

13. BIRTHPLACE OF MOTHER Iowa
(State or Country)

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) J. B. Davis
(Address) Blackfoot Ida

15. Filed April 17 1913

W. E. Patric
Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH April 16 1913
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from Apr 15 1913, to Apr 16 1913
that I last saw her alive on April 16 1913
and that death occurred on the date stated above, at 9 A. M.
The CAUSE OF DEATH* was as follows:

Pneumonia

(Duration) 11 yrs. 11 mos. 11 ds.

Contributory (Secondary) J. B. Davis M. D.

(Signed) J. B. Davis M. D.
Apr 16 1913 (Address) Blackfoot Ida

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death 11 yrs. 11 mos. 11 ds. State 11 yrs. 11 mos. 11 ds.
Where was disease contracted?
If not at place of death?
Former or usual residence.

19. PLACE OF BURIAL OR REMOVAL DATE OF BURIAL

Gravelly Cem. Blackfoot April 16 1913

20. UNDERTAKER ADDRESS

G. J. Park Blackfoot

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Form V. S. No. 5 20M.1-16-12

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics
File No. 5096
Registered No. 46

1. PLACE OF DEATH.

Registration District No. 13

County of Benjamin

Primary Registration District No. 1007

City of Blackfoot

(No. 353, South University St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Benjamin Benjamin Deeter

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX

Male

4. COLOR OR RACE

White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED.

Divorced
(Write the word.)

6. DATE OF BIRTH

act
17
(Month)

3
17
(Day)

1864
1
(Year)

7. AGE

46 yrs. 6 mos. 14 ds.

IF LESS than 1 day
how many hrs. or
mins.?

8. OCCUPATION

(a) Trade, profession or particular kind of work

Farmer

(b) General nature of industry business, or establishment in which employed (or employer)

9. BIRTHPLACE

(State or Country)

Pikes Del.

10. NAME OF FATHER

11. BIRTHPLACE OF FATHER

(State or Country)

12. MAIDEN NAME OF MOTHER

13. BIRTHPLACE OF MOTHER

(State or Country)

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

Percy E. Deeter

(Address)

Blackfoot Del.

15.

Filed

April 19 1913

M. E. Patie

Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

4
(Month)

17
(Day)

1913
(Year)

17. I HEREBY CERTIFY, That I attended deceased from

Apr 15 1913, to Apr 17 1913,

that I last saw him alive on Apr 17 1913,

and that death occurred on the date stated above, at 2 P.M.

The CAUSE OF DEATH* was as follows:

Pneumonia following
Pleurisy

(Duration)

yrs. 4

mos.

ds.

Contributory
(Secondary)

Pleurisy

(Duration)

yrs. 4

mos.

ds.

(Signed)

Percy E. Deeter

M. D.

4/18 1913 (Address) Blackfoot, Del.

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place

of death yrs. mos. days.

In the

State yrs. mos. days.

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

Buried in

April 21 1913

20. UNDERTAKER

E. J. Beck

ADDRESS

Blackfoot.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Form V. S. No. 5. 10M. 6-20-11.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH.

Registration District No. 13County of BinghamPrimary Registration District No. 2053City of Blackfoot(No. Idaho Bureau of Vital Statistics)File No. 5087Registered No. 47

If death occurred in a hospital, institution or camp give its NAME instead of street and number.

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

Clara Merrill

PERSONAL AND STATISTICAL PARTICULARS

3. SEX

Male

4. COLOR OR RACE

White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED.

Married
(Write the word.)

6. DATE OF BIRTH

July181881

(Month)

(Day)

(Year)

7. AGE

32

yrs.

mos.

ds.

IF LESS than 1 day
how many hrs. or
..... min.?

8. OCCUPATION

(a) Trade, profession, or particular kind of work

Laborer

(b) General nature of industry, business, or establishment in which employed (or employer)

9. BIRTHPLACE

(State or Country)

Utah

10. NAME OF FATHER

?

11. BIRTHPLACE OF FATHER

(State or Country)

?

12. MAIDEN NAME OF MOTHER

?

13. BIRTHPLACE OF MOTHER

(State or Country)

?

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

(Address)

Blackfoot, Ida.

15.

Filed

Apr 20 1913W. E. Patrick

Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

April181913

(Month)

(Day)

(Year)

17. I HEREBY CERTIFY, That I attended deceased from

Feb. 171913

to

Apr. 181913that I last saw him alive on Apr. 18 1913and that death occurred on the date stated above, at 1:30 P. M.

The CAUSE OF DEATH* was as follows:

Exhaustion due to continued mania(Duration) yrs. 2 mos. ds.Contributory
(Secondary)

(Duration) yrs. mos. ds.

(Signed) Francis H. Poole M. D.

19 (Address)

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL,

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place

In the

of death yrs. 2 mos. ds. State yrs. mos. ds.

Where was Disease contracted,

If not at place of death? Idaho Falls, Ida.

Former or

usual residence " " "

19. PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

Asylum CemeteryApr. 20 1913

20. UNDERTAKER

ADDRESS

D. J. H. PooleBlackfoot

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Form V. S. No. 5. 12½ M. 7-24-11

CERTIFICATE OF DEATH

1. PLACE OF DEATH.
County of Bingham
City of Aberdeen

Registration District No. 13
Primary Registration District No. 2028
(No. _____, St.)

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics
File No. 5098
Registered No. 48

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Delos Andrew Dodge

If death occurred in a hospital, institution or camp give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX male 4. COLOR OR RACE white 5. SINGLE, MARRIED, WIDOWED OR DIVORCED. single
(Write the word.)
6. DATE OF BIRTH Jan. 2 1913
(Month) (Day) (Year)

7. AGE _____ yrs. _____ mos. 106 ds. IF LESS than 1 day
how many _____ hrs. or _____ min?

8. OCCUPATION
(a) Trade, profession or particular kind of work _____
(b) General nature of industry business or establishment in which employed (or employer) _____

9. BIRTHPLACE
(State or Country) Michigan

10. NAME OF FATHER George Dodge

11. BIRTHPLACE OF FATHER
(State or Country) Michigan

12. MAIDEN NAME OF MOTHER Julia Holmberg

13. BIRTHPLACE OF MOTHER
(State or Country) Sweden

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Geo. A. Dodge
(Address) Aberdeen Ida

15. Filed ap 20 1913 McCrackin
Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH april 18 1913
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from ap 7 1913, to ap 18 1913
that I last saw him alive on ap 18 1913
and that death occurred on the date stated above, at 10 P.M.

The CAUSE OF DEATH* was as follows:

Hydrocephalus

(Duration) _____ yrs. _____ mos. 106 ds.

Contributory (Secondary) _____

(Duration) _____ yrs. _____ mos. _____ ds.

(Signed) McCrackin M. D.
ap 20 1913 (Address) Aberdeen Ida

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place _____ In the _____
of death _____ yrs. _____ mos. _____ ds. State _____ yrs. _____ mos. _____ ds.
Where was disease contracted, _____
If not at place of death? _____
Former or _____
usual residence _____

19. PLACE OF BURIAL OR REMOVAL DATE OF BURIAL
Mountain Cemetery ap 20 1913

20. UNDERTAKER ADDRESS
Geo. Dodge Aberdeen

WRITE FULLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Form V. S. No. 5. 12½ M. 7-24-11

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics
File No. 5099
Registered No. 49

1. PLACE OF DEATH Registration District No. 13
County of Bingham Primary Registration District No. 2053
City of Thomas Ward (No. _____ St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Phoebe Maus Stander

If death occurred in a hospital, institution or camp give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX Female 4. COLOR OR RACE White 5. SINGLE, MARRIED, WIDOWED OR DIVORCED. W
(Write the word.)

6. DATE OF BIRTH Oct 6th 1908
(Month) (Day) (Year)

7. AGE 4 yrs. 6 mos. 16 ds. IF LESS than 1 day how many _____ hrs. or _____ min?

8. OCCUPATION
(a) Trade, profession or particular kind of work. _____
(b) General nature of industry business or establishment in which employed (or employer) _____

9. BIRTHPLACE Idaho
(State or Country)

10. NAME OF FATHER John H. Stander

11. BIRTHPLACE OF FATHER Utah
(State or Country)

12. MAIDEN NAME OF MOTHER Katherine R. Adams

13. BIRTHPLACE OF MOTHER Utah
(State or Country)

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) John H. Stander
(Address) Blackfoot 270 #2

15. April 22 1913 W. E. Patie
Filed _____ Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH April 22nd 1913
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from April 21 1913, to April 22 1913
that I last saw him alive on April 21 1913
and that death occurred on the date stated above, at 10 M.
The CAUSE OF DEATH* was as follows:

Pneumonia - lobar
9 measles
(Duration) _____ yrs. _____ mos. 1 ds.

Contributory (Secondary) Measles
(Duration) _____ yrs. _____ mos. 2 ds.
(Signed) W. E. Patie M. D.
4-22 1913 (Address) Blackfoot

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place _____ In the _____
of death _____ yrs. _____ mos. _____ ds. State _____ yrs. _____ mos. _____ ds.
Where was disease contracted, _____
If not at place of death? _____
Former or _____
usual residence. _____

19. PLACE OF BURIAL OR REMOVAL Presbyterian Thomas Cem. DATE OF BURIAL 4-22 1913

20. UNDERTAKER John H. Stander ADDRESS Blackfoot.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics
51001. PLACE OF DEATH.
County of Bingham
City of BlackfootRegistration District No. 13
Primary Registration District No. 1007
(No. 93, So. aan St.)File No. 50
Registered No. 50

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

Unnamed Lindsay

If death occurred in a hospital, institution or camp give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX Male 4. COLOR OR RACE White 5. SINGLE, MARRIED, WIDOWED OR DIVORCED. Single
(Write the word.)6. DATE OF BIRTH April 19 1913
(Month) (Day) (Year)7. AGE 51 yrs. mos. ds. IF LESS than 1 day how many hrs. or min?

8. OCCUPATION

(a) Trade, profession or particular kind of work.
(b) General nature of industry business or establishment in which employed (or employer)9. BIRTHPLACE Blackfoot Idaho
(State or Country)10. NAME OF FATHER Wm T Lindsay11. BIRTHPLACE OF FATHER Idaho
(State or Country)12. MAIDEN NAME OF MOTHER Thelma R. Gray13. BIRTHPLACE OF MOTHER Australia
(State or Country)14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) William T Lindsay
(Address) Blackfoot Idaho15. Apr 24 1913 W T Lindsay
File No. 1913 Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH April 24 1913
(Month) (Day) (Year)17. I HEREBY CERTIFY, That I attended deceased from April 19 1913 to Apr 24 1913
that I last saw her alive on Apr 24 1913
and that death occurred on the date stated above, at 10:00 M.

The CAUSE OF DEATH* was as follows:

Diphtheria neonatorum(Duration) yrs. mos. ds. 51Contributory
(Secondary)(Signed) W T Lindsay M. D.
4-24-13 (Address) Blackfoot

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death yrs. mos. ds. State yrs. mos. ds.
Where was disease contracted,
If not at place of death?
Former or usual residence.19. PLACE OF BURIAL OR REMOVAL Mountain Idaho DATE OF BURIAL 4-25 191320. UNDERTAKER William T Lindsay ADDRESS Blackfoot

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Form V. S. No. 5 20M.1-16-12

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH.

Registration District No. 13

County of Bench

Primary Registration District No. 1007

City of Blackfoot

(No. 689, East, Bridge St.)

File No. 5101

Registered No. 51

If death occurs away from usual residence, give facts calling for under special information.

2. FULL NAME

Jessie C Griffin

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX

4. COLOR OR RACE

5. SINGLE, MARRIED, WIDOWED OR DIVORCED.
widowed
(Write the word.)

White

6. DATE OF BIRTH

May 5 1828
(Month) (Day) (Year)

7. AGE

84 yrs. 11 mos. 20 ds.

IF LESS than 1 day
how many hrs. or
..... mins.?

8. OCCUPATION

(a) Trade, profession or particular kind of work
(b) General nature of industry, business, or establishment in which employed (or employer)

House wife

9. BIRTHPLACE

(State or Country)

Ind.

10. NAME OF FATHER

Benny Blair

11. BIRTHPLACE OF FATHER

(State or Country)

Vir.

12. MAIDEN NAME OF MOTHER

Elma Johnson

13. BIRTHPLACE OF MOTHER

(State or Country)

Vir.

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Mrs. Jessie Brown

(Address)

15.

Filed Apr 30 1913

W. E. Latie
Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH

April 29 1913
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from Investigated death
191, to 191, that I last saw h. alive on 191.

and that death occurred on the date stated above, at 6 P. M.

The CAUSE OF DEATH* was as follows:

No apparent cause of death
in bed 6 months

(Duration) yrs. mos. ds.

Contributory
(Secondary)

(Duration) yrs. mos. ds.

(Signed) W. E. Latie M. D.

5-1 1913 (Address) Blackfoot

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death yrs. mos. days. In the State yrs. mos. days.

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL | DATE OF BURIAL

Home city, Cam Blackfoot 5-2 1913

20. UNDERTAKER

ADDRESS

E. J. Luck Blackfoot

Form V. S. No. 5 20M.1-16-12

CERTIFICATE OF DEATH

1. PLACE OF DEATH.

Registration District No. 13County of BinghamPrimary Registration District No. 2053City of Blackfoot

(No. _____)

St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Wilbert O. ReddickState of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics
File No. 5102Registered No. 52

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX

4. COLOR OR RACE

5. SINGLE, MARRIED, WID-
OWED OR DIVORCED.MaleWhiteSingle
(Write the word.)

6. DATE OF BIRTH

JulyCan't say131888

(Month)

(Day)

(Year)

7. AGE

24

yrs.

mos.

ds.

IF LESS than 1 day
how many hrs. or
..... mins.?

8. OCCUPATION

(a) Trade, profession or
particular kind of workFarm Laborer(b) General nature of industry
business, or establishment in
which employed (or employer)

9. BIRTHPLACE

(State or Country)

Indiana, U.S.A10. NAME OF
FATHERJohn B. Reddick11. BIRTHPLACE
OF FATHER

(State or Country)

? Indiana12. MAIDEN NAME
OF MOTHER?13. BIRTHPLACE
OF MOTHER

(State or Country)

?

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

B. F. Reddick

(Address)

Blackfoot Ida.

15.

Filed

Apr. 31, 1913W. E. Patric

Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH

4
(Month)30
(Day)1913
(Year)

17. I HEREBY CERTIFY, That I attended deceased from

Apr 28 1913, to Apr 30 1913,that I last saw him alive on Apr 30 1913,and that death occurred on the date stated above, at 7:30 P.M.

The CAUSE OF DEATH* was as follows:

Spinal
Cerebro, meningitis(Duration) yrs. mos. 24 ds.Contributory
(Secondary)

(Duration) yrs. mos. ds.

(Signed) E. J. Glumond M. D.5/2 1913 (Address) Blackfoot, Ida.

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death yrs. mos. days. In the State yrs. mos. days.

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

E. J. Glumond1913

20. UNDERTAKER

ADDRESS

E. J. PuckBlackfoot

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Form V. S. No. 5 20M.1-16-12

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH. Registration District No. 13
County of Bingham Primary Registration District No. 2053
City of Blackfoot (No. 1, St.)

File No. 5103
Registered No. 53

If death occurs away from usual residence, give facts called for under special information.

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX Male 4. COLOR OR RACE white 5. SINGLE, MARRIED, WIDOWED OR DIVORCED. Single
(Write the word.)

6. DATE OF BIRTH Jul 31 1888
(Month) (Day) (Year)

7. AGE 14 yrs. 9 mos. ds.
IF LESS than 1 day how many hrs. or mins.?

8. OCCUPATION

(a) Trade, profession or particular kind of work In school
(b) General nature of industry business, or establishment in which employed (or employer)

9. BIRTHPLACE

(State or Country) Utah

10. NAME OF FATHER

Bartholomew Combe

11. BIRTHPLACE OF FATHER

(State or Country) Idaho

12. MAIDEN NAME OF MOTHER

13. BIRTHPLACE OF MOTHER

(State or Country)

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Bartholomew Combe

(Address) Blackfoot Idaho

15.

Filed May 1 1913 W. E. Patric
Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH

May 1 1913
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from Apr 26 1913, to May 1 1913,

that I last saw him alive on May 1 1913

and that death occurred on the date stated above, at 11:30 A.M.

The CAUSE OF DEATH* was as follows:

Appendicitis

(Duration) yrs. mos. 5 ds.

Contributory
(Secondary)

(Duration) yrs. mos. ds.

(Signed) F. W. Mitchell M. D.

7/1 1913 (Address) Blackfoot, Idaho

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death.....yrs.....mos.....days. In the State.....yrs.....mos.....ds.

Where was disease contracted if not at place of death?

Former or usual residence.....

19. PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

area Idaho

19

20. UNDERTAKER

ADDRESS

E. J. Park

Blackfoot

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Form V. S. No. 5 20M.1-16-12

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH.

Registration District No. 13County of BinghamPrimary Registration District No. 2053City of Blackfoot (No. _____ St.)File No. 5104Registered No. 54

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME.

Erma Opal Peterson

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX

Female

4. COLOR OR RACE

white

5. SINGLE, MARRIED, WIDOWED OR DIVORCED.

Single
(Write the word.)

6. DATE OF BIRTH

Dec

(Month)

(Day)

1913
(Year)

7. AGE

2 yrs. 6 mos. 15 ds.IF LESS than 1 day
how many hr. or
..... min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work

(b) General nature of industry, business, or establishment in which employed (or employer)

9. BIRTHPLACE

(State or Country)

Idaho

10. NAME OF FATHER

Basal Peterson

11. BIRTHPLACE OF FATHER

(State or Country)

Idaho

12. MAIDEN NAME OF MOTHER

Stella Smart

13. BIRTHPLACE OF MOTHER

(State or Country)

Utah

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

Clarence White

(Address)

Thomas Idaho

15.

Filed

May 8 1913M. E. Patin
Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH

May

(Month)

6

(Day)

1913

(Year)

17. I HEREBY CERTIFY, That I attended deceased from

May 6 1913 to May 7 1913that I last saw her alive on May 7 1913and that death occurred on the date stated above, at 1 P.M.

The CAUSE OF DEATH* was as follows:

Broncho Pneumonia

(Duration)

yrs.

3 ds.Contributory
(Secondary)measles

(Duration)

yrs.

18 ds.

(Signed)

H. J. Summers M. D.May 8 1913(Address) Blackfoot Idaho

*Name the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place

of death

yrs.

mos.

days.

In the

State

yrs.

mos.

days.

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

Thomas-Buried Cem.May 9 1913

20. UNDERTAKER

ADDRESS

Clarence WhiteBlackfootR 710 #2

Form V. S. No. 5 20M.1-16-12

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH.

Registration District No. 13County of BinghamPrimary Registration District No. 1007City of Blackfoot(No. Blackfoot County Hospital)File No. 5105Registered No. 55

If death occurs away from usual residence, give facts called for under special information.

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX

4. COLOR OR RACE

5. SINGLE, MARRIED, WID-
OWED OR DIVORCED.malewhitesingle
(Write the word.)

6. DATE OF BIRTH

Cent Day1879

(Month)

(Day)

(Year)

7. AGE

36

yrs.

mos.

ds.

IF LESS than 1 day
how many hrs. or
..... mins.?

8. OCCUPATION

(a) Trade, profession or
particular kind of workcarpenter(b) General nature of industry
business, or establishment in
which employed (or employer)

9. BIRTHPLACE

(State or Country)

Hamilton, Georgia, Ohio10. NAME OF
FATHERAsa Smith11. BIRTHPLACE
OF FATHER

(State or Country)

Ohio12. MAIDEN NAME
OF MOTHERIsabel McCleary13. BIRTHPLACE
OF MOTHER

(State or Country)

Hamilton, Ohio

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

J. A. McCleary

(Address)

15.

Filed

May 91913W. E. Sahie
Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH

May71913

(Month)

(Day)

(Year)

17. I HEREBY CERTIFY, That I attended deceased from

May 4 1913, to May 6 1913that I last saw him alive on May 6 1913and that death occurred on the date stated above, at 9 A.M.

The CAUSE OF DEATH* was as follows:

Pulmonary Tuberculosis(Duration) 6 yrs. 6 mos. — ds.Contributory
(Secondary)(Duration) — yrs. — mos. — ds.

(Signed)

J. B. Davis M. D.578 1913 (Address) Blackfoot, Ida

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place

of death.....yrs.....mos.....days.

In the

State.....yrs.....mos.....days.

Where was disease contracted
if not at place of death?

Former or

usual residence.....

19. PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

East Overell OhioMay 9 1913

20. UNDERTAKER

ADDRESS

W. D. Macer Blackfoot, Ida

Form V. S. No. 5 20M.1-16-12

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH. Registration District No. 13
 County of Bingham Primary Registration District No. 2053
 City of Blackfoot (No. _____ St.)

File No. 5106
 Registered No. 56

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Mary Byrns

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX Female 4. COLOR OR RACE White 5. SINGLE, MARRIED, WIDOWED OR DIVORCED.
Widowed
 (Write the word.)

6. DATE OF BIRTH Can't say
 (Month) (Day) (Year)

7. AGE 62 yrs. — mos. — ds.
 IF LESS than 1 day how many hrs. or mins.?

8. OCCUPATION
 (a) Trade, profession or particular kind of work Housewife
 (b) General nature of industry, business, or establishment in which employed (or employer)

9. BIRTHPLACE England
 (State or Country)

10. NAME OF FATHER James Peacock

11. BIRTHPLACE OF FATHER Ireland
 (State or Country)

12. MAIDEN NAME OF MOTHER Mary Hickey

13. BIRTHPLACE OF MOTHER Ireland
 (State or Country)

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Mrs Nellie Jacobson

(Address) Blackfoot, Idaho

15. Filed May 9 1913 W E Lahr

Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH 5 8 1913
 (Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from Aug 13 1912, to May 8 1913, that I last saw her alive on May 7 1913, and that death occurred on the date stated above, at 5 P.M.

The CAUSE OF DEATH* was as follows:

Heart Failure

(Duration) yrs. mos. ds.

Contributory Valvular Disease of
 (Secondary) Heart with Dilatation

(Duration) 3 yrs. mos. ds.

(Signed) Carl H. Hovner M. D.

19 (Address) Blackfoot, Idaho

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death. yrs. mos. days. In the State. yrs. mos. days.

Where was disease contracted if not at place of death?

Former or usual residence.

19. PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

Pross City Cem B May 9 1913

20. UNDERTAKER

ADDRESS

D. H. Belcher Blackfoot

Form V. S. No. 5 20M.1-16-12

CERTIFICATE OF DEATH

 State of Idaho
 BOARD OF HEALTH
 Bureau of Vital Statistics

1. PLACE OF DEATH.

Registration District No. 13

County of _____

Primary Registration District No. 1007

City of _____

(No. Cottage Hotel St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Edward HinesFile No. 5107Registered No. 57

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX M4. COLOR OR RACE W5. SINGLE, MARRIED, WIDOWED OR DIVORCED. Single6. DATE OF BIRTH Don't know

(Month)

(Day)

(Year)

7. AGE 23 yrs. — mos. — ds.
 IF LESS than 1 day
 how many hrs. or
mins.?

8. OCCUPATION

(a) Trade, profession or particular kind of work ?(b) General nature of industry, business, or establishment in which employed (or employer) ?9. BIRTHPLACE ?

(State or Country)

10. NAME OF FATHER ?11. BIRTHPLACE OF FATHER ?

(State or Country)

12. MAIDEN NAME OF MOTHER ?13. BIRTHPLACE OF MOTHER ?

(State or Country)

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) J. Davis(Address) Blackfoot Ida15. Filed May 12 1913Local Registrar W. E. Price

Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH May 11 1913

(Month)

(Day)

(Year)

17. I HEREBY CERTIFY, That I attended deceased from May 11 19131913, to May 11 1913that I last saw h. — alive on dead when arrivedand that death occurred on the date stated above, at 6 A.M.

The CAUSE OF DEATH* was as follows:

Pulmonary Tuberculosis

(Duration) — yrs. — mos. — ds.

Contributory

(Secondary)

(Duration) — yrs. — mos. — ds.

(Signed) J. Davis

M. D.

5-12-1913 (Address)

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death — yrs. — mos. — days. In the State — yrs. — mos. — days.

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL Blackfoot IdahoDATE OF BURIAL 191320. UNDERTAKER E. J. ParkADDRESS Blackfoot

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Form V. S. No. 5. 12½M.7-24-11

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics
File No. 5108
Registered No. 58

1. PLACE OF DEATH. Registration District No. 13
County of Bingham Primary Registration District No. 2029
City of Aberdeen (No. _____, _____ St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

John Mooney

If death occurred in a hospital, institution or camp give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX male 4. COLOR OR RACE white 5. SINGLE, MARRIED, WIDOWED OR DIVORCED. widowed
(Write the word.)

6. DATE OF BIRTH Aug 10 1892
(Month) (Day) (Year)

7. AGE 70 yrs. 8 mos. 10 ds. IF LESS than 1 day how many _____ hrs. or _____ min?

8. OCCUPATION

(a) Trade, profession or particular kind of work Carpenter
(b) General nature of industry business or establishment in which employed (or employer) _____

9. BIRTHPLACE

(State or Country) Ireland

10. NAME OF FATHER

Mathias Mooney

11. BIRTHPLACE OF FATHER

(State or Country) Ireland

12. MAIDEN NAME OF MOTHER

do not know

13. BIRTHPLACE OF MOTHER

(State or Country) do not know

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) T. H. Langer

(Address) Aberdeen, Ida

15.

Filed May 20 1913 M. C. McKinnon
Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH

May 20 1913
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from Apr 13 1913, to May 19 1913 that I last saw h. alive on May 19 1913 and that death occurred on the date stated above, at 1 A. M.
The CAUSE OF DEATH* was as follows:

Bright's Disease

(Duration) more than 6 wks. yrs. _____ mos. _____ ds.

Contributory none
(Secondary)

(Duration) _____ yrs. _____ mos. _____ ds.

(Signed) M. C. McKinnon M. D.
May 20 1913 (Address) M. C. McKinnon

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place _____ In the _____
of death _____ yrs. _____ mos. _____ ds. State _____ yrs. _____ mos. _____ ds.
Where was disease contracted, _____
If not at place of death? _____
Former or _____
usual residence _____

19. PLACE OF BURIAL OR REMOVAL DATE OF BURIAL

Marshalltown Iowa 1913

20. UNDERTAKER

E. T. Beck

ADDRESS

Block 400
Idaho

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Form V. S. No. 5. 12½ M. 7-24-11

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics
File No. 5109
Registered No. 59

1. PLACE OF DEATH.
County of Bingham
City of Blackfoot

Registration District No. 13
Primary Registration District No. 2053
(No. Idaho Avenue Asylum St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Elizabeth Ferguson

If death occurred in a hospital, institution or camp give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX Female 4. COLOR OR RACE W. 5. SINGLE, MARRIED, WIDOWED OR DIVORCED. Widow
(Write the word.)

6. DATE OF BIRTH 1840
(Month) (Day) (Year)

7. AGE 70 yrs. mos. ds. IF LESS than 1 day how many hrs. or min?

8. OCCUPATION
(a) Trade, profession or particular kind of work Housewife
(b) General nature of industry business or establishment in which employed (or employer)

9. BIRTHPLACE England
(State or Country)

10. NAME OF FATHER

11. BIRTHPLACE OF FATHER
(State or Country)

12. MAIDEN NAME OF MOTHER

13. BIRTHPLACE OF MOTHER
(State or Country)

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Francis H. Poole
(Address) Blackfoot, Ida.

15. May 13, 1913 W. E. Patrick
Filed Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH May 21 1913
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from Nov. 15 1911, to May 20 1913
that I last saw her alive on May 20 1913
and that death occurred on the date stated above, at 8 P. M.

The CAUSE OF DEATH* was as follows:

Heart Disease
mitral regurgitation
(Duration) ? yrs. mos. ds.

Contributory (Secondary)
(Duration) ? yrs. mos. ds.
(Signed) Francis H. Poole, M. D.
May 22 1913. (Address)

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place 11 yrs. mos. ds. In the State Idaho
of death
Where was disease contracted,
If not at place of death?
Former or usual residence.

19. PLACE OF BURIAL OR REMOVAL Victor Reicks DATE OF BURIAL 1913

20. UNDERTAKER E. J. Truck ADDRESS Blackfoot

File No. 5112
Registered No. 60

If death occurred in a hospital, institution or camp give its NAME instead of street and number.

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 18872

CERTIFICATE OF DEATH

State of Idaho

BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH.

Registration District No. 13County of BinghamPrimary Registration District No. 2053City of Blackfoot(No. Idaho Board of Health)File No. 5111Registered No. 61

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Hyrum Peterson

If death occurred in a hospital, institution or camp give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX

M.

4. COLOR OR RACE

W.

5. SINGLE, MARRIED, WIDOWED OR DIVORCED.

Married
(Write the word.)

6. DATE OF BIRTH

Oct.161862

(Month)

(Day)

(Year)

7. AGE

5055ds.IF LESS than 1 day
how many hrs. or
..... min?

8. OCCUPATION

(a) Trade, profession or particular kind of work.

Laborer

(b) General nature of industry business or establishment in which employed (or employer)

9. BIRTHPLACE

(State or Country)

Utah

10. NAME OF FATHER

11. BIRTHPLACE OF FATHER

(State or Country)

12. MAIDEN NAME OF MOTHER

13. BIRTHPLACE OF MOTHER

(State or Country)

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

Frank St. Paul

(Address)

15.

Filed May 23 1913M. E. Patric
Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH

May311913

(Month)

(Day)

(Year)

17. I HEREBY CERTIFY, That I attended deceased from

Apr. 231913to May 211913that I last saw him alive on May 20 1913and that death occurred on the date stated above, at 12

The CAUSE OF DEATH* was as follows:

Killed by means of patient
fractured skull &
multiple injury

(Duration) yrs. mos. ds.

Contributory
(Secondary)

(Duration) yrs. mos. ds.

(Signed) Frank St. Paul M. D.May 22 1913 (Address) Blackfoot, Id.

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place

In the

of death yrs. mos. ds. State yrs. mos. ds.

Where was disease contracted,

If not at place of death? Idaho Falls

Former or

usual residence

19. PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

Logan Utah1913

20. UNDERTAKER

ADDRESS

E. F. HickBlackfoot, Id.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Form V. S. No. 5. 10M. 6-20-11.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

File No. 5112

Registered No. 62

If death occurred in a hospital, institution or camp give its NAME instead of street and number.

1. PLACE OF DEATH.

County of Bingham
City of BlackfootRegistration District No. 13Primary Registration District No. 2053
(No. Idaho State Asylum St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

Elias Bagley

PERSONAL AND STATISTICAL PARTICULARS

3. SEX

Male

4. COLOR OR RACE

Caucasian

5. SINGLE, MARRIED, WIDOWED OR DIVORCED.

Single
(Write the word.)

6. DATE OF BIRTH

1890
(Month) (Day) (Year)

7. AGE

23 yrs. mos. ds.IF LESS than 1 day
how many hrs. or
min.?

8. OCCUPATION

(a) Trade, profession, or particular kind of work none
(b) General nature of industry business, or establishment in which employed (or employer)

9. BIRTHPLACE

(State or Country)

Idaho

10. NAME OF FATHER

11. BIRTHPLACE OF FATHER

(State or Country)

12. MAIDEN NAME OF MOTHER

13. BIRTHPLACE OF MOTHER

(State or Country)

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

(Address)

Francis H. Poole
Blackfoot Idaho

15.

Filed

May 27 1913W. E. Patrie

Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

May 21 1913
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from

March 1911, to May 21 1913that I last saw him alive on May 20 1913,and that death occurred on the date stated above, at 2:30 A.M.

The CAUSE OF DEATH* was as follows:

Killed by insane patient
fractured skull and
multiple injury.(Duration) 12 yrs. mos. ds.Contributory
(Secondary)

(Duration) yrs. mos. ds.

(Signed) Francis H. Poole M. D.May 24 1913 (Address) Blackfoot.

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place In the
of death 12 yrs. mos. ds. State yrs. mos. ds.

Where was Disease contracted,

If not at place of death?

Former or

usual residence

Morland, Idaho.

19. PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

Asylum CemeteryMay 24 1913

20. UNDERTAKER

ADDRESS

F. H. Poole & Son Blackfoot

Form V. S. No. 5. 10M. 6-20-11.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital StatisticsFile No. **5113**Registered No. **63**

If death occurred in a hospital, institution or camp give its NAME instead of street and number.

1. PLACE OF DEATH.

County of **Bingham**
City of **Blackfoot**Registration District No. **103**Primary Registration District No. **2053**
(No. **Idaho Insane Asylum** St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

George Shepherd

PERSONAL AND STATISTICAL PARTICULARS

3. SEX

male

4. COLOR OR RACE

Caucassian

5. SINGLE, MARRIED, WIDOWED OR DIVORCED.

Single
(Write the word.)

6. DATE OF BIRTH

1894
(Month) (Day) (Year)

7. AGE

19 yrs. mos. ds.IF LESS than 1 day
how many hrs. or
..... min.?

8. OCCUPATION

(a) Trade, profession, or particular kind of work

None

(b) General nature of industry business, or establishment in which employed (or employer)

9. BIRTHPLACE

(State or Country)

Wisconsin

10. NAME OF FATHER

Chas. Shepherd

11. BIRTHPLACE OF FATHER

(State or Country)

12. MAIDEN NAME OF MOTHER

13. BIRTHPLACE OF MOTHER

(State or Country)

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

(Address)

Blackfoot, Idaho

15.

Filed

May 27 1913**M.E. Patrie**

Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

May **21** **1913**
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from

July 25 **1913** to **May 21** **1913**that I last saw him alive on **May 20** **1913**and that death occurred on the date stated above, at **12:30 P.M.**

The CAUSE OF DEATH* was as follows:

Killed by insane patient
Fractured skull and
multiple injury.(Duration) **3** yrs. mos. ds.Contributory
(Secondary)

(Duration) yrs. mos. ds.

(Signed) **Francis H. Poole** M. D.**May 24** **1913** (Address) **Blackfoot, Ida.**

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place **6** In the
of death yrs. mos. ds. State yrs. mos. ds.

Where was Disease contracted,

If not at place of death?

Former or

usual residence

Pocatello, Idaho.

19. PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

Asylum Cemetery**May 24** **1913**

20. UNDERTAKER

ADDRESS

F.H. Poole, E. J. Pruck **Blackfoot**

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Form V. S. No. 5 20M.1-16-12

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics
File No. 5114
Registered No. 64

1. PLACE OF DEATH.

Registration District No. 13County of BinghamPrimary Registration District No. 2053City of Blackfoot

(No. _____, St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Elin Frances Bates

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX

4. COLOR OR RACE

5. SINGLE, MARRIED, WIDOWED OR DIVORCED.

MaleWhiteWidowed
(Write the word.)

6. DATE OF BIRTH

11
(Month)25
(Day)1855
(Year)

7. AGE

57 yrs. 6 mos. 2 ds.IF LESS than 1 day
how many hrs. or
..... mins.?

8. OCCUPATION

(a) Trade, profession or

particular kind of work

Farmer(b) General nature of industry
business, or establishment in
which employed (or employer)

9. BIRTHPLACE

(State or Country)

Id10. NAME OF
FATHER?11. BIRTHPLACE
OF FATHER

(State or Country)

?12. MAIDEN NAME
OF MOTHER?13. BIRTHPLACE
OF MOTHER

(State or Country)

?

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

Elmer F. Ziegler

(Address)

15.

Filed

May 28 1913M. E. Patrio
Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH

May261913

(Month)

(Day)

(Year)

17. I HEREBY CERTIFY, That I attended deceased from

May 20 1913, to May 26 1913,that I last saw him alive on May 26 1913,and that death occurred on the date stated above, at 7:30 P. M.

The CAUSE OF DEATH* was as follows:

Bronchial Asthma(Duration) yrs. 1 mos. 10 ds.

Contributory

(Secondary)

(Duration) yrs. mos. ds.

(Signed)

F. C. Mitchell M. D.May 26 1913 (Address) Blackfoot, Idaho

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death yrs. mos. days. In the State yrs. mos. days.

Where was disease contracted if not at place of death?

Former or

usual residence

19. PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

Silver Creek, Idaho1913

20. UNDERTAKER

E. J. Peck

ADDRESS

Blackfoot
Idaho

Form V. S. No. 5. 10M. 6-20-11.

CERTIFICATE OF DEATH

1. PLACE OF DEATH.

County of Bingham
City of BlackfootRegistration District No. 13Primary Registration District No. 2053(No. Idaho Home Asylum)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

Otto G. Giller

Bureau of Vital Statistics

File No. 5115Registered No. 65

If death occurred in a hospital, institution or camp give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX

M.

4. COLOR OR RACE 5. SINGLE, MARRIED, WIDOWED OR DIVORCED.

W.

(Write the word.)

6. DATE OF BIRTH

September131837

(Month)

(Day)

(Year)

7. AGE

75

yrs.

mos.

ds.

IF LESS than 1 day
how many hrs. or
..... min.?

8. OCCUPATION

(a) Trade, profession, or particular kind of work

Retired Farmer

(b) General nature of industry business, or establishment in which employed (or employer)

9. BIRTHPLACE

(State or Country)

Germany

10. NAME OF FATHER

11. BIRTHPLACE OF FATHER

(State or Country)

12. MAIDEN NAME OF MOTHER

13. BIRTHPLACE OF MOTHER

(State or Country)

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

Francis K. Moore

(Address)

Blackfoot, Idaho.

15.

Filed

May 29 1913W. E. Patie

Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

May

(Month)

28

(Day)

1913

(Year)

17. I HEREBY CERTIFY, That I attended deceased from

May 20 1913, to May 28 1913that I last saw him alive on May 27 1913,and that death occurred on the date stated above, at 4:30 A.M.

The CAUSE OF DEATH* was as follows:

Exhaustion(Duration) yrs. 1 mos. ds.Contributory
(Secondary)Senile Dementia(Duration) yrs. 3 mos. ds.(Signed) Francis K. Moore M. D.May 28 1913 (Address) Blackfoot

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL,

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place

In the

of death yrs. mos. 7 ds. State yrs. mos. ds.

Where was Disease contracted,

If not at place of death?

Boise, Idaho

Former or

usual residence

19. PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

Boise IdahoMay 28 1913

20. UNDERTAKER

ADDRESS

E. J. HubBlackfoot

Form V. S. No. 5 20M.1-16-12

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH

Registration District No. 13County of BinghamPrimary Registration District No. 1007City of Blackfoot(No. 250 So University St.)File No. 5116Registered No. 66

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

Kurt H. Hopkins

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX

Male

4. COLOR OR RACE

White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED.

Single
(Write the word.)

6. DATE OF BIRTH

July 24 1865
(Month) (Day) (Year)

7. AGE

47 yrs. 10 mos. 3 ds.IF LESS than 1 day
how many hrs. or
..... mins.?

8. OCCUPATION

(a) Trade, profession or particular kind of work

Rancher

(b) General nature of industry business, or establishment in which employed (or employer)

9. BIRTHPLACE

(State or Country)

Dandridge Jefferson Co Tennessee

10. NAME OF FATHER

W. M. Hopkins

11. BIRTHPLACE OF FATHER

(State or Country)

Cocke Co Tennessee

12. MAIDEN NAME OF MOTHER

Elizabeth A Russell

13. BIRTHPLACE OF MOTHER

(State or Country)

Wynnesboro South Carolina

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

J. H. Hopkins

(Address)

Blackfoot Idaho

15.

Filed

May 29 1913M. S. Patrick

Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH

May 28 1913
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from

Jan 1 1913, to May 28 1913that I last saw him alive on May 28 1913and that death occurred on the date stated above, at 10 A.M.

The CAUSE OF DEATH* was as follows:

Suppurative Myelitis(Duration) 1 yrs. 6 mos. 1 ds.

Contributory

(Secondary)

(Duration) yrs. mos. ds.

(Signed)

J. W. Mitchell M. D.
May 28 1913 (Address) Blackfoot Idaho

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place

of death yrs. mos. days.

In the

State yrs. mos. days.

Where was disease contracted if not at place of death?

Former or

usual residence

19. PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

Union City Cemetery Blackfoot May 28 1913

20. UNDERTAKER

ADDRESS

E. J. RichBlackfoot

Form V. S. No. 5 20M.1-16-12

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH.

Registration District No. 13County of BinghamPrimary Registration District No. 1007City of Blackfoot(No. 610 E. Alice St.)File No. 5117Registered No. 67

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Annand Morgan

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX

Female

4. COLOR OR RACE

White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED.

Single
(Write the word.)

6. DATE OF BIRTH

May 29 1913
(Month) (Day) (Year)

7. AGE

— yrs. — mos. — ds.IF LESS than 1 day
how many — hrs. or
— mins.

8. OCCUPATION

- (a) Trade, profession or particular kind of work
-
- (b) General nature of industry, business, or establishment in which employed (or employer)

9. BIRTHPLACE

(State or Country) Blackfoot Idaho

10. NAME OF FATHER

James O. Morgan

11. BIRTHPLACE OF FATHER

(State or Country) Utah

12. MAIDEN NAME OF MOTHER

Mattie Lemmon

13. BIRTHPLACE OF MOTHER

(State or Country) Utah Id

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) J. O. Morgan(Address) Blackfoot

15.

Filed May 30 1913W. E. Fabric
Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH

May 29 1913
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from

May 29 1913, to May 29 1913,that I last saw her alive on May 29 1913,and that death occurred on the date stated above, at 8:18 M.

The CAUSE OF DEATH* was as follows:

Premature 5 months(Duration) — yrs. — mos. — ds.

Contributory

(Secondary)

(Duration) — yrs. — mos. 10 mins. — ds.(Signed) F. W. Mitchell

M. D.

May 29 1913 (Address) Blackfoot, Idaho

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death — yrs. — mos. — days. In the State — yrs. — mos. — days.

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL DATE OF BURIAL

Grave City Cemetery Blackfoot May 30 1913

20. UNDERTAKER

ADDRESS

E. J. RichBlackfoot

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Form V, S. No. 5. 12½M. 7-24-11

CERTIFICATE OF DEATH

1. PLACE OF DEATH.
County of Bingham
City of Blackfoot

Registration District No. 13
Primary Registration District No. 2053
(No. Idaho Idaho Idaho St.)

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics
File No. 5118
Registered No. 68

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Dusan Hodgkin

If death occurred in a hospital, institution or camp give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX Female 4. COLOR OR RACE White 5. SINGLE, MARRIED, WIDOWED OR DIVORCED. Widow
(Write the word.)

6. DATE OF BIRTH 1846
(Month) (Day) (Year)

7. AGE 67 yrs. mos. ds. IF LESS than 1 day how many hrs. or min?

8. OCCUPATION
(a) Trade, profession or particular kind of work. Housewife
(b) General nature of industry business or establishment in which employed (or employer)

9. BIRTHPLACE Missouri
(State or Country)

10. NAME OF FATHER ?

11. BIRTHPLACE OF FATHER ?
(State or Country)

12. MAIDEN NAME OF MOTHER ?

13. BIRTHPLACE OF MOTHER ?
(State or Country)

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Francis H. Poole
(Address) Blackfoot, Idaho

15. June 23 1913
Filed W. E. Purie
Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH May 29 1913
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from March 15 1911, to May 29 1913
that I last saw her alive on May 29 1913
and that death occurred on the date stated above, at 2 P. M.

The CAUSE OF DEATH* was as follows:

Cancer of Liver

(Duration) 1 yrs. mos. ds.

Contributory (Secondary)

(Duration) 1 yrs. mos. ds.

(Signed) Francis H. Poole M. D.
May 31 1913 (Address) Blackfoot, Idaho

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place 6 yrs. mos. ds. In the State Idaho
of death 6 yrs. mos. ds. State Idaho
Where was disease contracted, Idaho
If not at place of death? Idaho
Former or usual residence "

19. PLACE OF BURIAL OR REMOVAL Blackfoot Cemetery DATE OF BURIAL June 3 1913

20. UNDERTAKER E. J. Puck ADDRESS Blackfoot, Idaho

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Form V. S. No. 5 20M.1-16-12

CERTIFICATE OF DEATH

 State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH.

Registration District No. 13County of BinghamPrimary Registration District No. 1007City of Blackfoot(No. Blackfoot Hospital St.)File No. 5119Registered No. 69

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

Leroy Howell

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX

Male

4. COLOR OR RACE

White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED.

(Write the word.)

6. DATE OF BIRTH

10 4 1875
(Month) (Day) (Year)

7. AGE

37 yrs. 7 mos. 25 ds.
 IF LESS than 1 day
how many hrs. or
..... mins.?

8. OCCUPATION

- (a) Trade, profession or particular kind of work
(b) General nature of industry, business, or establishment in which employed (or employer)

Fanner

9. BIRTHPLACE

(State or Country)

Buxtehude Utah

10. NAME OF FATHER

James Howell

11. BIRTHPLACE OF FATHER

(State or Country)

Id

12. MAIDEN NAME OF MOTHER

Rasanaiah Mump

13. BIRTHPLACE OF MOTHER

(State or Country)

Tenn.

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

(Address)

J. Howell
Malad Idaho

15.

Filed

June 2 1913 W. E. Patie
Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH

May 30 1913
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from

May 16 1913, to May 30 1913

 that I last saw him alive on May 30 1913

 and that death occurred on the date stated above, at 8 P. M.

The CAUSE OF DEATH* was as follows:

Appendicitis(Duration) yrs. mos. 16 ds.Contributory
(Secondary)

(Duration) yrs. mos. ds.

(Signed) F. W. M. M. D.(Address) Blackfoot Idaho

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death.....yrs.....mos.....days. In the State.....yrs.....mos.....days.

Where was disease contracted if not at place of death?.....

Former or usual residence.....

19. PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

Portage Utah1913

20. UNDERTAKER

ADDRESS

E. J. PuckBlackfoot
Operation for removal of appendix - Peritonitis

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Form V. S. No. 5 20M.1-16-12

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH.

Registration District No. 13County of MinghamPrimary Registration District No. 1007City of Blackfoot(No. 495, north Stout St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

Lilly Elizabeth EzellFile No. 5120Registered No. 170

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX

Female

4. COLOR OR RACE

white

5. SINGLE, MARRIED, WIDOWED OR DIVORCED.

Single
(Write the word.)

6. DATE OF BIRTH

Jan
(Month)30
(Day)1902
(Year)

7. AGE

11 yrs. 7 mos. 22 ds.IF LESS than 1 day
how many hrs. or
..... min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work.

School girl

(b) General nature of industry, business, or establishment in which employed (or employer).

9. BIRTHPLACE

(State or Country)

Idaho

10. NAME OF FATHER

George Ezell

11. BIRTHPLACE OF FATHER

(State or Country)

Kentucky

12. MAIDEN NAME OF MOTHER

Minnie Jackson

13. BIRTHPLACE OF MOTHER

(State or Country)

Kentucky

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

Geo. R. Ezell

(Address)

Blackfoot Idaho

15.

Filed

Jan 1 1913W. E. Patrick

Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH

May
(Month)31
(Day)1913
(Year)

17. I HEREBY CERTIFY, That I attended deceased from

May 30 1913, to May 31 1913,that I last saw her alive on May 30 1913,and that death occurred on the date stated above, at 7:45 A.M.

THE CAUSE OF DEATH* was as follows:

Acute Laryngitis

(Duration)

yrs.

mos.

ds.

Contributory (Secondary)

Beginning Solar Pneumonia

(Duration)

yrs.

mos.

2 ds.

(Signed)

H. J. Summers M. D.July 1913(Address) Blackfoot

*Give the DISEASE CAUSING DEATH; as in deaths from VIOLENT CAUSES, state (1) NATURE OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death

yrs.

mos.

days.

In the State

yrs.

mos.

days.

Where was disease contracted if not at place of death?

Former or usual residence.

19. PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

Iron City Cem Blackfoot1913

20. UNDERTAKER

E. F. Puck

ADDRESS

Blackfoot

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Form V. S. No. 5 20M.1-16-12

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH. Registration District No. 9
County of Mountain Primary Registration District No. 2037
City of Bates (No. _____ St.)

File No. 5121
Registered No. 80

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Sadie Norton

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX 7 4. COLOR OR RACE white 5. SINGLE, MARRIED, WIDOWED OR DIVORCED. Child
(Write the word.)

6. DATE OF BIRTH Apr. 11 1913
(Month) (Day) (Year)

7. AGE 1 21 yrs. mos. ds. IF LESS than 1 day how many hrs. or mins.

8. OCCUPATION

(a) Trade, profession or particular kind of work
(b) General nature of industry, business, or establishment in which employed (or employer)

Child

9. BIRTHPLACE

(State or Country)

Idaho

10. NAME OF FATHER

Glen Norton

11. BIRTHPLACE OF FATHER

(State or Country)

Nephi, Utah

12. MAIDEN NAME OF MOTHER

Julia Daniels

13. BIRTHPLACE OF MOTHER

(State or Country)

Utah

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

Glen Norton

(Address)

Bates-Idaho

15.

Filed

June 3 1913 Ray Fisher
Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH

May 12 1913
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from May 11 1913 to May 12 1913 that I last saw him alive on May 11 1913 and that death occurred on the date stated above, at 11 P. M. The CAUSE OF DEATH* was as follows:

Broncho-pneumonia

(Duration) yrs. mos. ds.

Contributory (Secondary)

(Duration) yrs. mos. ds.

(Signed)

Dr. J. S. Reith M. D.

May 14 1913 (Address Dr. J. S. Reith)

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death yrs. mos. days. In the State yrs. mos. days.

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

Bates-Ida. May 14 1913

20. UNDERTAKER

ADDRESS

Dr. J. S. Reith Driggs-Ida.

Form V. S. No. 5 20M.1-16-12

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics
File No. 5122

Registered No. 79

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

1. PLACE OF DEATH.

Registration District No. 9

County of

Primary Registration District No. 2037

City of

(No.)

St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

PERSONAL AND STATISTICAL PARTICULARS

3. SEX

4. COLOR OR RACE

5. SINGLE, MARRIED, WIDOWED OR DIVORCED.

(Write the word.)

6. DATE OF BIRTH

7. AGE

IF LESS than 1 day
how many hrs. or
..... mins.?

8. OCCUPATION

(a) Trade, profession or

particular kind of work

(b) General nature of industry
business, or establishment in
which employed (or employer)

9. BIRTHPLACE

(State or Country)

10. NAME OF
FATHER11. BIRTHPLACE
OF FATHER

(State or Country)

12. MAIDEN NAME
OF MOTHER13. BIRTHPLACE
OF MOTHER

(State or Country)

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

(Address)

15.

Filed

June 10 1913

Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH

May 10 1913
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from

1913, to 1913,

that I last saw him alive on 1913,

and that death occurred on the date stated above, at M.

The CAUSE OF DEATH* was as follows:

Suicide
according to coroners
(Duration) yrs. mos. ds.Contributory
(Secondary) Inquest.

(Duration) yrs. mos. ds.

(Signed) M. D.

19 (Address)

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death yrs. mos. days. In the State yrs. mos. days.

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

Morgan Utah May 13 1913

20. UNDERTAKER

ADDRESS

C. Cherrington Duggs

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Form V. S. No. 5-20M.1-16-12

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH

Registration District No.

County of

Primary Registration District No.

City of

(No.)

St.)

File No.

Registered No.

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX

4. COLOR OR RACE

5. SINGLE, MARRIED, WIDOWED OR DIVORCED.

(Write the word.)

6. DATE OF BIRTH

7. AGE

IF LESS than 1 day
how many hrs. or mins.?

8. OCCUPATION

(a) Trade, profession or particular kind of work

(b) General nature of industry, business, or establishment in which employed (or employer)

9. BIRTHPLACE

(State or Country)

10. NAME OF FATHER

11. BIRTHPLACE OF FATHER

(State or Country)

12. MAIDEN NAME OF MOTHER

13. BIRTHPLACE OF MOTHER

(State or Country)

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

(Address)

15.

Filed

1913

Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

17. I HEREBY CERTIFY, That I attended deceased from

that I last saw him alive on

and that death occurred on the date stated above, at M.

The CAUSE OF DEATH* was as follows:

Contributory
(Secondary)

(Signed)

(Address)

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death.....yrs.....mos.....days. In the State.....yrs.....mos.....days.

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

20. UNDERTAKER

ADDRESS

MARGIN RESERVED FOR BINDING
WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Form V. S. No. 5 20M.1-16-12

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH.

Registration District No. 9

County of

Primary Registration District No. 2037

City of

(No.

St.)

File No. 5124

Registered No. 78

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

Lois Hellman

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX

7

4. COLOR OR RACE

W.

5. SINGLE, MARRIED, WIDOWED OR DIVORCED.

Child
(Write the word.)

6. DATE OF BIRTH

July 23 1917
(Month) (Day) (Year)

7. AGE

5 yrs. 9 mos. 24 ds.

IF LESS than 1 day
how many hrs. or
..... mins.?

8. OCCUPATION

(a) Trade, profession or particular kind of work

(b) General nature of industry, business, or establishment in which employed (or employer)

Child

9. BIRTHPLACE

(State or Country)

Idaho

10. NAME OF FATHER

J. S. Hellman

11. BIRTHPLACE OF FATHER

(State or Country)

Utah

12. MAIDEN NAME OF MOTHER

Meutette Robinson

13. BIRTHPLACE OF MOTHER

(State or Country)

Utah

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

Ray Hellman

(Address)

Driggs - Idaho

15.

Filed

June 10 1918

Ray Hellman
Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH

May 17 1918
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from

1918, to 1918,

that I last saw h. alive on 1918,

and that death occurred on the date stated above, at M.

The CAUSE OF DEATH* was as follows:

Thrown from wagon; slight on head. Picked up dead.

(Duration) yrs. mos. ds.

Contributory (Secondary)

(Duration) yrs. mos. ds.

(Signed)

M. D.

19 (Address)

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death yrs. mos. days. In the State yrs. mos. days.

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

Driggs Idaho 5/19 1918

20. UNDERTAKER

ADDRESS

C. Cherrington Driggs

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Form V. S. No. 5 20M.1-16-12

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics
File No. 5126
Registered No. 82

1. PLACE OF DEATH.

Registration District No. _____

County of Jerome

Primary Registration District No. 2039

City of Sugar

(No. _____)

(St. _____)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

Edward Birch

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX

4. COLOR OR RACE

5. SINGLE, MARRIED, WIDOWED OR DIVORCED.

M

W.

married
(Write the word.)

6. DATE OF BIRTH

July 7
(Month) (Day)

1853
(Year)

7. AGE

59 yrs. 10 mos. 28 ds.

IF LESS than 1 day
how many _____ hrs. or
_____ mins.?

8. OCCUPATION

(a) Trade, profession or particular kind of work
(b) General nature of industry, business, or establishment in which employed (or employer)

Farmer

9. BIRTHPLACE

(State or Country)

England

10. NAME OF FATHER

James Birch

11. BIRTHPLACE OF FATHER

(State or Country)

England

12. MAIDEN NAME OF MOTHER

Mary Hale

13. BIRTHPLACE OF MOTHER

(State or Country)

A. Morfield England

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

A. Morfield

(Address)

St. Anthony - Ida.

15.

Filed

June 10 1913

Reg. H. Phillips
Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

June 5 1913
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from June 5 1913, to June 5 1913, that I last saw him alive on June 5 1913, and that death occurred on the date stated above, at 7:30 M.

The CAUSE OF DEATH* was as follows:

Myocarditis

(Duration) _____ yrs. _____ mos. _____ ds.

Contributory (Secondary) Chronic gastritis

(Duration) _____ yrs. _____ mos. _____ ds.

(Signed) A. Morfield M. D.
June 1913 (Address) St. Anthony, Ida.

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death _____ yrs. _____ mos. _____ days. In the State _____ yrs. _____ mos. _____ days.

Where was disease contracted if not at place of death?

Former or usual residence.

19. PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

Sugar City

June 7 1913

20. UNDERTAKER

ADDRESS

John Phillips

Reburg

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Form V. S. No. 5 20M.1-16-12

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH.

Registration District No. 9

County of Benson

Primary Registration District No. 2039

City of Rexburg

(No. , St.)

File No. 5127

Registered No. 76

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

May Catherine Fausett

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX

F

4. COLOR OR RACE

W

5. SINGLE, MARRIED, WIDOWED OR DIVORCED.

Married
(Write the word.)

6. DATE OF BIRTH

May 16 1913
(Month) (Day) (Year)

7. AGE

1 yrs. 1 mos. 1 ds.

IF LESS than 1 day
how many hrs. or mins.?

8. OCCUPATION

(a) Trade, profession or particular kind of work

(b) General nature of industry, business, or establishment in which employed (or employer)

Baker

9. BIRTHPLACE

(State or Country)

Idaho

10. NAME OF FATHER

John M. Fausett
Utah

11. BIRTHPLACE OF FATHER

(State or Country)

12. MAIDEN NAME OF MOTHER

Mary C. Horiman

13. BIRTHPLACE OF MOTHER

(State or Country)

Utah

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

John M. Fausett

(Address)

Rexburg, Idaho

15.

Filed

June 10 1913

Ray Fisher, M.D.

Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH

May 17 1913
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from

May 16 1913 to 1913

that I last saw him alive on 1913

and that death occurred on the date stated above, at 7 P. M.

The CAUSE OF DEATH* was as follows:

Probably, atelactasis.

+ Congenital heart trouble.

(Duration) yrs. mos. ds.

Contributory (Secondary) No physician, midwife present

(Duration) yrs. mos. ds.

(Signed) Ray Fisher, M.D.

May 1913 (Address) Rexburg, Idaho

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death yrs. mos. days. In the State yrs. mos. days.

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL DATE OF BURIAL

Homestead on Creek May 19 1913

20. UNDERTAKER ADDRESS

J.R. Young Rexburg

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Form V. S. No. 5 20M.1-16-12

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH.

Registration District No. 9

County of Fremont

Primary Registration District No. 2039

City of Reburg

(No.

St.)

File No. 5128

Registered No. 75

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

Ida P. Raylaunce

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX

4. COLOR OR RACE

5. SINGLE, MARRIED, WIDOWED OR DIVORCED.

7

W

married
(Write the word.)

6. DATE OF BIRTH

Jan 8

1877

(Month)

(Day)

(Year)

7. AGE

36 yrs. 4 mos. 3 ds.

IF LESS than 1 day
how many hrs. or
..... mins.?

8. OCCUPATION

(a) Trade, profession or particular kind of work

(b) General nature of industry business, or establishment in which employed (or employer)

Housewife

9. BIRTHPLACE

(State or Country)

Utah

10. NAME OF FATHER

Pete. Nostrom

11. BIRTHPLACE OF FATHER

(State or Country)

Sweden

12. MAIDEN NAME OF MOTHER

Josephine VanValter

13. BIRTHPLACE OF MOTHER

(State or Country)

America

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

Chas. Nostrom

(Address)

Reburg, Ida

15.

Filed

Jan 10 1913

Raylaunce

Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH

May 11

1913

(Month)

(Day)

(Year)

17. I HEREBY CERTIFY, That I attended deceased from

March 11 1913 to May 11 1913

that I last saw her alive on May 8 1913

and that death occurred on the date stated above, at 8:10 P. M.

The CAUSE OF DEATH* was as follows:

Acute regurgitation
myocarditis

(Duration)

yrs.

mos.

ds.

Contributory
(Secondary)

(Duration)

yrs.

mos.

ds.

(Signed)

W. C. Truman, M. D.

May 12 1913 (Address) Reburg, Ida.

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place

of death.....yrs.....mos.....days.

In the

State.....yrs.....mos.....days.

Where was disease contracted
if not at place of death?

Former or
usual residence.....

19. PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

Bury or City - Ida

May 12 1913

20. UNDERTAKER

ADDRESS

John Phillips

Reburg, Ida.

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Form V. S. No. 5 20M.1-16-12

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics
File No. 5129

1. PLACE OF DEATH

Registration District No. 9

County of Fremont

Primary Registration District No. 2040.

City of Regley

(No. , St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

Myron Morris Bates

Registered No. 72

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX

M

4. COLOR OR RACE

W

5. SINGLE, MARRIED, WIDOWED OR DIVORCED.

(Write the word.)

6. DATE OF BIRTH

12

(Month)

3

(Day)

1910

(Year)

7. AGE

2 yrs 4 mos 19 ds.

IF LESS than 1 day
how many hrs. or
mins.?

8. OCCUPATION

(a) Trade, profession or particular kind of work

(b) General nature of industry, business, or establishment in which employed (or employer)

9. BIRTHPLACE

(State or Country)

10. NAME OF FATHER

John S. Bates

11. BIRTHPLACE OF FATHER

(State or Country)

12. MAIDEN NAME OF MOTHER

Eda F. Jones

13. BIRTHPLACE OF MOTHER

(State or Country)

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

John S. Bates

(Address)

Regley, Idaho

15.

Filed

June 10 1913

Ray H. Hildebrand

Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

Apr. 22

(Month)

(Day)

1913

17. I HEREBY CERTIFY, That I attended deceased from

Apr 18 1913, to Apr 22 1913, that I last saw him alive on Apr 21 1913,

and that death occurred on the date stated above, at 7 A. M.

The CAUSE OF DEATH* was as follows:

Gastro-enteritis

Possibly Plomarian poisoning

(Duration) yrs. mos. ds.

Contributory

(Secondary)

(Duration) yrs. mos. ds.

(Signed)

Am. Talbot M. D.

Apr 23 1913 (Address) Regley, Ida.

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death.....yrs.....mos.....days. In the State.....yrs.....mos.....days.

Where was disease contracted if not at place of death?

Former or usual residence.....

19. PLACE OF BURIAL OR REMOVAL

Regley, Idaho

DATE OF BURIAL

Apr 23 1913

20. UNDERTAKER

2 friends

ADDRESS

Regley, Ida

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Form V. S. No. 5 20M.1-16-12

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics
File No. 5139
Registered No. 74

1. PLACE OF DEATH.

Registration District No. 9County of VermontPrimary Registration District No. 7040City of Gorfield

(No. _____, St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Martin Severson

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX M

4. COLOR OR RACE

5. SINGLE, MARRIED, WIDOWED OR DIVORCED.

(Write the word.)

6. DATE OF BIRTH May 31 1913
(Month) (Day) (Year)7. AGE 5 yrs. 5 mos. 5 ds.
IF LESS than 1 day how many hrs. or mins.?8. OCCUPATION 5 mos. Gestation

(a) Trade, profession or particular kind of work

(b) General nature of industry, business, or establishment in which employed (or employer)

9. BIRTHPLACE Idaho
(State or Country)10. NAME OF FATHER Oscar Severson11. BIRTHPLACE OF FATHER Norway
(State or Country)12. MAIDEN NAME OF MOTHER Agnes Rasmussen13. BIRTHPLACE OF MOTHER Idaho
(State or Country)

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Oscar Severson(Address) Rigby R.T.D.15. Filed June 10 1913 Ray H. Hibbs
Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH May 31 1913
(Month) (Day) (Year)17. I HEREBY CERTIFY, That I attended deceased from 191, to 191, that I last saw h. alive on 191, and that death occurred on the date stated above, at M.The CAUSE OF DEATH* was as follows:
5 mo. Gestation
(Duration) yrs. mos. ds.
Contributory (Secondary)
(Duration) yrs. mos. ds.
(Signed) E. E. Portner, M.D.
May 31 1913 (Address) Rigby Idaho

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death.....yrs.....mos.....days. In the State.....yrs.....mos.....days.
Where was disease contracted if not at place of death?
Former or usual residence.....19. PLACE OF BURIAL OR REMOVAL Grav.DATE OF BURIAL May 31 191320. UNDERTAKER Freeds.ADDRESS Gorfield

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. Exact state-
ment of OCCUPATION is very important. See instructions on back of certificate.

Form V. S. No. 5 20M.1-16-12

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics
File No. 5131

1. PLACE OF DEATH.

Registration District No. 9

County of Grant

Primary Registration District No. 2040

City of Goodfield

(No. _____, _____ St.)

Registered No. 73

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

Oscar Merle Peterson

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX

M.

4. COLOR OR RACE

5. SINGLE, MARRIED, WID-
OWED OR DIVORCED.

(Write the word.)

6. DATE OF BIRTH.

May 30

1913

7. AGE

_____ yrs. _____ mos. _____ ds.

IF LESS than 1 day
how many _____ hrs. or
_____ mins.?

8. OCCUPATION

- (a) Trade, profession or
particular kind of work
(b) General nature of industry
business, or establishment in
which employed (or employer)

Mal-
lister
Idaho

9. BIRTHPLACE

(State or Country)

10. NAME OF
FATHER

Oscar Peterson

11. BIRTHPLACE
OF FATHER

(State or Country)

Norway

12. MAIDEN NAME
OF MOTHER

Agnes. Rasmussen

13. BIRTHPLACE
OF MOTHER

(State or Country)

Idaho

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

(Address)

Oscar Peterson
Goodfield, Idaho

15.

Filed

May 31 1913 Ray St. L. M. D.
Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH

May 31

1913

17. I HEREBY CERTIFY, That I attended deceased from

191, to 191,

that I last saw h. alive on 191,

and that death occurred on the date stated above, at M.

The CAUSE OF DEATH* was as follows:

6 mo. illness
Tuberculosis

(Duration) _____ yrs. _____ mos. _____ ds.

Contributory
(Secondary)

(Duration) _____ yrs. _____ mos. _____ ds.

(Signed)

May 1913 (Address) Reilly, Idaho.

*State the DISEASE CAUSING DEATH; or in death from VIOLENT CAUSES, state (1)
MEANS OF INJURY; and (2) whether ACCIDENTAL SUICIDAL OR HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions,
Transients or Recent Residents.)

At place of death _____ yrs. _____ mos. _____ days. In the State _____ yrs. _____ mos. _____ days.

Where was disease contracted
if not at place of death? _____

Former or
usual residence _____

19. PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

Grant

May 31 1913

20. UNDERTAKER

ADDRESS

Friends

Goodfield

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Form V. S. No. 5 20M.1-16-12

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH.

Registration District No. 9County of JeromePrimary Registration District No. 2040City of Arvids.

(No. _____ St.)

File No. 5132Registered No. 77

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Bluford Bybee

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX

M

4. COLOR OR RACE

W.

5. SINGLE, MARRIED, WIDOWED OR DIVORCED.

Married
(Write the word.)

6. DATE OF BIRTH

Oct.41184

(Month)

(Day)

(Year)

7. AGE

72

yrs.

7

mos.

2

ds.

IF LESS than 1 day
how many hrs. or
..... mins.?

8. OCCUPATION

(a) Trade, profession or particular kind of work

(b) General nature of industry, business, or establishment in which employed (or employer)

Farmer

9. BIRTHPLACE

(State or Country)

Iowa

10. NAME OF FATHER

Bluford Bybee

11. BIRTHPLACE OF FATHER

(State or Country)

Unknown

12. MAIDEN NAME OF MOTHER

"

13. BIRTHPLACE OF MOTHER

(State or Country)

"

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

(Address)

Laurance BybeeMeridian, Ida.

15.

Filed

June 10 1913Ray H. Hunt

Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH

June31913

(Month)

(Day)

(Year)

17. I HEREBY CERTIFY, That I attended deceased from

May 28 1913, to June 3 1913,that I last saw him alive on June 1 1913and that death occurred on the date stated above, at 10 P. M.

The CAUSE OF DEATH* was as follows:

Uremia - following Cystitis and Prostatitis

(Duration) yrs. mos. ds.

Contributory

(Secondary)

(Duration) Indefinite yrs. mos. ds.

(Signed)

J. E. Meenan M. D.
June 10 1913 (Address)

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death yrs. mos. days. In the State yrs. mos. days.

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

Little Butte CemeteryJune 4 1913

20. UNDERTAKER

ADDRESS

J. H. HuntIda Falls

SYMS - YORK CO., PTRS. & BDRS. 19780

Form V. S. No. 5 20M.1-16-12

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH. *Grant* Registration District No. *9*
 County of *Grant* Primary Registration District No. *2040*
 City of *Goodfield* (No. _____ St.)

File No. *5135*
 Registered No. *86*

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

Geo. W. Godfrey

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX *M* 4. COLOR OR RACE _____ 5. SINGLE, MARRIED, WIDOWED OR DIVORCED. _____

(Write the word.)

6. DATE OF BIRTH

Nov. 7 *1865*
 (Month) (Day) (Year)

7. AGE

47 yrs. *6* mos. *5* ds.

IF LESS than 1 day
 how many _____ hrs. or
 _____ mins.?

8. OCCUPATION

(a) Trade, profession or particular kind of work
 (b) General nature of industry, business, or establishment in which employed (or employer)

Farmer

9. BIRTHPLACE

(State or Country)

Utah

10. NAME OF FATHER

Chas. Godfrey

11. BIRTHPLACE OF FATHER

(State or Country)

Don't know

12. MAIDEN NAME OF MOTHER

Sophia Clifton

13. BIRTHPLACE OF MOTHER

(State or Country)

Don't know

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

Hyrum Severson

(Address)

Goodfield, Ida.

15.

Filed

June 10 *1913* *Ray H. Fisher*
 Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

May 12 *1913*
 (Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from *Jan 16* *1913*, to *May 12* *1913*
 that I last saw him alive on *May 5* *1913*

and that death occurred on the date stated above, at *10* P. M.

The CAUSE OF DEATH* was as follows:

Myocarditis
Cerebral hemorrhage
 (Duration) _____ yrs. _____ mos. _____ ds.

Contributory
(Secondary)

(Duration) _____ yrs. _____ mos. _____ ds.

(Signed) *Ray H. Fisher* M. D.*May 19 13* (Address) *Regley, Idaho*

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death _____ yrs. _____ mos. _____ days. In the State _____ yrs. _____ mos. _____ days.

Where was disease contracted if not at place of death? _____

Former or usual residence _____

19. PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

*Grant**May 14* *1913*

20. UNDERTAKER

ADDRESS

*R. H. Hunt**Idaho Falls*

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. N. B.—Every item of information should be carefully supplied. AGE should be state EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Form V. S. No. 5. 10M. 6-20-11.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH.

Registration District No. 11County of BannockPrimary Registration District No. 2048City of Bannock

(No. _____, _____ St.)

File No. 5137Registered No. 33

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

Jens J. J. J. J.

If death occurred in a hospital, institution or camp give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX

M

4. COLOR OR RACE

W

5. SINGLE, MARRIED, WIDOWED OR DIVORCED.

married
(Write the word.)

6. DATE OF BIRTH

Feb.91866

(Month)

(Day)

(Year)

7. AGE

5338ds.

IF LESS than 1 day
how many hrs. or
..... min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work

Rancher

(b) General nature of industry business or establishment in which employed (or employer)

9. BIRTHPLACE

(State or Country)

Denmark

10. NAME OF FATHER

Jens Peter Jensen

11. BIRTHPLACE OF FATHER

(State or Country)

Denmark

12. MAIDEN NAME OF MOTHER

Charles Peter Jensen

13. BIRTHPLACE OF MOTHER

(State or Country)

Denmark

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

Mrs. Charles Jensen

(Address)

Bannock

15.

June 10,

Filed

May 24 1913E. E. K. K. K.

Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

May

(Month)

17

(Day)

1913

(Year)

17. I HEREBY CERTIFY, That I attended deceased from

April 10 1913, to April 23 1913that I last saw him alive on April 23 1913and that death occurred on the date stated above, at 7 P. M.

The CAUSE OF DEATH* was as follows:

breakdown of liver(Duration) yrs. 6 mos. — ds.

Contributory (Secondary)

(Duration) yrs. — mos. — ds.(Signed) E. E. K. K. K. M. D.May 24, 1913 (Address) Seattle, Wash.

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death yrs. mos. ds. State yrs. mos. ds.

Where was disease contracted,

If not at place of death?

Former or

usual residence

19. PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

BannockMay 16 1913

20. UNDERTAKER

ADDRESS

H. E. JohnsonBannock

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Form V. S. No. 5 20M.1-16-12

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics
File No. 5138
Registered No. 34

1. PLACE OF DEATH Barnock Registration District No. 11
County of Barnock Primary Registration District No. 2047
City of McCammon (No. Guy Hospital St.)
If death occurs away from usual residence, give facts called for under special information. 2. FULL NAME John Weller

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX Male 4. COLOR OR RACE White 5. SINGLE, MARRIED, WIDOWED OR DIVORCED. Single
(Write the word.)
6. DATE OF BIRTH 1-856
(Month) (Day) (Year)

7. AGE 55 yrs. mos. ds. IF LESS than 1 day how many hrs. or mins.

8. OCCUPATION
(a) Trade, profession or particular kind of work Farmer
(b) General nature of industry business, or establishment in which employed (or employer)

9. BIRTHPLACE Sweden
(State or Country)

10. NAME OF FATHER

11. BIRTHPLACE OF FATHER
(State or Country)

12. MAIDEN NAME OF MOTHER

13. BIRTHPLACE OF MOTHER
(State or Country)

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) L. Bishop
(Address) 842 N. Main Pocatello

15. Filed June 10, 1913 Earl E. Cannon
Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH 5-2-1913
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from 4-28-1913, to 5-3-1913, that I last saw him alive on 5-2-1913, and that death occurred on the date stated above, at 2 PM.

The CAUSE OF DEATH* was as follows:
Myocardial Disease
Heart Disease

(Duration) yrs. mos. ds.

Contributory (Secondary)

(Duration) yrs. mos. ds.

(Signed) W. H. Cannon M. D.
May 3, 1913 (Address) McCammon, Idaho

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death. yrs. mos. days. In the State. yrs. mos. days.

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL Barnock DATE OF BURIAL May 4, 1913

20. UNDERTAKER M. H. MacPhee ADDRESS Pocatello, Idaho

MARGIN RESERVED FOR BINDING
ANY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. PHYSI-
cal information should be carefully supplied. AGE should be stated EXACTLY. Exact state-
cause of DEATH in plain terms, so that it may be properly classified. See instructions on back of certificate.

Form V. S. No. 5. 12½M.7-24-11

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH. Registration District No. 16
County of BozPerce Primary Registration District No. 2074
City of Melrose (No. _____, _____ St.)

File No. 5129
Registered No. 62

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Francis E. Reed

If death occurred in a hospital, institution or camp give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX Male 4. COLOR OR RACE White 5. SINGLE, MARRIED, WIDOWED OR DIVORCED. Married (Write the word.)

6. DATE OF BIRTH Oct 23 1871
(Month) (Day) (Year)

7. AGE 41 yrs. 5 mos. 16 ds. IF LESS than 1 day how many hrs. or min?

8. OCCUPATION Farmer
(a) Trade, profession or particular kind of work.
(b) General nature of industry business, or establishment in which employed (or employer)

9. BIRTHPLACE Iowa
(State or Country)

10. NAME OF FATHER Frank Reed

11. BIRTHPLACE OF FATHER England
(State or Country)

12. MAIDEN NAME OF MOTHER Sabina Flory

13. BIRTHPLACE OF MOTHER Vermont
(State or Country)

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) (signed) Naomi Reed
(Address) Melrose Idaho.

6-10 1913 R. J. Perkins
Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH April 9 1913
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from Mar 12 1913, to April 8 1913 that I last saw him alive on April 8 1913 and that death occurred on the date stated above, at M.

The CAUSE OF DEATH* was as follows:

Tuberculosis of spine

(Duration) 12 yrs. mos. ds.

Contributory (Secondary)

(Duration) yrs. mos. ds.
(Signed) J. M. Lyle M. D.
19 (Address) Melrose

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place In the
of death. yrs. mos. ds. State. yrs. mos. ds.
Where was disease contracted,
If not at place of death?
Former or
usual residence.

19. PLACE OF BURIAL OR REMOVAL DATE OF BURIAL
Melrose Idaho 1913

20. UNDERTAKER ADDRESS

W. E. Stoddard Lifford

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Form V. S. No. 5 20M.1-16-12

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics
File No. 5140
Registered No. 63

1. PLACE OF DEATH. Registration District No. 16
County of Lewiston Primary Registration District No. 1009
City of Lewiston (No. 1416, 13th Ave, St.)
If death occurs away from usual residence, give facts called for under special information. 2. FULL NAME Russell E. Strong

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX M 4. COLOR OR RACE W 5. SINGLE, MARRIED, WIDOWED OR DIVORCED. Single
(Write the word.)

6. DATE OF BIRTH Jan 19 1913
(Month) (Day) (Year)

7. AGE 3 yrs 3 mos 15 ds. IF LESS than 1 day how many hrs. or mins.?

8. OCCUPATION
(a) Trade, profession or particular kind of work none
(b) General nature of industry business, or establishment in which employed (or employer)

9. BIRTHPLACE (State or Country) Lewiston

10. NAME OF FATHER E. Strong

11. BIRTHPLACE OF FATHER (State or Country) Ohio

12. MAIDEN NAME OF MOTHER Bessie Blake

13. BIRTHPLACE OF MOTHER (State or Country) Kansas

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) E. O. Strong
(Address) Lewiston

15. Filed 6-10 1913 L. Perkins
Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH May 1 1913
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from 1913, to 1913, that I last saw h. alive on 1913, and that death occurred on the date stated above, at M.
The CAUSE OF DEATH* was as follows:

Intemperance, was found dead in bed

(Duration) yrs. mos. ds.

Contributory (Secondary)

(Duration) yrs. mos. ds.

(Signed) Russell E. Strong M. D.

19 (Address)

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death.....yrs.....mos.....days. In the State.....yrs.....mos.....days.

Where was disease contracted if not at place of death?

Former or usual residence.....

19. PLACE OF BURIAL OR REMOVAL Lewiston DATE OF BURIAL May 5th 1913

20. UNDERTAKER C. J. Vaseau ADDRESS Lewiston

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Form V. S. No. 5. 12½ M. 7-24-11

CERTIFICATE OF DEATH

State of Idaho

BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH.
County of Ada
City of Lewiston

Registration District No. 16
Primary Registration District No. 1009
(No. _____ St.)

File No. 5141
Registered No. 37

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

John Carlan

If death occurred in a hospital, institution or camp give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX male 4. COLOR OR RACE white 5. SINGLE, MARRIED, WIDOWED OR DIVORCED. single
(Write the word.)

6. DATE OF BIRTH Aug 17 1847
(Month) (Day) (Year)

7. AGE 64 yrs. 8 mos. ds. IF LESS than 1 day how many.....hrs. or min?

8. OCCUPATION

(a) Trade, profession or particular kind of work
(b) General nature of industry business or establishment in which employed (or employer)

Cooper

9. BIRTHPLACE

(State or Country)

Germany

10. NAME OF FATHER

John Carlan

11. BIRTHPLACE OF FATHER

(State or Country)

Germany

12. MAIDEN NAME OF MOTHER

Louisa Albrecht

13. BIRTHPLACE OF MOTHER

(State or Country)

Germany

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) C.T. Stranahan
(Address) Lewiston Ida

15. Filed 6-10 1913 L. J. Beckius
Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH

May 4 1913
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from Mar 31 1913, to May 4 1913

that I last saw him alive on May 3rd 1913

and that death occurred on the date stated above, at 1 A. M.

The CAUSE OF DEATH* was as follows:

Progress of Liver
Sclerosis of Liver
(Duration) Unknown yrs. mos. ds.

Contributory
(Secondary)

(Duration) _____ yrs. mos. ds.

(Signed) C.T. Stranahan
May 4 1913 (Address) Supt. County Hospital

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place County Hospital In the
of death _____ yrs. mos. ds. State _____ yrs. mos. ds.

If not at place of death?
Former or
usual residence _____

19. PLACE OF BURIAL OR REMOVAL DATE OF BURIAL

C. J. Vassar May 5 1913

20. UNDERTAKER ADDRESS

C. J. Vassar Lewiston

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Form V. S. No. 5 20M.1-16-12

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics
File No. 5144
Registered No. 37

1. PLACE OF DEATH. Registration District No. 16
County of Boise Primary Registration District No. 1009
City of Walla (No. _____ St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Henry Hassel

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX M 4. COLOR OR RACE W 5. SINGLE, MARRIED, WIDOWED OR DIVORCED. Single
(Write the word.)

6. DATE OF BIRTH May 8 1913
(Month) (Day) (Year)

7. AGE 68 yrs. mos. ds. IF LESS than 1 day how many hrs. or mins.?

8. OCCUPATION

(a) Trade, profession or particular kind of work farmer
(b) General nature of industry business, or establishment in which employed (or employer)

9. BIRTHPLACE

(State or Country) Mont. France

10. NAME OF FATHER

11. BIRTHPLACE OF FATHER

(State or Country)

12. MAIDEN NAME OF MOTHER

13. BIRTHPLACE OF MOTHER

(State or Country)

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) J. B. Vassar

(Address) Leaverton

15.

Filed 6-10 1913 J. B. Vassar Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

May 8 1913
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from _____ 191____, to _____ 191____, that I last saw h_____ alive on _____ 191____, and that death occurred on the date stated above, at _____ M.

The CAUSE OF DEATH* was as follows:

Accidental fall on his head

(Duration) _____ yrs. mos. ds.

Contributory (Secondary)

(Duration) _____ yrs. mos. ds.

(Signed) J. B. Vassar

19____ (Address) Leaverton

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death _____ yrs. mos. days. In the State _____ yrs. mos. days.

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL DATE OF BURIAL

Leaverton May 22 1913

20. UNDERTAKER ADDRESS

C. J. Vassar Leaverton

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Form V. S. No. 5 20M.1-16-12

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH.

Registration District No. 16County of Nez PercePrimary Registration District No. 1039City of Lewiston(No. 134, Main St. St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

L. LeibickFile No. 5115Registered No. 58

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX

M

4. COLOR OR RACE

W

5. SINGLE, MARRIED, WIDOWED OR DIVORCED.

Single
(Write the word.)

6. DATE OF BIRTH

Not known

(Month)

(Day)

(Year)

7. AGE

40 yrs. 0 mos. 0 ds.IF LESS than 1 day
how many hrs. or
..... mins.?

8. OCCUPATION

(a) Trade, profession or particular kind of work

Jeweler

(b) General nature of industry business, or establishment in which employed (or employer)

9. BIRTHPLACE

(State or Country)

Germany

10. NAME OF FATHER

Not known

11. BIRTHPLACE OF FATHER

(State or Country)

12. MAIDEN NAME OF MOTHER

13. BIRTHPLACE OF MOTHER

(State or Country)

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

(Address)

J. J. Vassar
City

15.

Filed 6-10

1913

Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH

May
(Month)12
(Day)1913
(Year)

17. I HEREBY CERTIFY, That I attended deceased from

May 12

1913, to

May 12

1913,

that I last saw him alive on May 12 1913and that death occurred on the date stated above, at 1:30 P.M.

The CAUSE OF DEATH* was as follows:

apoplexy

(Duration) yrs. mos. ds.

Contributory
(Secondary)

(Duration) yrs. mos. ds.

(Signed)

P. H. Arthur M. D.May 12 (Address) Lewiston Idaho

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death yrs. mos. days. In the State yrs. mos. days.

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

LewistonMay 14 1913

20. UNDERTAKER

ADDRESS

C. J. VassarLewiston

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Form V. S. No. 5 20M.1-16-12

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH

Registration District No. 16

County of Latah

Primary Registration District No. 1009

City of Lewiston

(No. 228, 5th St.)

File No. 5146

Registered No. 59

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Lulu Larson

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX

4. COLOR OR RACE

5. SINGLE, MARRIED, WIDOWED OR DIVORCED.

F

W

Single
(Write the word.)

6. DATE OF BIRTH

March 31

1

1

(Month)

(Day)

(Year)

7. AGE

19 yrs. 1 mos. 16 ds.

IF LESS than 1 day
how many hrs. or
..... mins.?

8. OCCUPATION

(a) Trade, profession or particular kind of work

(b) General nature of industry business, or establishment in which employed (or employer)

Housekeeper

9. BIRTHPLACE

(State or Country)

Idaho

10. NAME OF FATHER

E. Larson

11. BIRTHPLACE OF FATHER

(State or Country)

not known

12. MAIDEN NAME OF MOTHER

Inghar Hanson

13. BIRTHPLACE OF MOTHER

(State or Country)

not known

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

(Address) Albert Miller

15.

Filed

6-10

1913

L. J. Berk

Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

May

16

1913

(Month)

(Day)

(Year)

17. I HEREBY CERTIFY, That I attended deceased from

May 16 1913, to May 16 1913,

that I last saw her alive on May 16 1913,

and that death occurred on the date stated above, at 2 P.M.

The CAUSE OF DEATH* was as follows:

Sudden death probably
inhalation of gas

(Duration) yrs. mos. ds.

Contributory Starvation
(Secondary)

(Duration) yrs. mos. ds.

(Signed) T. H. Harker M. D.

5/17/13 (Address) Lewiston Idaho

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death yrs. mos. days. In the State yrs. mos. days.

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

Idaho

1913

20. UNDERTAKER

ADDRESS

O. G. Warner

Lewiston

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Form V. S. No. 5 20M.1-16-12

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics
File No. 5147
Registered No. 60

1. PLACE OF DEATH.

Registration District No. 16

County of Key River

Primary Registration District No. 1009

City of Lewiston

(No. _____ St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME J P Code

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX

M

4. COLOR OR RACE

W

5. SINGLE, MARRIED, WID-
OWED OR DIVORCED.

married
(Write the word.)

6. DATE OF BIRTH

May 23 1913
(Month) (Day) (Year)

7. AGE

72 yrs. _____ mos. _____ ds.

IF LESS than 1 day
how many _____ hrs. or
_____ mins.?

8. OCCUPATION

(a) Trade, profession or
particular kind of work

Retired Farmer

(b) General nature of industry
business, or establishment in
which employed (or employer)

9. BIRTHPLACE

(State or Country)

Ireland

10. NAME OF
FATHER

Thos Code

11. BIRTHPLACE
OF FATHER

(State or Country)

Ireland

12. MAIDEN NAME
OF MOTHER

Anna Statia

13. BIRTHPLACE
OF MOTHER

(State or Country)

Ireland

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

(Address)

J P Code
Lewiston Ida

15.

Filed

6 - 10

191 3

L P Perkins

Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH

May 23 1913
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from

Nov Jan 15 1913, to May 23 1913,

that I last saw him alive on May 23 about 1913.

and that death occurred on the date stated above, at 8 P M.

The CAUSE OF DEATH* was as follows:

Cancer of the face

(Duration) _____ yrs. _____ mos. _____ ds.

Contributory

(Secondary)

(Duration) _____ yrs. _____ mos. _____ ds.

(Signed)

J B Thorpe M. D.
Lewiston Idaho

19 (Address)

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death 72 yrs. _____ mos. _____ days. In the State _____ yrs. _____ mos. _____ days.

Where was disease contracted if not at place of death?

Lewiston Idaho

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL

Lewiston

DATE OF BURIAL

May 25 1913

20. UNDERTAKER

C J Vassar

ADDRESS

Lewiston

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Form V. S. No. 5 20M.1-16-12

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics
File No. 5145
Registered No. 61

1. PLACE OF DEATH. Registration District No. 16
County of Nez Perce Primary Registration District No. 1009
City of Lewiston (No. _____ St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Gordon Rud

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX M 4. COLOR OR RACE W 5. SINGLE, MARRIED, WIDOWED OR DIVORCED. Single
(Write the word.)

6. DATE OF BIRTH May 16 1913
(Month) (Day) (Year)

7. AGE _____ yrs. _____ mos. 9 ds. IF LESS than 1 day how many _____ hrs. or _____ mins.?

8. OCCUPATION
(a) Trade, profession or particular kind of work None
(b) General nature of industry business, or establishment in which employed (or employer) _____

9. BIRTHPLACE Lewiston
(State or Country)

10. NAME OF FATHER T B Rud

11. BIRTHPLACE OF FATHER Mo
(State or Country)

12. MAIDEN NAME OF MOTHER Grace E Pierstoffs

13. BIRTHPLACE OF MOTHER Id
(State or Country)

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) DR Rud
(Address) Prace. Idaho

15. Filed 6-10 1913 L. J. Vassar
Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH May 25 1913
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from May 17 1913, to May 25 1913, that I last saw him alive on May 25 1913, and that death occurred on the date stated above, at St. Mam

The CAUSE OF DEATH* was as follows:

Lung fever
(Pneumonia)

(Duration) _____ yrs. _____ mos. 9 ds.

Contributory (Secondary) _____

(Duration) _____ yrs. _____ mos. _____ ds.

(Signed) L. J. Vassar

19 (Address) Lewiston Idaho

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death _____ yrs. _____ mos. _____ days. In the State _____ yrs. _____ mos. _____ days.

Where was disease contracted if not at place of death? _____

Former or usual residence _____

19. PLACE OF BURIAL OR REMOVAL Lewiston DATE OF BURIAL May 25 1913

20. UNDERTAKER C J Vassar ADDRESS Lewiston

Idaho State Board of Health

BUREAU OF VITAL STATISTICS

BOISE,

11-14-13

Dr. L. F. Inman
Lewiston, Idaho

Dear Doctor:

We have received at this office a death certificate signed by you May 25th, 1913 for Gordon Reed of Lewiston, in which the cause of death is given as "Lung Fever." We are rather at a loss to classify this--not knowing whether the case was one of bronchial pneumonia, lobar pneumonia, or tubercular disease of the lungs. Will you kindly advise me fully concerning this?

I enclose copy of "Physician's Pocket Reference to the Inter-national List of Causes of Death." Our Vital Statistics Law, as amended at the 1913 Session of the Legislature, provides for the use of the Inter-national list by physicians.

Thanking you in advance for the courtesy of a prompt reply, I am

Very truly yours,

RECEIVED

NOV 28 1913

OFFICE
STATE BOARD OF HEALTH

State Registrar.

RF:JS

M.D.

*Dear Doctor you will
please correct by putting
it "Bronchial Pneumonia,"
yours truly
L F Inman M.D.*

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIAN'S should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

1. PLACE OF DEATH		Registration District No. 16		Bureau of Vital Statistics	
County of <u>Desperce</u>	Primary Registration District No. <u>2074</u>		File No. <u>5149</u>		
City of <u>Gifford</u>	(No. _____)	(St. _____)		Registered No. <u>62</u>	
If death occurs away from usual residence, give facts called for under special information.					
2. FULL NAME <u>William Marlatt</u>					
If death occurred in a hospital, institution or camp give its NAME instead of street and number.					
PERSONAL AND STATISTICAL PARTICULARS			MEDICAL CERTIFICATE OF DEATH		
3. SEX <u>Male</u>	4. COLOR OR RACE <u>White</u>	5. SINGLE, MARRIED, WIDOWED OR DIVORCED. <u>Divorced</u> (Write the word.)	16. DATE OF DEATH <u>May 27th</u> 191 <u>3</u> (Month) (Day) (Year)		
6. DATE OF BIRTH <u>July 18th</u> 18 <u>86</u> (Month) (Day) (Year)			17. I HEREBY CERTIFY, That I attended deceased from <u>May 7th</u> 191 <u>3</u> , to <u>May 27th</u> 191 <u>3</u> that I last saw him alive on <u>May 7th</u> 191 <u>3</u> and that death occurred on the date stated above, at <u>3 P.</u> M. The CAUSE OF DEATH* was as follows: <u>Old age and General Decay</u>		
7. AGE <u>77 yrs.</u> <u>3</u> mos. <u>9</u> ds. IF LESS than 1 day how many <u>5</u> hrs. or <u>min?</u>			(Duration) <u>7</u> yrs. <u>0</u> mos. <u>0</u> ds.		
8. OCCUPATION (a) Trade, profession or particular kind of work. (b) General nature of industry business or establishment in which employed (or employer) <u>Farmer</u>			Contributory <u>Leakage of Heart valves</u> (Secondary)		
9. BIRTHPLACE (State or Country) <u>Indiana</u>			(Duration) <u>years</u> <u>0</u> mos. <u>0</u> ds.		
10. NAME OF FATHER <u>Fredrick Marlatt</u>			(Signed) <u>J. Harrington M. D.</u> <u>May 27th</u> 19 <u>13</u> (Address) <u>Gifford, Ore.</u>		
11. BIRTHPLACE OF FATHER (State or Country) <u>Ohio</u>			*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.		
12. MAIDEN NAME OF MOTHER <u>Boy</u>			18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)		
13. BIRTHPLACE OF MOTHER (State or Country) <u>Ohio</u>			At place of death.....yrs.....mos.....ds. State.....yrs.....mos.....ds. Where was disease contracted, If not at place of death?..... Former or usual residence.....		
14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE (Informant) <u>J. M. Marlatt</u> (Address) <u>Brewster Oregon</u>					
15. <u>Filed 5-28 1913</u> <u>6-10-1913-29</u> <u>E. E. Thatto</u> Local Registrar					
19. PLACE OF BURIAL OR REMOVAL <u>Gifford</u>			DATE OF BURIAL <u>5-28</u> 191 <u>3</u>		
20. UNDERTAKER <u>H. E. Stoddard</u>			ADDRESS <u>Gifford</u>		

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

1. PLACE OF DEATH County of <u>Lincoln</u> City of <u>Burlington</u>		Registration District No. <u>2087</u> (No. _____ St.)		BOARD OF HEALTH Bureau of Vital Statistics File No. <u>5151</u> Registered No. _____	
If death occurs away from usual residence, give facts called for under special information.		2. FULL NAME <u>Chas. T. Verdug</u>		If death occurred in a hospital, institution or camp give its NAME instead of street and number.	
PERSONAL AND STATISTICAL PARTICULARS					
3. SEX <u>Male</u>	4. COLOR OR RACE <u>White</u>	5. SINGLE, MARRIED, WIDOWED OR DIVORCED. <u>Single</u> (Write the word.)			
6. DATE OF BIRTH <u>Nov. 30</u> 191 <u>3</u> (Month) (Day) (Year)					
7. AGE _____ yrs. <u>5</u> mos. <u>22</u> ds.		IF LESS than 1 day how many _____ hrs. or _____ min?			
8. OCCUPATION (a) Trade, profession or particular kind of work. (b) General nature of industry business or establishment in which employed (or employer)					
9. BIRTHPLACE (State or Country) <u>North Dakota</u>					
10. NAME OF FATHER <u>Frank Tordy</u>					
11. BIRTHPLACE OF FATHER (State or Country) <u>Bulgaria</u>					
12. MAIDEN NAME OF MOTHER <u>Hattie Koller</u>					
13. BIRTHPLACE OF MOTHER (State or Country) <u>North Dakota</u>					
14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE (Informant) <u>Thomas Tordy</u> (Address) <u>Burlington</u>					
15. Filed <u>May 23</u> 191 <u>3</u> <u>John R. Longhine</u> Local Registrar					
MEDICAL CERTIFICATE OF DEATH					
16. DATE OF DEATH <u>May</u> <u>22</u> 191 <u>3</u> (Month) (Day) (Year)					
17. I HEREBY CERTIFY, That I attended deceased from <u>May 16</u> 191 <u>3</u> , to <u>May 16</u> 191 <u>3</u> that I last saw him alive on <u>May 16</u> 191 <u>3</u> and that death occurred on the date stated above, at <u>X</u> M. The CAUSE OF DEATH* was as follows: <u>Whomping cough</u>					
_____ (Duration) <u>about 3 wks.</u> yrs. _____ mos. _____ ds.					
Contributory (Secondary) <u>Enteric colitis</u>					
_____ (Duration) _____ yrs. _____ mos. _____ ds.					
(Signed) <u>Chas. W. Lethbrun</u> M. D. <u>May 22</u> 191 <u>3</u> (Address) <u>Burlington</u>					
*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.					
18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.) At place _____ In the _____ of death _____ yrs. _____ mos. _____ ds. State _____ yrs. _____ mos. _____ ds. Where was disease contracted, _____ If not at place of death? _____ Former or _____ usual residence _____					
19. PLACE OF BURIAL OR REMOVAL <u>Swiss Falls</u>				DATE OF BURIAL <u>5/23</u> 191 <u>3</u>	
20. UNDERTAKER <u>J. J. Grossman</u>				ADDRESS <u>Swiss Falls</u>	

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Form V. S. No. 5 20M.1-16-12

CERTIFICATE OF DEATH

1. PLACE OF DEATH

County of *Juniata*

City of *Buile*

Registration District No. *2087*

Primary Registration District No. *23*

(No. , St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

Harry King

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics
File No. *5152*

Registered No. _____

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX

Male

4. COLOR OR RACE

W.

5. SINGLE, MARRIED, WIDOWED OR DIVORCED.

(Write the word.)

6. DATE OF BIRTH

July

5

1884

(Month)

(Day)

(Year)

7. AGE

29 yrs. *10* mos. *1* ds.

IF LESS than 1 day
how many hrs. or mins.?

8. OCCUPATION

(a) Trade, profession or particular kind of work

Electric Lineman

(b) General nature of industry, business, or establishment in which employed (or employer)

9. BIRTHPLACE

(State or Country)

Colorado

10. NAME OF FATHER

John Edw. King

11. BIRTHPLACE OF FATHER

(State or Country)

Colorado

12. MAIDEN NAME OF MOTHER

13. BIRTHPLACE OF MOTHER

(State or Country)

Colorado

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

Mrs Harry King

(Address)

Buile

15.

Filed

5-7

191*3*

J. H. Murphy

Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH

May

6

1913

(Month)

(Day)

(Year)

17. I HEREBY CERTIFY, That I attended deceased from

191*3*, to

191*3*,

that I last saw h..... alive on..... 191*3*,

and that death occurred on the date stated above, at..... M.

The CAUSE OF DEATH* was as follows:

Killed by coming in contact with electric wire.

(Duration)

yrs.

mos.

ds.

Contributory

(Secondary)

(Duration)

yrs.

mos.

ds.

(Signed)

J. H. Murphy M. D.

5-6 191*3*

(Address)

Buile

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place

of death.....yrs.....mos.....days.

In the

State.....yrs.....mos.....days.

Where was disease contracted if not at place of death?.....

Former or

usual residence.....

19. PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

Drummers Cove

May 11 191*3*

20. UNDERTAKER

ADDRESS

H. H. Evans

Buile

Form V. S. No. 5 20M.1-16-12

CERTIFICATE OF DEATH

 State of Idaho
 BOARD OF HEALTH
 Bureau of Vital Statistics

 1. PLACE OF DEATH
 County of Idaho
 City of Buhl
 (No. _____ St.)
 Registration District No. 2087
 Primary Registration District No. 23
File No. 5153

Registered No. _____

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Margaret L. Allen

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

 3. SEX Male 4. COLOR OR RACE White 5. SINGLE, MARRIED, WIDOWED OR DIVORCED.

(Write the word.)

 6. DATE OF BIRTH Nov 3 1907
 (Month) (Day) (Year)

 7. AGE 5 yrs 6 mos 10 ds.
 IF LESS than 1 day how many hrs. or mins.?

8. OCCUPATION

- (a) Trade, profession or particular kind of work
-
- (b) General nature of industry, business, or establishment in which employed (or employer)

Child

9. BIRTHPLACE

(State or Country)

Buhl

10. NAME OF FATHER

J. R. Allen

11. BIRTHPLACE OF FATHER

(State or Country)

Cant. Co Oregon

12. MAIDEN NAME OF MOTHER

Lula E Barstow

13. BIRTHPLACE OF MOTHER

(State or Country)

Oregon

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

J. R. Allen

(Address)

Buhl Idaho

15.

Filed

5-131913

Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

May 13 1913
 (Month) (Day) (Year)

 17. I HEREBY CERTIFY, That I attended deceased from Mar 31 1913, to May 13 1913,

 that I last saw him alive on May 13 1913,

 and that death occurred on the date stated above, at 12:5 AM.

The CAUSE OF DEATH* was as follows:

Cholera following
Scarlet fever
(Duration) 2 yrs. 2 mos. 2 ds.

Contributory (Secondary)

Cholera(Duration) 3 yrs. 3 mos. 3 ds.

(Signed)

J. D. McCurdy M. D.
5/13/1913 (Address) Buhl Idaho

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death.....yrs.....mos.....days. In the State.....yrs.....mos.....days.

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

Buhl5-14 1913

20. UNDERTAKER

ADDRESS

H. B. EvansBuhl

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Form V. S. No. 5 20M.1-16-12

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH

Registration District No. 23

County of Twin Falls

Primary Registration District No. 2085

City of "

(No. "

St.)

Registered No.

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

Etta Pries

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX

4. COLOR OR RACE

5. SINGLE, MARRIED, WID-
OWED OR DIVORCED.

Female White

Single (Write the word.)

6. DATE OF BIRTH

Aug. 4 1882
(Month) (Day) (Year)

7. AGE

20 yrs. 9 mos. 24 ds.

IF LESS than 1 day
how many hrs. or
..... mins.?

8. OCCUPATION

(a) Trade, profession or
particular kind of work(b) General nature of industry
business, or establishment in
which employed (or employer)

School teacher

9. BIRTHPLACE

(State or Country)

Michigan

10. NAME OF
FATHER

Thomas Pries

11. BIRTHPLACE
OF FATHER

(State or Country)

Germany

12. MAIDEN NAME
OF MOTHER

Ross Gerischer

13. BIRTHPLACE
OF MOTHER

(State or Country)

Missouri

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

Etta Brunner

(Address)

Contact Neri

15.

Filed

5-30 1913

John Dugheim
Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH

May 28 1913
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from

May 16 1913, to May 28 1913,

that I last saw her alive on May 28 1913,

and that death occurred on the date stated above, at 3 P.M.

The CAUSE OF DEATH* was as follows:

Nephritis

(Duration) yrs. mos. ds.

Contributory
(Secondary)

Edema of Lung

(Duration) yrs. mos. 12 ds.

(Signed)

J. R. Morgan

M. D.

May 28 1913

(Address)

Quinn Falls, Ida.

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions,
Transients or Recent Residents.)

At place

of death

yrs. mos. 12 days

In the

State

yrs. mos. days.

Where was disease contracted
if not at place of death?

Contact her

Former or
usual residence

19. PLACE OF BURIAL OR REMOVAL DATE OF BURIAL

Cheboygan Mich. 191

20. UNDERTAKER

ADDRESS

J. Roseman Twin Falls

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact state-ment of OCCUPATION is very important. See instructions on back of certificate.

Form V. S. No. 5 20M.1-16-12

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics
File No. **5155**
Registered No. _____

1. PLACE OF DEATH _____ Registration District No. **23**
County of **Lincoln** Primary Registration District No. **2085**
City of _____ (No. _____)
If death occurs away from usual residence, give facts called for under special information. 2. FULL NAME **R. Earnest Medley**

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX **M.** 4. COLOR OR RACE **White** 5. SINGLE, MARRIED, WIDOWED OR DIVORCED. **Single**

6. DATE OF BIRTH **June 12 1882**
(Month) (Day) (Year)

7. AGE **30** yrs. **11** mos. **3** ds.
IF LESS than 1 day how many _____ hrs. or _____ mins.?

8. OCCUPATION
(a) Trade, profession or particular kind of work **farmer**
(b) General nature of industry, business, or establishment in which employed (or employer) _____

9. BIRTHPLACE
(State or Country) **Idaho**

10. NAME OF FATHER **James Medley**

11. BIRTHPLACE OF FATHER
(State or Country) **North Carolina**

12. MAIDEN NAME OF MOTHER **Elizabeth Goforth**

13. BIRTHPLACE OF MOTHER
(State or Country) **Ill.**

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) **Clinton Medley**
(Address) **Eden, Ida.**

15. Filed **May 16** 191**3** **John P. Engelman**
Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH **May 15 1913**
(Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from **May 4** 191**3**, to **May 15** 191**3**, that I last saw him on **May 15** 191**3**, and that death occurred on the date stated above, at **6 P.M.**

The CAUSE OF DEATH was as follows:
Subacute pneumonia of Bronchi

Contributory (Secondary) _____
(Signed) _____ M. D.
19 _____

*State the DISEASE CAUSE; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF ILLNESS (For Hospitals, Institutions, Transients and Residents.)

At place of death _____ yrs. _____ mos. _____ ds.
In the State _____ yrs. _____ mos. _____ days.
Where was disease contracted if not at place of death _____
Former or usual residence _____

19. PLACE OF BURIAL OR REMOVAL **Idaho Falls** DATE OF BURIAL **May 17 1913**
20. UNDERTAKER **J. J. Grossman** ADDRESS **Idaho Falls**

Form V. S. No. 5 20M.1-16-12

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics
File No. 5156

1. PLACE OF DEATH.

Registration District No. 23

County of Twin Falls

Primary Registration District No. 2085

City of Twin Falls

(No. St.)

Registered No.

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

Revi N Ballenger

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX

4. COLOR OR RACE

5. SINGLE, MARRIED, WIDOWED OR DIVORCED

6. DATE OF BIRTH

7. AGE

IF LESS than 1 day
how many hrs. or
..... mins.?

8. OCCUPATION

(a) Trade, profession or particular kind of work

(b) General nature of industry business, or establishment in which employed (or employer)

9. BIRTHPLACE

(State or Country)

10. NAME OF FATHER

11. BIRTHPLACE OF FATHER

(State or Country)

12. MAIDEN NAME OF MOTHER

13. BIRTHPLACE OF MOTHER

(State or Country)

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

(Address)

15.

Filed

1913

Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH

6 (Month) 1 (Day) 1913 (Year)

17. I HEREBY CERTIFY, That I attended deceased from

6/1/1913 to 6/1/1913

that I last saw him alive on 6/1/1913

and that death occurred on the date stated above, at 7 P.M.

The CAUSE OF DEATH* was as follows:

Angina Pectoris

(Duration) Not known yrs. mos. ds.

Contributory

(Secondary)

(Duration) yrs. mos. ds.

(Signed)

M. D.

6/1/1913 (Address) Twin Falls, Ida

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death yrs. mos. days. In the State yrs. mos. days.

Where was disease contracted if not at place of death?

Former or usual residence.

19. PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

Calloo. Mo.

1913

20. UNDERTAKER

ADDRESS

6 of Crosby

Twin Falls

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Form V. S. No. 5 20M.1-16-12

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH.

Registration District No. 23

County of Twin Falls

Primary Registration District No. 2085

City of " " " "

(No. , St.)

File No. 5157

Registered No. _____

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

Kenneth Handley

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX

Male

4. COLOR OR RACE

White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED.

Single (word.)

6. DATE OF BIRTH

Feb. 14 1913
(Month) (Day) (Year)

7. AGE

1 yrs. 3 mos. 16 ds.

IF LESS than 1 day
how many hrs. or
mins.?

8. OCCUPATION

(a) Trade, profession or particular kind of work

(b) General nature of industry business, or establishment in which employed (or employer)

9. BIRTHPLACE

(State or Country)

Idaho

10. NAME OF FATHER

Thomas Handley

11. BIRTHPLACE OF FATHER

(State or Country)

Canada

12. MAIDEN NAME OF MOTHER

Dora B Thomas

13. BIRTHPLACE OF MOTHER

(State or Country)

Iowa

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

(Address)

Thomas Handley
Twin Falls

15.

Filed 5-31 1913

Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH

5 30 1913
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from

5/23/ 1913, to 5/30/ 1913

that I last saw him alive on 5/30/ 1913,

and that death occurred on the date stated above, at 11:30 A.M.

The CAUSE OF DEATH* was as follows:

Broncho pneumonia

(Duration) yrs. mos. 10 ds.

Contributory
(Secondary)

(Duration) yrs. mos. ds.

(Signed) H. E. Pike M. D.

5/21/1913 (Address) Twin Falls, Ida

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death yrs. mos. days. In the State yrs. mos. days.

Where was disease contracted if not at place of death?

Former or usual residence.

19. PLACE OF BURIAL OR REMOVAL DATE OF BURIAL

Twin Falls June 1 1913

20. UNDERTAKER

ADDRESS

J. J. Grossman Twin Falls

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Form V. S. No. 5 20M.1-16-12

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics
File No. 5158

1. PLACE OF DEATH. Registration District No. 23
County of Twin Falls Primary Registration District No. 2085
City of " (No. " St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Eda Trivilla Perry

Registered No. _____
If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX Female 4. COLOR OR RACE White 5. SINGLE, MARRIED, WIDOWED OR DIVORCED. Single (Write the word.)

6. DATE OF BIRTH July 14 1907
(Month) (Day) (Year)

7. AGE 5 yrs. 10 mos. 14 ds.
IF LESS than 1 day how many hrs. or mins.?

8. OCCUPATION
(a) Trade, profession or particular kind of work Child
(b) General nature of industry business, or establishment in which employed (or employer)

9. BIRTHPLACE Idaho
(State or Country)

10. NAME OF FATHER Edgar Perry

11. BIRTHPLACE OF FATHER Utah
(State or Country)

12. MAIDEN NAME OF MOTHER Maud Wilkinson

13. BIRTHPLACE OF MOTHER Utah
(State or Country)

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Edgar Perry

(Address) Twin Falls

15. Filed 5-30 1913 John H. Bogle Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH May 29 1913
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from May 22 1913, to May 29 1913, that I last saw her alive on May 29 1913, and that death occurred on the date stated above, at 1 A.M.

The CAUSE OF DEATH* was as follows:

Peritonitis

(Duration) yrs. mos. 7 ds.

Contributory (Secondary)

(Duration) yrs. mos. ds.

(Signed) J. R. Morgan M. D.

May 30 1913 (Address) Twin Falls

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death yrs. mos. days. In the State yrs. mos. days.

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL DATE OF BURIAL

Twin Falls 5/30 1913

20. UNDERTAKER ADDRESS

J. J. Groseman Twin Falls

Idaho State Board of Health

BUREAU OF VITAL STATISTICS

BOISE, Nov. 14, 1913.

Dr. J. P. Morgan,

Twin Falls, Idaho.

Dear Doctor:

We have received at this office, the following death certificates:

James H. McCabe of Twin Falls,

Filed June 14, 1913

Cause of death, given as "pneumonia;

Ada Avilla Perry,

Filed May 29, 1913.

Cause of death given as "peritonitis."

Broncho Pneumonia
Secondary to Peritonitis.

We rather at a loss to classify these. Will you kindly advise us whether the case of pneumonia was one of bronchial pneumonia, lobar pneumonia or tubercular pneumonia; and whether the case of peritonitis resulted as a consequence of hernia, perforating ulcer of the stomach or bowels, or whether the case was a traumatic one?

I enclose copy of "Physicians' Pocket Reference to the International List of Causes of Death." Our Vital Statistics Law, as amended at the 1913 Session of the Legislature, provides for the use of the International List by physicians.

Thanking you in advance for the courtesy of an early reply, I am

Very truly yours,

M.D.

RF/FM
Enc.

RECEIVED

DEC 13 1913

SECRETARY'S OFFICE
STATE BOARD OF HEALTHRalph Falk
State Registrar.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Form V. S. No. 5 20M.1-16-12

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics
File No. 5159

1. PLACE OF DEATH. Registration District No. 23
County of Twin Falls Primary Registration District No. 2085
City of (No. St.)

Registered No.

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX 4. COLOR OR RACE 5. SINGLE, MARRIED, WIDOWED OR DIVORCED.

Male White Widower

6. DATE OF BIRTH

Sept. 20 1853
(Month) (Day) (Year)

7. AGE

59 yrs. 8 mos. 8 ds.

IF LESS than 1 day
how many hrs. or
mins?

8. OCCUPATION

(a) Trade, profession or
particular kind of work

(b) General nature of industry
business, or establishment in
which employed (or employer)

Farmer

9. BIRTHPLACE

(State or Country)

Missouri

10. NAME OF FATHER

Thomas J. Bledsoe

11. BIRTHPLACE OF FATHER

(State or Country)

Miss.

12. MAIDEN NAME OF MOTHER

Marjorie White

13. BIRTHPLACE OF MOTHER

(State or Country)

Idaho

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

(Address)

J. E. Bledsoe

Kimberly

15.

Filed

5-28

1913

John W. Laughlin
Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH

May 28 1913
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from

May 26" 1913, to May 28" 1913,

that I last saw him alive on 28 1913,

and that death occurred on the date stated above, at 2:00 PM

The CAUSE OF DEATH* was as follows:

Septicemia
1st septococcal infection
through index finger (tag)
(Duration) yrs. mos. 8 ds.

Contributory
(Secondary)

(Duration) yrs. mos. ds.

(Signed) 2083 J. E. Bledsoe M. D.

May 28 1913 (Address) Twin Falls, Idaho

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death yrs. mos. 7 days. In the State yrs. mos. days.

Where was disease contracted if not at place of death? Kimberly, Ida.

Former or usual residence.

19. PLACE OF BURIAL OR REMOVAL DATE OF BURIAL

Farthington N. Mexico 6/4 1913

20. UNDERTAKER

ADDRESS

J. Grossman Twin Falls

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Form V. S. No. 5 20M.1-16-12

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics
File No. **5160**

1. PLACE OF DEATH. Registration District No. **23**
County of **Twin Falls** Primary Registration District No. **2085**
City of **Twin Falls** (No. _____, St.)

Registered No. _____
If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

If death occurs away from usual residence, give facts called for under special information. 2. FULL NAME **Marion Adline Gibson**

PERSONAL AND STATISTICAL PARTICULARS

3. SEX **Female** 4. COLOR OR RACE **White** 5. SINGLE, MARRIED, WIDOWED OR DIVORCED. **---** (Write the word.)

6. DATE OF BIRTH **Jan. 17th, 1913**
(Month) (Day) (Year)

7. AGE **3** IF LESS than 1 day how many hrs. or mins.?
1 yrs. **1** mos. **27** ds.

8. OCCUPATION
(a) Trade, profession or particular kind of work **None**
(b) General nature of industry business, or establishment in which employed (or employer)

9. BIRTHPLACE
(State or Country) **Twin Falls**

10. NAME OF FATHER **Fred H. Gibson**

11. BIRTHPLACE OF FATHER
(State or Country) **Iowa**

12. MAIDEN NAME OF MOTHER **Iva K. Smith**

13. BIRTHPLACE OF MOTHER
(State or Country) **Iowa**

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) **Fred H. Gibson**
(Address) **Twin Falls**

15. Filed **5** 191**3** **Marion Adline Gibson**
Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH **May 14** 191**3**
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from **May 9** 191**3** to **May 14** 191**3**
that I last saw **her** alive on **May 13** 191**3**
and that death occurred on the date stated above, at **8:30 P.**

The CAUSE OF DEATH* was as follows:
Erysipelas.

(Duration) yrs. mos. **7** ds.
Contributory
(Secondary)

(Duration) yrs. mos. ds.
(Signed) **W. C. Gibson** M. D.
19 (Address) **Twin Falls, Ida.**

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death yrs. mos. days. In the State yrs. mos. days.

Where was disease contracted if not at place of death?

Former or usual residence.

19. PLACE OF BURIAL OR REMOVAL **Twin Falls** DATE OF BURIAL **May 15** 191**3**

20. UNDERTAKER **C. J. Glasby** ADDRESS **Twin Falls**

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
N. B.—Every item of information should be carefully supplied. AGE should be state EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Form V. S. No. 5. 10M. 6-20-11.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics
File No. 5161

1. PLACE OF DEATH.
County of Sunni Hills
City of Huber

Registration District No. 23
Primary Registration District No. 2085
(No. _____, St.)

Registered No. _____
If death occurred in a hospital, institution or camp give its NAME instead of street and number.

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

Pearl Spencer

PERSONAL AND STATISTICAL PARTICULARS

3. SEX F 4. COLOR OR RACE W 5. SINGLE, MARRIED, WIDOWED OR DIVORCED.
Single
(Write the word.)

6. DATE OF BIRTH _____
(Month) (Day) (Year)

7. AGE 3 yrs. _____ mos. _____ ds.
IF LESS than 1 day how many _____ hrs. or _____ min.?

8. OCCUPATION

(a) Trade, profession, or particular kind of work
(b) General nature of industry, business, or establishment in which employed (or employer)

None

9. BIRTHPLACE
(State or Country)

Idaho

10. NAME OF FATHER

Claude Spencer

11. BIRTHPLACE OF FATHER
(State or Country)

Mo.

12. MAIDEN NAME OF MOTHER

Lulu Pressler

13. BIRTHPLACE OF MOTHER
(State or Country)

Kansas

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

(Address)

15.

Filed

May 6 1913

Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

May 6th 1913
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from April 26th 1913, to May 6th 1913

that I last saw her alive on May 5th 1913, and that death occurred on the date stated above, at 10 a. M.

The CAUSE OF DEATH* was as follows:

Broncho-Pneumonia

(Duration) _____ yrs. _____ mos. 12 ds.

Contributory (Secondary)

Measles or whooping cough

(Duration) _____ yrs. _____ mos. _____ ds.

(Signed)

J. C. Patterson M. D.

May 6 1913 (Address) Bushy 2 dake

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place _____ In the _____
of death _____ yrs. _____ mos. _____ ds. State _____ yrs. _____ mos. _____ ds.
Where was Disease contracted,
If not at place of death?
Former or
usual residence _____

19. PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

Melmer

May 7 1913

20. UNDERTAKER

ADDRESS

W. J. Grossman

Sunni Hills

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Form V. S. No. 5 20M.1-16-12

CERTIFICATE OF DEATH

1. PLACE OF DEATH
County of Twin Falls
City of " " (No. " " St.)

Registration District No. 23
Primary Registration District No. 2085

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics
File No. 5162
Registered No. _____

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Gayle Nott

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX Female 4. COLOR OR RACE White 5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.)

6. DATE OF BIRTH Nov 29 1913
(Month) (Day) (Year)

7. AGE 5 yrs. 5 mos. 5 ds.
IF LESS than 1 day how many hrs. or mins.?

8. OCCUPATION
(a) Trade, profession or particular kind of work None
(b) General nature of industry business, or establishment in which employed (or employer)

9. BIRTHPLACE Twin Falls
(State or Country)

10. NAME OF FATHER N. F. Nott

11. BIRTHPLACE OF FATHER Iowa
(State or Country)

12. MAIDEN NAME OF MOTHER Edith May Stratton

13. BIRTHPLACE OF MOTHER Idaho
(State or Country)

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) N. F. Nott
(Address) Twin Falls

15. Filed May 5 1913 John C. Hughes
Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH May 4 1913
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from May 4 1913, to May 4 1913, that I last saw her alive on May 4 1913, and that death occurred on the date stated above, at 7 P. M.

The CAUSE OF DEATH* was as follows:

Broncho-pneumonia

(Duration) yrs. mos. / ds.

Contributory (Secondary)

(Duration) yrs. mos. ds.

(Signed) Charles R. Scott M. D.

5-5 1913 (Address) Twin Falls, Idaho

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death yrs. mos. days. In the State yrs. mos. days.

Where was disease contracted if not at place of death?

Former or usual residence.

19. PLACE OF BURIAL OR REMOVAL DATE OF BURIAL

Twin Falls May 5 1913

20. UNDERTAKER ADDRESS

Glensky Twin Falls

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Form V. S. No. 5 20M.1-16-12

CERTIFICATE OF DEATH

1. PLACE OF DEATH.

Registration District No.

23

County of Twin Falls

Primary Registration District No.

2085

City of

(No.

St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

Clarence W. DunlapState of Idaho
BOARD OF HEALTH
Bureau of Vital StatisticsFile No. 5163

Registered No.

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX

4. COLOR OR RACE

5. SINGLE, MARRIED, WIDOWED OR DIVORCED.

(Write the word.)

6. DATE OF BIRTH

Dec. 23 1908
(Month) (Day) (Year)

7. AGE

4 yrs. 4 mos. 7 ds.IF LESS than 1 day
how many hrs. or
..... mins.?

8. OCCUPATION

- (a) Trade, profession or particular kind of work
(b) General nature of industry business, or establishment in which employed (or employer)

9. BIRTHPLACE

(State or Country)

10. NAME OF FATHER

11. BIRTHPLACE OF FATHER

(State or Country)

12. MAIDEN NAME OF MOTHER

13. BIRTHPLACE OF MOTHER

(State or Country)

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

(Address)

15.

Filed

1913

Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH

May 1 1913
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from

April 20 1913, to May 1 1913,that I last saw him alive on May 1 1913,and that death occurred on the date stated above, at 11 A.M.

The CAUSE OF DEATH* was as follows:

Osteomyelitis(Duration) yrs. 1 1/2 mos. ds.Contributory
(Secondary)

(Duration) yrs. mos. ds.

(Signed)

For Boyd

M. D.

May 1 1913 (Address) Twin Falls, Idaho

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death yrs. mos. 10 days. In the State 4 yrs. mos. days.Where was disease contracted if not at place of death? Robert Ida

Former or usual residence.

19. PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

Robert Ida May 2 1913

20. UNDERTAKER

ADDRESS

J. G. Grossman Twin Falls

Form V. S. No. 5 20M.1-16-12

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics
File No. **5161**

1. PLACE OF DEATH.

Registration District No. **23**County of **Twin Falls**Primary Registration District No. **2085**City of **Idaho Falls**(No. **1** St.)Registered No. **5161**

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME **Robert Moe Moore**

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX

4. COLOR OR RACE

5. SINGLE, MARRIED, WIDOWED OR DIVORCED

6. DATE OF BIRTH

7. AGE

IF LESS than 1 day
how many hrs. or
..... mins.?

8. OCCUPATION

(a) Trade, profession or particular kind of work

(b) General nature of industry business, or establishment in which employed (or employer)

9. BIRTHPLACE

(State or Country)

10. NAME OF FATHER

11. BIRTHPLACE OF FATHER

(State or Country)

12. MAIDEN NAME OF MOTHER

13. BIRTHPLACE OF MOTHER

(State or Country)

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

(Address)

15.

Filed

5-22191**3**

Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH

May**22****1913**

(Month)

(Day)

(Year)

17. I HEREBY CERTIFY, That I attended deceased from

May 2 191**3**, to **May 22** 191**3**,that I last saw him alive on **May 22** 191**3**and that death occurred on the date stated above, at **830 M.**

The CAUSE OF DEATH* was as follows:

Pneumonia (Broncho)
following operation for appendicitis
three weeks previous

(Duration) yrs. mos. ds.

Contributory

(Secondary)

(Duration) yrs. mos. ds.

(Signed)

H. W. Wilson M. D.**May 22 1913** (Address) **Twin Falls, Idaho**

State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death yrs. mos. days. In the State yrs. mos. days.

Where was disease contracted if not at place of death? **Burly Ida**Former or usual residence **Idaho**

19. PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

Greeley Col.**1913**

20. UNDERTAKER

ADDRESS

J. F. Grossman **Twin Falls**

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
 B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Form V. S. No. 5 20M.1-16-12

CERTIFICATE OF DEATH

1. PLACE OF DEATH.

Registration District No. 3County of CanyonPrimary Registration District No. 2005City of Caldwell

(No. _____ St.)

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics
File No. 5165Registered No. 77

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME George H. Deane

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX M.4. COLOR OR RACE W.5. SINGLE, MARRIED, WIDOWED OR DIVORCED.
Single
(Write the word.)6. DATE OF BIRTH About 1863

(Month)

(Day)

(Year)

7. AGE 50 yrs. — mos. — ds.IF LESS than 1 day
how many hrs. or
..... mins.

8. OCCUPATION

(a) Trade, profession or particular kind of work Labor.

(b) General nature of industry business, or establishment in which employed (or employer)

9. BIRTHPLACE

(State or Country) Ohio10. NAME OF FATHER Don't know

11. BIRTHPLACE OF FATHER

(State or Country)

12. MAIDEN NAME OF MOTHER

13. BIRTHPLACE OF MOTHER

(State or Country)

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Thos E. Buerner(Address) Caldwell Idaho

15.

Filed July 13 1913

1913

Local Registrar John S. Mayes

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH July 10 1913

(Month)

(Day)

(Year)

17. I HEREBY CERTIFY, That I attended deceased from July 6 1913 to July 10 1913that I last saw him alive on July 9 1913 and that death occurred on the date stated above, at 7 AM.

The CAUSE OF DEATH* was as follows:

Cerebral Haemorrhage(Duration) yrs. mos. 4 ds.

Contributory (Secondary)

(Duration) yrs. mos. ds.

(Signed) Chas. H. Deane M. D.July 12 1913 (Address) Caldwell, Id.

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death yrs. mos. days. In the State yrs. mos. days.

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL Canyon HillDATE OF BURIAL July 13 191320. UNDERTAKER W. C. DyerADDRESS Caldwell, Idaho

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Form V. S. No. 5 20M.1-16-12

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH.

Registration District No. 3County of CanyonPrimary Registration District No. 2005-City of Caldwell

(No. _____, St.)

File No. 5168Registered No. 79

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

Pryor Burnett

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX

4. COLOR OR RACE

5. SINGLE, MARRIED, WIDOWED OR DIVORCED.

(Write the word.)

6. DATE OF BIRTH

Dec 16 1833
(Month) (Day) (Year)

7. AGE

79 yrs 6 mos 26 ds.IF LESS than 1 day
how many _____ hrs. or
_____ mins.?

8. OCCUPATION

(a) Trade, profession or particular kind of work

Farmer

(b) General nature of industry business, or establishment in which employed (or employer)

Retired

9. BIRTHPLACE

(State or Country)

Tennessee

10. NAME OF FATHER

Rowland Burnett

11. BIRTHPLACE OF FATHER

(State or Country)

Douk know

12. MAIDEN NAME OF MOTHER

13. BIRTHPLACE OF MOTHER

(State or Country)

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

D. V. Stafford

(Address)

Caldwell, Idaho

15.

Filed

July 15 - 1913Jahrd Meyer
Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH

July 12 1913
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from

191, to 191,that I last saw h. alive on 191,and that death occurred on the date stated above, at 530 B.M.

The CAUSE OF DEATH* was as follows:

Acute insufficiency(Duration) 5 yrs. mos. ds.Contributory acute dilation of
(Secondary) stomach(Duration) 1/2 yrs. mos. ds.(Signed) J. W. King M. D.7/14/1913 (Address) Caldwell, Idaho

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death _____ yrs. _____ mos. _____ days. In the State _____ yrs. _____ mos. _____ days.

Where was disease contracted if not at place of death? _____

Former or usual residence _____

19. PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

Bury on Hill July 16 1913

20. UNDERTAKER

ADDRESS

W. G. Dyer Caldwell, Idaho

Form V. S. No. 5. 10M. 6-20-11.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH.

Registration District No. 3County of CanyonPrimary Registration District No. 2005City of Caldwell

(No. _____ St.)

Registered No. 80

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

Jessie R. Bakes

If death occurred in a hospital, institution or camp give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX

Male

4. COLOR OR RACE

White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED.

(Write the word.)

6. DATE OF BIRTH

July
31
(Month)1893
(Day)1893
(Year)

7. AGE

19 yrs. 11 mos. 12 ds.IF LESS than 1 day
how many _____ hrs. or
min.?

8. OCCUPATION

- (a) Trade, profession or particular kind of work
(b) General nature of industry business or establishment in which employed (or employer)

School Boy

9. BIRTHPLACE

(State or Country)

Baire Idaho

10. NAME OF FATHER

J. G. L. Bakes

11. BIRTHPLACE OF FATHER

(State or Country)

K. C.

12. MAIDEN NAME OF MOTHER

Hattie Brown

13. BIRTHPLACE OF MOTHER

(State or Country)

Texas

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

My Hattie Bakes
my wife
Caldwell

(Address)

15.

Filed

July 12 - 1913J. G. L. Meyer
Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

7
(Month)12
(Day)1913
(Year)

17. I HEREBY CERTIFY, That I attended deceased from

6/23/13 191, to 7/12/13 191that I last saw her alive on 7/12/13 191and that death occurred on the date stated above, at 29, M.

The CAUSE OF DEATH* was as follows:

Cholera, Embolism,

(Duration) _____ yrs. _____ mos. _____ ds.

Contributory
(Secondary)Endocarditis & Typhoid

(Duration) _____ yrs. _____ mos. _____ ds.

(Signed) Wm. J. Gorman M. D.7/12/13 (Address) Caldwell, Idaho

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death _____ yrs. _____ mos. _____ ds. State _____ yrs. _____ mos. _____ ds.

Where was disease contracted.

If not at place of death?

Former or

usual residence.

19. PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

Star IdahoJuly 13 - 1913

20. UNDERTAKER

ADDRESS

Platt-Richman &CaldwellIdaho

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Form V. S. No. 5 20M.1-16-12

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH.

Registration District No. 3

County of Canyon

Primary Registration District No. 2005-

City of _____

(No. _____, St.)

File No. 5168

Registered No. 82

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Nerechal Goodson

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX Male 4. COLOR OR RACE White 5. SINGLE, MARRIED, WIDOWED OR DIVORCED. Single
(Write the word.)

6. DATE OF BIRTH

Nov 20 1911
(Month) (Day) (Year)

7. AGE

1 yrs. 7 mos. 8 ds.

IF LESS than 1 day
how many hrs. or
..... mins.?

8. OCCUPATION

(a) Trade, profession or particular kind of work
(b) General nature of industry business, or establishment in which employed (or employer)

None

9. BIRTHPLACE

(State or Country)

Idaho

10. NAME OF FATHER

S. H. Goodson

11. BIRTHPLACE OF FATHER

(State or Country)

Virginia

12. MAIDEN NAME OF MOTHER

Lily Carson

13. BIRTHPLACE OF MOTHER

(State or Country)

North Carolina

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

(Address)

S. H. Goodson
Notis, Ida

15.

Filed

July 31 - 1913

Local Registrar

John D. Meyer

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH

July 28 1913
(Month) (Day) (Year)

17. I HEREBY CERTIFY, THAT I attended deceased from

191 to 191

that I last saw him alive on 191

and that death occurred on the date stated above, at 12 M.

The CAUSE OF DEATH* was as follows:

Accidental Drowning

(Duration) yrs. mos. ds.

Contributory
(Secondary)

(Duration) yrs. mos. ds.

(Signed) W. H. Robinson M. D.

19 (Address) Naupa, Ida

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death yrs. mos. days. In the State yrs. mos. days.

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

River Basin

7/29 1913

20. UNDERTAKER

ADDRESS

W. C. Dyer

Caldwell, Ida

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Form V. S. No. 5. 10M. 6-20-11.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics
File No. 5169
Registered No. 83

1. PLACE OF DEATH. Registration District No. 3
County of Canyon Primary Registration District No. 2005
City of Caldwell (No. _____, _____ St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Grant Garfield Hero

If death occurred in a hospital, institution or camp give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX Male 4. COLOR OR RACE White 5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.)

6. DATE OF BIRTH 10 - 25 - 1911
(Month) (Day) (Year)

7. AGE 1 yrs. 15 mos. 15 ds. IF LESS than 1 day how many _____ hrs. or _____ min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work None
(b) General nature of industry business or establishment in which employed (or employer)

9. BIRTHPLACE (State or Country) Vale Oregon

10. NAME OF FATHER Geo Hero

11. BIRTHPLACE OF FATHER (State or Country) Ida

12. MAIDEN NAME OF MOTHER Hallie Grant

13. BIRTHPLACE OF MOTHER (State or Country) Wisconsin

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE (Informant) George W Hero

(Address) Hamdale - Idaho

15. Filed Aug 2 - 1913 John S. Meyers
Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH August 1 1913
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from July 29 1913, to Aug 1 1913, that I last saw him alive on Aug 1 1913, and that death occurred on the date stated above, at 12 M.

The CAUSE OF DEATH* was, as follows:

Dis - Colic
(Duration) _____ yrs. _____ mos. 5 ds.
Contributory (Secondary) None

(Duration) _____ yrs. _____ mos. _____ ds.
(Signed) J. M. Hall M. D.
Aug 2, 1913 (Address) Caldwell, Ida

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents)

At place Caldwell Hospital in the city of Caldwell of death _____ yrs. _____ mos. _____ ds. State _____ yrs. _____ mos. 5 ds.
Where was disease contracted, Hamdale, Ida
If not at place of death? Hamdale, Ida
Former or usual residence. Hamdale, Ida

19. PLACE OF BURIAL OR REMOVAL Canyon Hill DATE OF BURIAL Aug 2 1913

20. UNDERTAKER Clatt Peckham Caldwell ADDRESS

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Form V. S. No. 5 20M.1-16-12

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics
File No. **5172**

1. PLACE OF DEATH.

Registration District No. **2043**

County of **Idaho**

Primary Registration District No. **2043**

City of **Butte**

(No. _____, _____ St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME **Scott B. Toye**

Registered No. **149**

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX

Male

4. COLOR OR RACE

White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED.

Married
(Write the word.)

6. DATE OF BIRTH

July 7 1868
(Month) (Day) (Year)

7. AGE

53 yrs. - 9 mos. 9 ds.

IF LESS than 1 day
how many _____ hrs. or
_____ mins.?

8. OCCUPATION

(a) Trade, profession or particular kind of work

Ware houseman

(b) General nature of industry business, or establishment in which employed (or employer)

9. BIRTHPLACE

(State or Country)

Canada

10. NAME OF FATHER

Unknown

11. BIRTHPLACE OF FATHER

(State or Country)

Unknown

12. MAIDEN NAME OF MOTHER

Unknown

13. BIRTHPLACE OF MOTHER

(State or Country)

Unknown

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

(Address)

J. A. Toye
Butte Idaho

15.

Filed

July 31

1913

J. M. Vanhook

Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH

July 16 1913
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from investigation of the death of deceased, that I last saw him alive on _____ 191_____, and that death occurred on the date stated above, at _____.

The CAUSE OF DEATH* was as follows:

Suicide by firearms

(Duration) _____ yrs. _____ mos. _____ ds.

Contributory (Secondary)

(Duration) _____ yrs. _____ mos. _____ ds.

(Signed) **Henry B. Baker** M. D.

July 19 1913 (Address) **Corner of Idaho Cottonwood St.**
*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death _____ yrs. _____ mos. _____ days. In the State _____ yrs. _____ mos. _____ days.

Where was disease contracted if not at place of death?

Former or usual residence _____

19. PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

2007 Cemetery Stiles **July 19 1913**

20. UNDERTAKER

ADDRESS

Ch. Johnson **Hannah Ida**

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
N. B.—Every item of information should be carefully supplied. AGE should be state EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Form V. S. No. 5. 10M. 6-20-11.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics
File No. 111
Registered No. #150

1. PLACE OF DEATH.

Registration District No. 20110

County of Idaho

Primary Registration District No. 2043

City of State - Idaho

(No. , St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

Edith Lyle Wallace

If death occurred in a hospital, institution or camp give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX

Female

4. COLOR OR RACE 5. SINGLE, MARRIED, WIDOWED OR DIVORCED.

White

Married
(Write the word.)

6. DATE OF BIRTH

Dec 6 1891
(Month) (Day) (Year)

7. AGE

21 yrs. 7 mos. 8 ds.

IF LESS than 1 day
how many hrs. or
min.?

8. OCCUPATION

- (a) Trade, profession or particular kind of work
(b) General nature of industry business or establishment in which employed (or employer)

Housewife

9. BIRTHPLACE

(State or Country)

Washington

10. NAME OF FATHER

Martin R. Allen

11. BIRTHPLACE OF FATHER

(State or Country)

Don't Know

12. MAIDEN NAME OF MOTHER

Rosa Hays

13. BIRTHPLACE OF MOTHER

(State or Country)

Don't Know

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) C. M. Wallace

(Address) State - Idaho

15.

Filed July 31 1913 Jm. Verbeekenes
Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

July 17 1913
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from 191 to 191

that I last saw h. er alive on June 8 1913, and that death occurred on the date stated above, at 10:20 A.M.

The CAUSE OF DEATH* was as follows:

Pulmonary Tuberculosis

(Duration) 4 yrs. mos. ds.

Contributory
(Secondary)

(Duration) yrs. mos. ds.

(Signed) Jm. Verbeekenes M. D.
July 14 1913 (Address) Kootenai Idaho

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death yrs. mos. ds. State yrs. mos. ds.

Where was disease contracted,

If not at place of death?

Former or

usual residence.

19. PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

L.O.O.F. Cemetery, State Idaho July 16 1913

20. UNDERTAKER

ADDRESS

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
N. B.—Every item of information should be carefully supplied. AGE should be state EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Form V. S. No. 5. 10M. 6-20-11.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics
File No. 0171

1. PLACE OF DEATH.

Registration District No. 2042 10County of IdahoPrimary Registration District No. to 2043City of Stites

(No. _____)

St.)

Registered No. 101

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

Alexander Litherland

If death occurred in a hospital, institution or camp give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX

Male

4. COLOR OR RACE 5. SINGLE, MARRIED, WIDOWED OR DIVORCED.

WhiteMarried
(Write the word.)

6. DATE OF BIRTH

March 221862

(Month)

(Day)

(Year)

7. AGE

51 yrs.3 mos.25 ds.

IF LESS than 1 day
how many..... hrs. or
..... min.?

8. OCCUPATION

- (a) Trade, profession or particular kind of work
(b) General nature of industry business or establishment in which employed (or employer)

Minister of Gospel

9. BIRTHPLACE

(State or Country)

Ills

10. NAME OF FATHER

William Litherland

11. BIRTHPLACE OF FATHER

(State or Country)

Indiana

12. MAIDEN NAME OF MOTHER

Susan Hall

13. BIRTHPLACE OF MOTHER

(State or Country)

Ky

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

Mrs Alex Litherland

(Address)

Stites Idaho

15.

Filed July 11913

John L. Rains
Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

June261913

(Month)

(Day)

(Year)

17. I HEREBY CERTIFY, That I attended deceased from

191

to

191that I last saw him alive on June 25 1913and that death occurred on the date stated above, at 7:00 P. M.

The CAUSE OF DEATH* was as follows:

Sudden, presumably Apoplexy

(Duration)

yrs.

mos.

ds.

Contributory
(Secondary)

(Duration)

yrs.

mos.

ds.

(Signed)

A. J. Mohlenberg

M. D.

June 27 1913

(Address)

Kooskia, Ida

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place

In the

of death..... yrs..... mos..... ds. State..... yrs..... mos..... ds.

Where was disease contracted.

If not at place of death?

Former or

usual residence.

19. PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

Stites CemeteryJune 27 1913

20. UNDERTAKER

ADDRESS

Joseph McEliskeyBatterson

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Form V. S. No. 5. 12½ M. 7-24-11

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics
File No. 5115
Registered No. 152

1. PLACE OF DEATH. Registration District No. 2042 10
County of Idaho Primary Registration District No. # 2042
City of Kentaville precinct (No. _____, _____ St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Mary Magdalena Suter

If death occurred in a hospital, institution or camp give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX Female 4. COLOR OR RACE White 5. SINGLE, MARRIED, WIDOWED OR DIVORCED. Single
(Write the word.)

6. DATE OF BIRTH May 14 1849
(Month) (Day) (Year)

7. AGE 64 yrs. 2 mos. 2 ds. IF LESS than 1 day how many hrs. or min?

8. OCCUPATION

(a) Trade, profession or particular kind of work..... Sister of Mercy
(b) General nature of industry business or establishment in which employed (or employer)

9. BIRTHPLACE Switzerland
(State or Country)

10. NAME OF FATHER Michael Suter

11. BIRTHPLACE OF FATHER Switzerland
(State or Country)

12. MAIDEN NAME OF MOTHER Unknown

13. BIRTHPLACE OF MOTHER Switzerland
(State or Country)

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Mother M. Hildegard
(Address) Priores of St. Gertrude's Convent

15.

Filed July 14 1913

Jose L. Rain
Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH July 14 1913
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from Oct 1 1912, to July 6 1913
that I last saw her alive on July 6th 1913
and that death occurred on the date stated above, at 6⁰⁰ M.

The CAUSE OF DEATH* was as follows:

Cancer of Liver

Unknown
(Duration) yrs. mos. ds.

Contributory (Secondary)
(Duration) yrs. mos. ds.

(Signed) Harry B. Burke M. D.
July 14 1913 (Address) Kentaville Idaho

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place yrs. mos. ds. In the State yrs. mos. ds.
Where was disease contracted,
If not at place of death?
Former or
usual residence.....

19. PLACE OF BURIAL OR REMOVAL DATE OF BURIAL

Cemetery of St. Gertrude's Convent near Cottonwood Id July 15 1913

20. UNDERTAKER ADDRESS

Joseph Melaskey Cottonwood

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Form V. S. No. 5 20M.1-16-12

CERTIFICATE OF DEATH

1. PLACE OF DEATH.

County of Idaho

City of _____

Registration District No. 2045 10Primary Registration District No. 10 2042

(No. _____, _____ St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

Charles Henry Seyller

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

File No. 5175Registered No. 153

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX

male

4. COLOR OR RACE

white

5. SINGLE, MARRIED, WIDOWED OR DIVORCED.

Single
(Write the word.)

6. DATE OF BIRTH

May
(Month)22nd
(Day)1895
(Year)

7. AGE

18 yrs. 2 mos. 3 ds.

IF LESS than 1 day
how many _____ hrs. or
_____ mins.?

8. OCCUPATION

- (a) Trade, profession or particular kind of work
(b) General nature of industry business, or establishment in which employed (or employer)

Seaman

9. BIRTHPLACE

(State or Country)

Harris Texas

10. NAME OF FATHER

Conrade Seyller

11. BIRTHPLACE OF FATHER

(State or Country)

Idaho

12. MAIDEN NAME OF MOTHER

Victoria Keppel

13. BIRTHPLACE OF MOTHER

(State or Country)

Idaho

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

Mrs. Victoire Seyller

(Address)

Cottamwood Idaho

15.

Filed

July 251913John L. Rains

Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH

July
(Month)23
(Day)1913
(Year)

17. I HEREBY CERTIFY, That I attended deceased from
July 23 1913, to July 25 1913,

that I last saw him alive on July 25 1913,

and that death occurred on the date stated above, at 10⁰⁰ M.

The CAUSE OF DEATH* was as follows:

Run over by Wagon
accidental

(Duration) _____ yrs. _____ mos. _____ ds.

Contributory
(Secondary)

(Duration) _____ yrs. _____ mos. _____ ds.

(Signed)

Henry B. Miller M. D.
July 25 1913 (Address) Cottamwood Idaho

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death _____ yrs. _____ mos. _____ days. In the State _____ yrs. _____ mos. _____ days.

Where was disease contracted if not at place of death?

Former or usual residence.

19. PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

Catholic Cemetery, Cottonwood July 27 1913

20. UNDERTAKER

ADDRESS

Joseph McElashy Cottonwood

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Form V. S. No. 5 20M.1-16-12

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH.

Registration District No. Zone 10County of IdahoPrimary Registration District No. 1042

City of _____

(No. _____ St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

John E. FarthingFile No. 517Registered No. 154

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX

Male

4. COLOR OR RACE

White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED.

Single (Write the word.)

6. DATE OF BIRTH

July
(Month)13
(Day)1913
(Year)

7. AGE

____ yrs. ____ mos. ____ ds.

IF LESS than 1 day
how many 11 hrs. or
____ mins.?

8. OCCUPATION

(a) Trade, profession or particular kind of work
(b) General nature of industry business, or establishment in which employed (or employer)

none

9. BIRTHPLACE

(State or Country)

4 miles S Cottonwood

10. NAME OF FATHER

S. J. Farthing

11. BIRTHPLACE OF FATHER

(State or Country)

Smethport North Carolina

12. MAIDEN NAME OF MOTHER

Jennie B. Gentry

13. BIRTHPLACE OF MOTHER

(State or Country)

Shut Wood North Carolina

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

S. J. Farthing

(Address)

Cottonwood Idaho

15.

Filed

July 14 1913John E. Rains
Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH

July
(Month)14
(Day)1913
(Year)17. I HEREBY CERTIFY, That I attended deceased from investigated the death of deceasedthat I last saw alive on July 14 1913and that death occurred on the date stated above, at 10 AM

The CAUSE OF DEATH* was as follows:

Natural Causes Unknown

(Duration) ____ yrs. ____ mos. ____ ds.

Contributory
(Secondary)

(Duration) ____ yrs. ____ mos. ____ ds.

(Signed)

Henry B. Rains M. D.July 14 1913 (Address) Corner Idaho County

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death ____ yrs. ____ mos. ____ days. In the State ____ yrs. ____ mos. ____ days.

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL DATE OF BURIAL

Protestant Cemetery Cottonwood July 16 1913

20. UNDERTAKER

ADDRESS

Joseph M. Moberly Cottonwood

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Form V. S. No. 5 20M.1-16-12

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH.

Registration District No. 10County of IdahoPrimary Registration District No. 2044File No. 5172City of Grangerville

(No. _____, St.)

Registered No. 155

If death occurs away from usual residence, give facts called for under special instruction.

2. FULL NAME Emma Lundy

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX Female4. COLOR OR RACE White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED.

(Write the word.)

6. DATE OF BIRTH

Aug 7 1893
(Month) (Day) (Year)

7. AGE

32 yrs. 11 mos. 13 ds.

IF LESS than 1 day
how many _____ hrs. or
_____ mins.?

8. OCCUPATION

(a) Trade, profession or particular kind of work

(b) General nature of industry business, or establishment in which employed (or employer)

House Wife

9. BIRTHPLACE

(State or Country)

Idaho Co Idaho

10. NAME OF FATHER

Peter Richold

11. BIRTHPLACE OF FATHER

(State or Country)

Germany

12. MAIDEN NAME OF MOTHER

Catherine Jungmiller

13. BIRTHPLACE OF MOTHER

(State or Country)

Germany

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

Geo D Briscoe

(Address)

Grangerville Idaho

15.

Filed

July 23 1913

1913

John L. Paine

Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

July 23 1913
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from May 18 1913, to July 19 1913, that I last saw her alive on July 17 1913 and that death occurred on the date stated above, at 7 A.M.

The CAUSE OF DEATH* was as follows:

Cerebral Septicemia

(Duration) _____ yrs. _____ mos. 34 ds.

Contributory
(Secondary)

(Duration) _____ yrs. _____ mos. _____ ds.

(Signed)

W. S. Stocklin M. D.
July 23 1913 (Address) Grangerville Idaho

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death _____ yrs. _____ mos. _____ days. In the State _____ yrs. _____ mos. _____ days.

Where was disease contracted if not at place of death?

Former or usual residence.

19. PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

Fair View

July 24 1913

20. UNDERTAKER

ADDRESS

W. S. Graham Grangerville

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Form V. S. No. 5 20M.1-16-12

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH.

Registration District No. 2044 10County of IdahoPrimary Registration District No. to 2044City of Denver precinct

(No.)

St.)

File No. 5111Registered No. 156

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

Sybil Cone

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX

4. COLOR OR RACE

5. SINGLE, MARRIED, WIDOWED OR DIVORCED.

FemaleWhiteMarried

6. DATE OF BIRTH

Nov.181886

(Month)

(Day)

(Year)

7. AGE

26 yrs. 8 mos. 14 ds.

IF LESS than 1 day
how many hrs. or
..... mins.?

8. OCCUPATION

(a) Trade, profession or particular kind of work

(b) General nature of industry, business, or establishment in which employed (or employer)

Housewife

9. BIRTHPLACE

(State or Country)

Labet Co. Kans.

10. NAME OF FATHER

B. W. Morris

11. BIRTHPLACE OF FATHER

(State or Country)

Unknown

12. MAIDEN NAME OF MOTHER

Molly Aubrey

13. BIRTHPLACE OF MOTHER

(State or Country)

Unknown

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

Fred Cone

(Address)

Grangerville Idaho

15.

Filed Aug. 21913Jesse L Rains

Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH

August 1

(Month)

(Day)

1913

(Year)

17. I HEREBY CERTIFY, That I attended deceased from

May 101910, toJune 41912,

that I last saw her alive on

June 41912,and that death occurred on the date stated above, at 12³⁰ p.m.

The CAUSE OF DEATH* was as follows:

Pulmonary Tuberculosis

(Duration) yrs. mos. ds.

Contributory
(Secondary)

(Duration) yrs. mos. ds.

(Signed)

Jesse L Rains

M. D.

Aug. 2 1913(Address) Grangerville, Idaho

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place

of death.

..... yrs. mos. days.

In the

State.

..... yrs. mos. days.

Where was disease contracted if not at place of death?

Former or usual residence.

19. PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

Denver CemeteryAug. 3 1913

20. UNDERTAKER

ADDRESS

Joseph McElashyBatterson

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Form V. S. No. 5 20M.1-16-12

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH.

Registration District No. 10

County of Idaho

Primary Registration District No. 2042

File No. 5180

City of Cottonwood

(No. _____ St.)

Registered No. 157

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME John Noel Snowden

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX

Male

4. COLOR OR RACE

white

5. SINGLE, MARRIED, WIDOWED OR DIVORCED.

Married
(Write the word.)

6. DATE OF BIRTH

July 18 1858
(Month) (Day) (Year)

7. AGE

55 yrs. 1 mos. 9 ds.

IF LESS than 1 day
how many hrs. or mins.?

8. OCCUPATION

(a) Trade, profession or particular kind of work

Furniture dealer

(b) General nature of industry business, or establishment in which employed (or employer)

9. BIRTHPLACE

(State or Country)

Cambridge England

10. NAME OF FATHER

Jon Snowden

11. BIRTHPLACE OF FATHER

(State or Country)

England

12. MAIDEN NAME OF MOTHER

Marth King

13. BIRTHPLACE OF MOTHER

(State or Country)

Cambridge England

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Ada Snowden

(Address)

15.

Filed July 19 1913

Jose L. Pains
Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH

July 18 1913
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from

May 19th 1913, to July 18th 1913, that I last saw him alive on July 15th 1913, and that death occurred on the date stated above, at P. M.

The CAUSE OF DEATH* was as follows:

Gout

(Duration) about 35 years yrs. mos. ds.

Contributory (Secondary)

Chronic interstitial nephritis

(Duration) Unknown yrs. mos. ds.

(Signed)

J. W. Burner M. D.

7-19-1913 (Address) Cottonwood, Ida

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death.....yrs.....mos.....days. In the State.....yrs.....mos.....days.

Where was disease contracted if not at place of death?

Former or usual residence.

19. PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

Cottonwood Cemetery

July 20 1913

20. UNDERTAKER

E. Hancock

ADDRESS

Harperville

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. MARGIN RESERVED FOR BINDING

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Form V. S. No. 5. 12½ M. 7-24-11

CERTIFICATE OF DEATH

1. PLACE OF DEATH.
County of Lincoln
City of Dietrich

Registration District No. 5
Primary Registration District No. 2016
(No. _____, St. _____)

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics
File No. 5151
Registered No. 22

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

Agnes M. Edwards

If death occurred in a hospital, institution or camp give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX female 4. COLOR OR RACE white 5. SINGLE, MARRIED, WIDOWED OR DIVORCED. single
(Write the word.)

6. DATE OF BIRTH June 9 1913
(Month) (Day) (Year)

7. AGE 20 14 hrs IF LESS than 1 day
yrs. mos. ds. how many hrs. or min?

8. OCCUPATION

(a) Trade, profession or particular kind of work. _____
(b) General nature of industry business or establishment in which employed (or employer) _____

9. BIRTHPLACE Dietrich Ida.
(State or Country)

10. NAME OF FATHER Harry Edwards

11. BIRTHPLACE OF FATHER Beaver Co. Utah
(State or Country)

12. MAIDEN NAME OF MOTHER Lilla Reckham

13. BIRTHPLACE OF MOTHER Ogden Utah
(State or Country)

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Harry Edwards
(Address) Dietrich Ida.

15. Filed June 12 1913 C. F. Zeller
Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH June 11 1913
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from June 9th 1913, to June 11th 1913
that I last saw her alive on June 10th 1913
and that death occurred on the date stated above, at 7:15 P. M.
The CAUSE OF DEATH* was as follows:

Pulmonary Congestion

(Duration) four hours yrs. mos. ds.
Contributory Cardiac Asthenia
(Secondary)

(Duration) _____ yrs. mos. ds.
(Signed) D. S. Lighthall M. D.
June 11 1913 (Address) Dietrich

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place _____ In the _____
of death _____ yrs. _____ mos. _____ ds. State _____ yrs. _____ mos. _____ ds.
Where was disease contracted, _____
If not at place of death? _____
Former or _____
usual residence _____

19. PLACE OF BURIAL OR REMOVAL Buried on ranch DATE OF BURIAL 191

20. UNDERTAKER _____ ADDRESS _____

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Form V. S. No. 5. 10M. 6-20-11.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH.

Registration District No. 5

County of Lincoln

Primary Registration District No. 2016

City of Shoshone

(No. _____, St.)

File No. 5182

Registered No. 21

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Sarah Estela aldrich

If death occurred in a hospital, institution or camp give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX

Female

4. COLOR OR RACE

white

5. SINGLE, MARRIED, WIDOWED OR DIVORCED.

married
(Write the word.)

6. DATE OF BIRTH

Sept Sept 1872

44 years

(Month) (Day) (Year)

7. AGE

40 yrs. 9 mos. 9 ds.

IF LESS than 1 day
how many hrs. or min.?

8. OCCUPATION

(a) Trade, profession, or particular kind of work
(b) General nature of industry, business, or establishment in which employed (or employer)

Housewife

9. BIRTHPLACE

(State or Country)

Iowa

10. NAME OF FATHER

James Smith

11. BIRTHPLACE OF FATHER

(State or Country)

England

12. MAIDEN NAME OF MOTHER

Ruma Haskins

13. BIRTHPLACE OF MOTHER

(State or Country)

Michigan

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

N. E. Aldrich

(Address)

Shoshone, Idaho

15.

Filed

6/17 1913

C. F. Zella

Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

June

13

1913

(Month)

(Day)

(Year)

17. I HEREBY CERTIFY, That I attended deceased from

Oct.

1912

to June

1913

that I last saw her alive on June 10 1913,

and that death occurred on the date stated above, at 4 a. M.

The CAUSE OF DEATH* was as follows:

Cancer of Breast

(Duration) 2 yrs. mos. ds.

Contributory

(Secondary) Metastatic Carcinoma

(Duration) yrs. mos. ds.

(Signed)

C. F. Zella

M. D.

June 14 1913 (Address) Shoshone, Idaho

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place

In the

of death..... yrs. mos. ds. State..... yrs. mos. ds.

Where was Disease contracted,

If not at place of death?

Former or

usual residence.

19. PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

Clearville, Iowa

191

20. UNDERTAKER

ADDRESS

O. J. Brennan Shoshone

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Form V. S. No. 5. 10M. 6-20-11.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

File No. 5183

Registered No. 28

If death occurred in a hospital, institution or camp give its NAME instead of street and number.

1. PLACE OF DEATH.

County of Lincoln

City of Shoshone

Registration District No. 5

Primary Registration District No. 216

(No. St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME John B Lumb

PERSONAL AND STATISTICAL PARTICULARS

3. SEX

Male

4. COLOR OR RACE

White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED.

Married
(Write the word.)

6. DATE OF BIRTH

June 4 th

(Month)

(Day)

1913
(Year)

7. AGE

35 yrs. 1 mos. 5 ds.

IF LESS than 1 day
how many hrs. or
..... min.?

8. OCCUPATION

(a) Trade, profession, or particular kind of work
(b) General nature of industry business, or establishment in which employed (or employer)

Farmer

9. BIRTHPLACE

(State or Country)

Yorkshire England

10. NAME OF FATHER

John S Lumb

11. BIRTHPLACE OF FATHER

(State or Country)

Yorkshire England

12. MAIDEN NAME OF MOTHER

Sarah Spooner

13. BIRTHPLACE OF MOTHER

(State or Country)

Derbyshire England

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

Charles Henry Lumb

(Address)

Shoshone Idaho

15.

Filed

June 6 1913

C. H. Zella

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

June 4 th 1913
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from

May 25 1913, to June 3 rd 1913

that I last saw him alive on June 3 rd 1913,

and that death occurred on the date stated above, at 3 a. m.

The CAUSE OF DEATH* was as follows:

Spotted Fever

(Duration) yrs. mos. 14 ds.

Contributory
(Secondary)

(Duration) yrs. mos. ds.

(Signed) H. B. Baugh M. D.

1913 (Address) Shoshone Ida

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL,

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place In the
of death yrs. mos. ds. State yrs. mos. ds.

Where was Disease contracted,
If not at place of death?
Former or
usual residence.....

19. PLACE OF BURIAL OR REMOVAL

Shoshone

DATE OF BURIAL

June 6 th 1913

20. UNDERTAKER

A. B.

ADDRESS

Shoshone

FOR BINDING

MARGIN RESERVE

WRITE PLAINLY, WITH UNFADING INK. B.—Every item of information should be carefully checked. AGE should be stated EXACTLY. PHYSICIAN should state CAUSE OF DEATH in plain language so that it may be properly classified. Exact statements on back of certificate. Statement of OCCUPATION is very important. See

Form V. S. No. 5. 10M. 6-20-11.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH.
County of Gooding
City of Gooding

Registration District No. 5
Primary Registration District No. 2018
(No. _____, _____ St.)

File No. 5185
Registered No. 15

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

If death occurred in a hospital, institution or camp give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX M 4. COLOR OR RACE W 5. SINGLE, MARRIED, WIDOWED OR DIVORCED. Infant
(Write the word.)

6. DATE OF BIRTH Sept 24 1909
(Month) (Day) (Year)

7. AGE 4 yrs. 3 mos. 16 ds. IF LESS than 1 day how many _____ hrs. or _____ min.?

8. OCCUPATION Infant
(a) Trade, profession, or particular kind of work
General nature of industry
Business, or establishment in which employed (or employer)

9. BIRTHPLACE Mo
(State or Country)

10. NAME OF FATHER W A Gibbs

11. BIRTHPLACE OF FATHER Mo
(State or Country)

12. MAIDEN NAME OF MOTHER Mamie Gibbs

13. BIRTHPLACE OF MOTHER Kansas
(State or Country)

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) W A Gibbs

(Address) Gooding, Ida

15. Filed April 5 1913 H E Lamb
Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH Feb 18 1913
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from 2-10 1913, to 2-18 1913
that I last saw him alive on 2-10 1913,
and that death occurred on the date stated above, at 10 P M.

The CAUSE OF DEATH* was as follows:

My postmortal examination I have
Pneumonia
(Duration) _____ yrs. _____ mos. _____ ds.

Contributory (Secondary) _____
(Duration) _____ yrs. _____ mos. _____ ds.
(Signed) F T Cary M. D.
2-11-1913 (Address) Gooding Idaho

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place _____ In the _____
of death _____ yrs. _____ mos. _____ ds. State _____ yrs. _____ mos. _____ ds.
Where was Disease contracted, _____
If not at place of death? _____
Former or _____
usual residence _____

19. PLACE OF BURIAL OR REMOVAL Gooding DATE OF BURIAL 2-12 1913

20. UNDERTAKER W B Thompson ADDRESS Gooding

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Form V. S. No. 5 20M.1-16-12

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH.

Registration District No. *016*

County of *Gooding*

Primary Registration District No. *2018*

City of *Gooding*

(No. _____, St.)

File No. *518*

Registered No. *12*

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

Olma F Loveland

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX

m

4. COLOR OR RACE

w

5. SINGLE, MARRIED, WIDOWED OR DIVORCED.

Infant
(Write the word.)

6. DATE OF BIRTH

Feb

26

1912

(Month)

(Day)

(Year)

7. AGE

11 yrs. *27* mos. *27* ds.

IF LESS than 1 day
how many hrs. or
..... mins.?

8. OCCUPATION

(a) Trade, profession or particular kind of work
(b) General nature of industry business, or establishment in which employed (or employer)

Infant

9. BIRTHPLACE

(State or Country)

Idaho

10. NAME OF FATHER

Wm Loveland

11. BIRTHPLACE OF FATHER

(State or Country)

Utah

12. MAIDEN NAME OF MOTHER

Ann L Gardue

13. BIRTHPLACE OF MOTHER

(State or Country)

Utah

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

Wm Loveland

(Address)

Bliss Idaho

15.

Filed

April 1

1913

H C Lumb

Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH

Feb

23

1913

(Month)

(Day)

(Year)

17. I HEREBY CERTIFY, That I attended deceased from

2-20-

1913, to

2-23

1913,

that I last saw him alive on *2-23* 1913,

and that death occurred on the date stated above, at *2 P.M.*

The CAUSE OF DEATH* was as follows:

Measles - broncho - pneumonia - mixed - white

(Duration)

yrs.

mos.

ds.

Contributory
(Secondary)

(Duration)

yrs.

mos.

ds.

(Signed)

F V Cary

M. D.

2-24 1913

(Address) *Gooding Idaho*

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place

of death.

yrs.

mos.

days.

In the

State.

yrs.

mos.

days.

Where was disease contracted if not at place of death?

Former or

usual residence.

19. PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

Utah

2-27

1913

20. UNDERTAKER

ADDRESS

A E Thompson

Gooding

Form V. S. No. 5 20M.1-16-12

CERTIFICATE OF DEATH

5189
State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics
File No. 450 **\$189**
Registered No. 761

1. PLACE OF DEATH.

Registration District No. 13

County of Bingham

Primary Registration District No. 1007

City of Blackfoot(No. Hospital Francis St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

Frank Simon

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX

4. COLOR OR RACE

5. SINGLE, MARRIED, WIDOWED OR DIVORCED.

MaleWhiteMarried
(Write the word.)

6. DATE OF BIRTH

(Month)

(Day)

(Year)

7. AGE

about 46

yrs.

mos.

ds.

IF LESS than 1 day
how many hrs. or
..... mins.?

8. OCCUPATION

(a) Trade, profession or particular kind of work

Book Layer

(b) General nature of industry business, or establishment in which employed (or employer)

9. BIRTHPLACE

(State or Country)

Subenlanger Germany

10. NAME OF FATHER

?

11. BIRTHPLACE OF FATHER

(State or Country)

?

12. MAIDEN NAME OF MOTHER

?

13. BIRTHPLACE OF MOTHER

(State or Country)

?

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

Joseph Teschendorf

(Address)

915 Concord St Chicago

15.

Filed

July 5 1913M. E. Patrick
Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH

July
(Month)3d
(Day)1913
(Year)

17. I HEREBY CERTIFY, That I attended deceased from

July 2d 1913, to July 3d 1913
that I last saw him alive on July 3d 1913.and that death occurred on the date stated above, at 7 A.M.

The CAUSE OF DEATH* was as follows:

General Peritonitis

(Duration)

yrs.

mos.

ds.

Contributory
(Secondary)Appendicitis
operation

(Duration)

yrs.

mos.

ds.

(Signed)

H. G. Simmons M. D.July 6 1913 (Address) Blackfoot Idaho

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL OR HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place

of death.

Where was disease contracted if not at place of death?

Former or

usual residence.

In the

State.

19. PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

Chicago Ill1913

20. UNDERTAKER

E. J. Rich

ADDRESS

Blackfoot

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Form V. S. No. 5. 12½ M. 7-24-11

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics
File No. 5199
Registered No. 71

1. PLACE OF DEATH Registration District No. 13
County of Blaine Primary Registration District No. 2053
City of Portland, Ore. St.

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

Robert Lee Randall

If death occurred in a hospital, institution or camp give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX M 4. COLOR OR RACE W 5. SINGLE, MARRIED, WIDOWED OR DIVORCED. Single
(Write the word.)

6. DATE OF BIRTH June 4 1913
(Month) (Day) (Year)

7. AGE yrs. mos. ds. 20 min?
IF LESS than 1 day how many hrs. or min?

8. OCCUPATION

- (a) Trade, profession or particular kind of work
(b) General nature of industry business or establishment in which employed (or employer)

9. BIRTHPLACE (State or Country) Portland, Idaho

10. NAME OF FATHER Thos. W. Randall

11. BIRTHPLACE OF FATHER Utah
(State or Country)

12. MAIDEN NAME OF MOTHER Ida Bringham

13. BIRTHPLACE OF MOTHER Utah
(State or Country)

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) T. W. Randall
(Address) Blackfoot # 4

15. Filed June 5 1913
Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH June 4 1913
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from June 4 1913, to June 5 1913, that I last saw him alive on June 5 1913, and that death occurred on the date stated above, at 12:30 A. M.
The CAUSE OF DEATH* was as follows:
Premature delivery at 7 months

(Duration) yrs. mos. ds.

Contributory (Secondary)

(Duration) yrs. mos. ds.
(Signed) M. E. Purdie M. D.
June 5 1913 (Address) Blackfoot

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place In the
of death yrs. mos. ds. State yrs. mos. ds.
Where was disease contracted,
If not at place of death?
Former or
usual residence.

19. PLACE OF BURIAL OR REMOVAL DATE OF BURIAL
Portland, Idaho June 5 1913

20. UNDERTAKER ADDRESS
W. Randall Blackfoot

T. W. Randall

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Form V. S. No. 5. 12½ M. 7-24-11

CERTIFICATE OF DEATH

1. PLACE OF DEATH. Registration District No. 13
 County of Burnham Primary Registration District No. 2053
 City of Blackfoot (No. not named St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

Infant not named

State of Idaho
 BOARD OF HEALTH
 Bureau of Vital Statistics

File No. 5191Registered No. 72

If death occurred in a hospital, institution or camp give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX Girl 4. COLOR OR RACE White 5. SINGLE, MARRIED, WIDOWED OR DIVORCED. Infant
 (Write the word.)

6. DATE OF BIRTH

June 5 1913
 (Month) (Day) (Year)

7. AGE

6 hours IF LESS than 1 day
 how many hrs. or
 yrs. mos. ds. min?

8. OCCUPATION

- (a) Trade, profession or particular kind of work.....
 (b) General nature of industry business or establishment in which employed (or employer)

9. BIRTHPLACE

(State or Country)

Idaho

10. NAME OF FATHER

Thomas Bible

11. BIRTHPLACE OF FATHER

(State or Country)

Illinois

12. MAIDEN NAME OF MOTHER

Effie Halloway

13. BIRTHPLACE OF MOTHER

(State or Country)

Mo.

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

(Address)

Mr. J. P. Bateman
J. B. Davis M. D. College of Physicians

15.

Filed

June 5 1913

Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH

June 5 1913
 (Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from four o'clock 1913, to ten o'clock 1913

that I last saw him alive on the 5/6 1913
 and that death occurred on the date stated above, at 12 A. M.

The CAUSE OF DEATH* was as follows:

Raised Placenta Ecterus

eight hours

(Duration) yrs. mos. ds.

Contributory
 (Secondary)

(Duration) yrs. mos. ds.

(Signed) Mr. J. P. Bateman Midnight M. D.

19. (Address) J. B. Davis M. D. College of Physicians

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place yrs. mos. ds. In the
 of death yrs. mos. ds. State yrs. mos. ds.

Where was disease contracted,

If not at place of death?

Former or

usual residence.....

19. PLACE OF BURIAL OR REMOVAL DATE OF BURIAL

Hope City Cemetery June 6 1913
Blackfoot Idaho

20. UNDERTAKER

ADDRESS

Thos Bible

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Form V. S. No. 5 20M.1-16-12

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH.

Registration District No. 13

County of Bingham

Primary Registration District No. 1007

City of Blackfoot

(No. Suppl addition St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Ruth Patter

File No. 5192

Registered No. 73

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX

4. COLOR OR RACE

5. SINGLE, MARRIED, WIDOWED OR DIVORCED.

Female White

(Write the word.)

6. DATE OF BIRTH

Dec 14 1912
(Month) (Day) (Year)

7. AGE

6 yrs. 9 mos. 9 ds.

IF LESS than 1 day
how many hrs. or mins.?

8. OCCUPATION

- (a) Trade, profession or particular kind of work
(b) General nature of industry, business, or establishment in which employed (or employer)

9. BIRTHPLACE

(State or Country) Bingham Co Idaho

10. NAME OF FATHER

Geo F Patter

11. BIRTHPLACE OF FATHER

(State or Country) Utah

12. MAIDEN NAME OF MOTHER

Russie Odunkirk

13. BIRTHPLACE OF MOTHER

(State or Country) Utah

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) G. F. Potter

(Address) Blackfoot

15.

Filed June 26 1913 W. E. Patrie
Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH

6 26 1913
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from June 26 1913, to Dec 20 1912

that I last saw her alive on Dec 20 1912 and that death occurred on the date stated above, at 10 P. M.

The CAUSE OF DEATH* was as follows:

Ischemic Heart trouble
from Brain
Valvular disease heart
mitral
(Duration) yrs. 6 mos. 9 ds.

Contributory
(Secondary)

(Duration) yrs. 6 mos. 9 ds.

(Signed) W. E. Patrie M. D.

6-26-1913 (Address) Blackfoot

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death... yrs. ... mos. ... days. In the State... yrs. ... mos. ... days.

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL DATE OF BURIAL

Emm City Cem Blackfoot June 27 1913

20. UNDERTAKER ADDRESS

G. J. Pack Blackfoot

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Form V. S. No. 5 20M.1-16-12

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics
File No. 5193

1. PLACE OF DEATH _____ Registration District No. 13
County of Bannock Primary Registration District No. 2053
City of Riverside Ward (No. _____ St.)

Registered No. 76
If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Josephine B. Johnson

PERSONAL AND STATISTICAL PARTICULARS

3. SEX Female 4. COLOR OR RACE White 5. SINGLE, MARRIED, WIDOWED OR DIVORCED. Married
(Write the word.)

6. DATE OF BIRTH Sept 30 1 865
(Month) (Day) (Year)

7. AGE 47 yrs. 9 mos. 7 ds.
IF LESS than 1 day how many hrs. or mins.?

8. OCCUPATION
(a) Trade, profession or particular kind of work Housewife
(b) General nature of industry business, or establishment in which employed (or employer) _____

9. BIRTHPLACE Provo Utah
(State or Country)

10. NAME OF FATHER John F. Westphal

11. BIRTHPLACE OF FATHER Germany
(State or Country)

12. MAIDEN NAME OF MOTHER Elsie Nicholson

13. BIRTHPLACE OF MOTHER Denmark
(State or Country)

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) J. A. Johnson
(Address) Blackfoot Idaho

15. Filed July 7 1913 W. E. Patric
Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH July 6 1913
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from Feb 16 1912, to July 6 1913, that I last saw her alive on June 23 1913, and that death occurred on the date stated above, at 11 A.M.

The CAUSE OF DEATH* was as follows:

Valvular disease of heart - mitral
Bright's disease
(Duration) 3 yrs. 6 mos. ds.
Contributory Embolism of liver
(Secondary)
(Duration) 3 yrs. mos. ds.

(Signed) W. E. Patric M. D.
July 7 1913 (Address) Blackfoot Idaho

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death yrs. mos. days. In the State yrs. mos. days.

Where was disease contracted if not at place of death? _____

Former or usual residence. _____

19. PLACE OF BURIAL OR REMOVAL Riverside Thomas DATE OF BURIAL July 10 1913

20. UNDERTAKER E. L. Peck ADDRESS Blackfoot

Form V. S. No. 5 20M.1-16-12

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH. Registration District No. 18
 County of Bingham Primary Registration District No. 2053
 City of Forks of River, (No. _____, St.)

File No. 5194
 Registered No. 77

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Unmanned Celand

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX 4. COLOR OR RACE 5. SINGLE, MARRIED, WIDOWED OR DIVORCED.

Male white (Write the word.)

6. DATE OF BIRTH

July 19 1913
 (Month) (Day) (Year)

7. AGE

IF LESS than 1 day
 how many 10 hrs. or
 _____ mins.
 _____ yrs. _____ mos. _____ ds.

8. OCCUPATION

(a) Trade, profession or particular kind of work
 (b) General nature of industry, business, or establishment in which employed (or employer)

9. BIRTHPLACE

(State or Country) Bingham Co Idaho

10. NAME OF FATHER

W A Celand

11. BIRTHPLACE OF FATHER

(State or Country) high sea

12. MAIDEN NAME OF MOTHER

Rudie Radue

13. BIRTHPLACE OF MOTHER

(State or Country) Narvik Dakota

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Chas L Clarke
 (Address) Blackfoot Idaho

15.

Filed July 20 1913 W E Pattee
 Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH

July 19 1913
 (Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from

July 19 1913, to July 19 1913,
 that I last saw him alive on July 19 1913,
 and that death occurred on the date stated above, at 7 P M.

THE CAUSE OF DEATH* was as follows:

Infantile Adenitis

(Duration) _____ yrs. _____ mos. _____ ds.

Contributory
 (Secondary)

(Duration) _____ yrs. _____ mos. _____ ds.

(Signed) J D Simmons M D

July 20 1913 (Address) Blackfoot Idaho

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death _____ yrs. _____ mos. _____ days. In the State _____ yrs. _____ mos. _____ days.

Where was disease contracted if not at place of death?

Former or usual residence.

19. PLACE OF BURIAL OR REMOVAL DATE OF BURIAL

Green City Cemetery July 12 1913

20. UNDERTAKER

E F Beck ADDRESS Blackfoot

Form V. S. No. 5 20M.1-16-12

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH. Registration District No. 13
 County of Burham Primary Registration District No. 1007
 City of Blackfoot (No. 306 Main St.)
 If death occurs away from usual residence, give facts called for under special information. 2. FULL NAME Ellen Laughlin

File No. 5195Registered No. 78

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX Female 4. COLOR OR RACE white 5. SINGLE, MARRIED, WID-
 OWED OR DIVORCED. Widowed
 (Write the word.)

6. DATE OF BIRTH July 1853
 (Month) (Day) (Year)

7. AGE 66 yrs. mos. ds.
 IF LESS than 1 day
 how many hrs. or mins.

8. OCCUPATION

(a) Trade, profession or particular kind of work
 (b) General nature of industry, business, or establishment in which employed (or employer)

9. BIRTHPLACE England
 (State or Country)

10. NAME OF FATHER James Peacock

11. BIRTHPLACE OF FATHER Ireland
 (State or Country)

12. MAIDEN NAME OF MOTHER Mary Hickey

13. BIRTHPLACE OF MOTHER Ireland
 (State or Country)

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Jas Peacock
 (Address) Blackfoot Idaho

15. Filed July 20 1913 W.E. Patrick
 Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH July 19 1913
 (Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from July 19 1913, to July 19 1913
 that I last saw her alive on July 19 1913
 and that death occurred on the date stated above, at 11 P. M.

The CAUSE OF DEATH* was as follows:

Valvular Disease
Heart - Mitral
(Sudden Death)
 (Duration) 10 yrs. mos. ds.

Contributory Myth Disease
 (Secondary)

(Duration) 1 yrs. mos. ds.

(Signed) W.E. Patrick M. D.

July 19 1913 (Address) Blackfoot

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death yrs. mos. days. In the State yrs. mos. days.

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL Betty Mont DATE OF BURIAL Jul 22 1913

20. UNDERTAKER E.T. Pick ADDRESS Blackfoot

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Form V. S. No. 5 20M.1-16-12

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH.

Registration District No. 13

County of BinghamPrimary Registration District No. 7053City of Blackfoot

(No. , St.)

File No. 5198Registered No. 79

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

Nelma Gertrude Jackman

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX

Female

4. COLOR OR RACE

White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED.

Single
(Write the word.)

6. DATE OF BIRTH

Feb1st1904

(Month)

(Day)

(Year)

7. AGE

9 yrs. 5 mos. 35 ds.IF LESS than 1 day
how many hrs. or
..... mins.

8. OCCUPATION

(a) Trade, profession or particular kind of work

School Girl

(b) General nature of industry business, or establishment in which employed (or employer)

9. BIRTHPLACE

(State or Country)

Idaho

10. NAME OF FATHER

Walter Jackman

11. BIRTHPLACE OF FATHER

(State or Country)

Utah

12. MAIDEN NAME OF MOTHER

Martha E Taylor

13. BIRTHPLACE OF MOTHER

(State or Country)

Utah

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

Walter Jackman

(Address)

Blackfoot R F D 1

15.

Filed

July 26 1913M. E. Patrick

Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH

July251913

(Month)

(Day)

(Year)

17. I HEREBY CERTIFY, That I attended deceased from

July 25 1913, to July 25 1913that I last saw her alive on July 25 1913and that death occurred on the date stated above, at 10 P M.

The CAUSE OF DEATH* was as follows:

Empysemata

(Duration) yrs. mos. ds.

Contributory Pneumonia

(Secondary)

(Duration) yrs. mos. ds.

(Signed) F. W. Mitchell M. D.July 19 1913 (Address) Blackfoot, Idaho

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death yrs. mos. days. In the State yrs. mos. days.

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL DATE OF BURIAL

Fun City Cem. Blackfoot July 27 1913

20. UNDERTAKER

E. F. Hick

ADDRESS

Blackfoot

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Form V. S. No. 5. 10M. 6-20-11.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics
File No. 519

1. PLACE OF DEATH. Registration District No. 1
County of Ada Primary Registration District No. 2003
City of Meridian (No. St.)

Registered No. _____
If death occurred in a hospital, institution or camp give its NAME instead of street and number.

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

Mary Jane Tracy

PERSONAL AND STATISTICAL PARTICULARS

3. SEX 4. COLOR OR RACE 5. SINGLE, MARRIED, WIDOWED OR DIVORCED.

Female White (Write the word.) Widowed

6. DATE OF BIRTH

April 16th 1825
(Month) (Day) (Year)

7. AGE

88 yrs. 1 mos. 12 ds. IF LESS than 1 day how many... hrs. or min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work
(b) General nature of industry business or establishment in which employed (or employer)

none

9. BIRTHPLACE

(State or Country)

Maryland

10. NAME OF FATHER

(State or Country)

Robert Hiscue

11. BIRTHPLACE OF FATHER

(State or Country)

Maryland

12. MAIDEN NAME OF MOTHER

(State or Country)

Mary Jane Rider

13. BIRTHPLACE OF MOTHER

(State or Country)

Maryland

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Mrs. Cora Doherty

(Address) Meridian

15.

Filed May 28 1913 C. L. Dutton Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

May 28th 1913
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from

May 15th 1913, to May 28 1913

that I last saw her alive on May 27 1913,

and that death occurred on the date stated above, at 2:10 P.M.

The CAUSE OF DEATH* was as follows:

General fading away of vital forces
gradual cessation of heart action
(Duration) yrs. mos. 20 ds.

Contributory

(Secondary)

(Duration) yrs. mos. ds.

(Signed)

C. L. Dutton M. D.
May 28 1913 (Address) Meridian

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and 2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death... yrs... mos... ds. State... yrs... mos... ds.

Where was disease contracted,

If not at place of death?

Former or usual residence.

19. PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

Meridian Cemetery May 29 1913

20. UNDERTAKER

ADDRESS

J. M. Anderson Meridian
acting Undertaker Ida

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.—N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

FORM V. S. No. 5-25 M. 1-16-13

CERTIFICATE OF DEATH.

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH.

Registration District No. 11County of AdaPrimary Registration District No. 2003City of New Meridian

(No. _____ St.)

File No. 5199

Registered No. _____

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

Charlie Nester Adee

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX

Male

4. COLOR OR RACE

White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED.

Married
(Write the word.)

6. DATE OF BIRTH.

May-31st
(Month) (Day) (Year)1864

7. AGE

49Yrs. 1Mos. 4ds. 4IF LESS than 1 day
how many _____ hrs. or
_____ min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work...
(b) General nature of industry, business, or establishment in which employed (or employer)...Farmer

9. BIRTHPLACE

(State or Country)

Evansville Wis.

10. NAME OF FATHER

Joshua Adee

11. BIRTHPLACE OF FATHER

(State or Country)

N. York State

12. MAIDEN NAME OF MOTHER

Mary Carle

13. BIRTHPLACE OF MOTHER

(State or Country)

Maine

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant)

Don Hackett

(Address)

15.

Filed

7-2-1913@ L. Lottou
Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

July-1st
(Month) (Day) (Year)1913

(Year)

17. I HEREBY CERTIFY, That I attended deceased from June 20th 1913 to June 20th 1913, that I last saw him alive on June 20 1913, and that death occurred on the date stated above, at 12:30 P.M.

The CAUSE OF DEATH* was as follows:

(Gastrointestinal toxemia) acute dilatation of the heart.

(Duration) _____ Yrs. _____ mos. _____ ds.

Contributory Gastrointestinal
(Secondary) Toxemia & Christain's
(Duration) _____ Yrs. _____ mos. 15 ds.(Signed) C. L. Lottou M. D.
7/2 1913 (Address) Meridian, Ida.

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death _____ yrs. _____ mos. _____ days. In the State _____ yrs. _____ mos. _____ days.

Where was disease contracted
If not at place of death? _____Former or
usual residence _____

19. PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

Meridian Cemetery 7-1 1913

20. UNDERTAKER

ADDRESS

SchriberB...

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
N. B.—Every item of information should be carefully supplied. AGE should be state EXACTLY IN YEARS, MONTHS AND DAYS. If the exact date of birth is not known, give the nearest date known. CLANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. See instructions on back of certificate. ment of OCCUPATION is very important.

6-20-11.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics
File No. 5201
Registered No. 134

PLACE OF DEATH.

Registration District No. 11
Primary Registration District No. 2131
(No. Arrowrock. St.)

2. FULL NAME

E. W. Salin

If death occurred in a hospital, institution or camp give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX m. 4. COLOR OR RACE W. 5. SINGLE, MARRIED, WIDOWED OR DIVORCED. Single
(Write the word.)

6. DATE OF BIRTH

? 1
(Month) (Day) (Year)

7. AGE

23 yrs. 23 mos. 23 ds. IF LESS than 1 day how many hrs. or min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work Skip Hooker
(b) General nature of industry business or establishment in which employed (or employer) U.S.R. Laborer

9. BIRTHPLACE (State or Country)

Spain

10. NAME OF FATHER

Christo Salin

11. BIRTHPLACE OF FATHER (State or Country)

Spain

12. MAIDEN NAME OF MOTHER

13. BIRTHPLACE OF MOTHER (State or Country)

Spain

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

Joseph H. Shaw

(Address) Arrowrock

15.

M. S. Parker

File

Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

May 31 1913
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from May 31 1913, to May 31 1913

that I last saw him alive on May 31 and that death occurred on the date stated above at 10

The CAUSE OF DEATH* was as follows:

Fracture Base Skull
Accidental fall from

(Duration) yrs. mos. Contributory (Secondary) Crushing Injury

(Signed) Joseph H. Shaw
May 31 1913 (Address) Arrowrock

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, MEANS OF INJURY; and 2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions or Recent Residents.)

At place of death 1 yrs. 1 mos. 1 ds. State. yrs. mos. ds. Where was disease contracted. If not at place of death? Former or usual residence.

19. PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

St. Louis Cemetery 6/1 1913

20. UNDERTAKER

ADDRESS

Schreiber & Vidensaden Boise

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Form V. S. No. 5. 12½ M. 7-24-11

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH.

Registration District No. 14

County of Custer

Primary Registrar District No. 2061

City of Challis

(No. St.)

File No. 5201

Registered No. 17

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

John Andersson

If death occurred in a hospital, institution or camp give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX

male

4. COLOR OR RACE

white

5. SINGLE, MARRIED, WIDOWED OR DIVORCED.

single
(Write the word.)

6. DATE OF BIRTH

Don't know 1854
(Month) (Day) (Year)

7. AGE

59 yrs. mos. ds.

IF LESS than 1 day
how many hrs. or
..... min?

8. OCCUPATION

(a) Trade, profession or particular kind of work.
(b) General nature of industry business or establishment in which employed (or employer)

miner

9. BIRTHPLACE

(State or Country)

Ireland.

10. NAME OF FATHER

Don't know.

11. BIRTHPLACE OF FATHER

(State or Country)

Ireland.

12. MAIDEN NAME OF MOTHER

Don't know.

13. BIRTHPLACE OF MOTHER

(State or Country)

Ireland.

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

(Address)

J. W. Keelley
Challis

15.

Filed 1913

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH

July 17 1913
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attest

April 17 1913, to July 17 1913
that I last saw him alive on July 16 1913
and that death occurred on the date stated above, at 10 P.M.

The CAUSE OF DEATH* was as follows:

Myocarditis

(Duration) yrs. 3 mos. ds.

Contributory (Secondary)

Dropsy.

(Duration) yrs. 3 mos. ds.

(Signed)

J. W. Keelley M. D.

July 18 1913. (Address) Challis

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place 1 yr. 3 mos. ds. In the Don't know.

Where was disease contracted,
If not at place of death?

Former or usual residence Challis, Ida.

19. PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

Challis

7/15 1913

20. UNDERTAKER

ADDRESS

J. W. Keelley
Challis

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Form V. S. No. 5. 12½ M. 7-24-11

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics
File No. 5203
Registered No. 52

1. PLACE OF DEATH Registration District No. 14
County of Gustav Primary Registration District No. 2057
City of Stanley (No. , St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

Fitz James Clyde

If death occurred in a hospital, institution or camp give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX Male 4. COLOR OR RACE white 5. SINGLE, MARRIED, WIDOWED OR DIVORCED. widowed (Write the word.)

6. DATE OF BIRTH 1 26 1891 (Month) (Day) (Year)

7. AGE 68 yrs. 3 mos. 28 ds. IF LESS than 1 day how many hrs. or min?

8. OCCUPATION

(a) Trade, profession or particular kind of work. Bookkeeper
(b) General nature of industry business or establishment in which employed (or employer)

9. BIRTHPLACE (State or Country) New York State

10. NAME OF FATHER don't know

11. BIRTHPLACE OF FATHER don't know (State or Country)

12. MAIDEN NAME OF MOTHER don't know

13. BIRTHPLACE OF MOTHER don't know (State or Country)

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE (Informant) Mattie Franklyn Stanley (Address)

15. May 24 1913 P. H. Rascher Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH May 24th 1913 (Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from May 7th. 1913, to May 24th. 13 191

that I last saw him alive on May 7th 13 191 and that death occurred on the date stated above, at M.

The CAUSE OF DEATH* was as follows:

Atheromatous arteries resulting gangrene.

(Duration) yrs. 2 mos. ds.

Contributory (Secondary)

(Duration) yrs. mos. ds.

(Signed) M. D.

May 24 1913 (Address) Challis, Ida.

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place In the of death yrs. mos. ds. State yrs. mos. ds.

Where was disease contracted,

If not at place of death?

Former or

usual residence.

19. PLACE OF BURIAL OR REMOVAL DATE OF BURIAL

Challis 5/26, 13 191

20. UNDERTAKER ADDRESS

Friends Stanley.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Form V. S. No. 5 20M.1-16-12

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics
File No. 5201
Registered No. 51

1. PLACE OF DEATH. Registration District No. 14
County of Custer Primary Registration District No. 2061
City of Challis (No. _____, _____ St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Guisseppi Pedrini

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX Male 4. COLOR OR RACE White 5. SINGLE, MARRIED, WIDOWED OR DIVORCED. Single (the word.)

6. DATE OF BIRTH Not known 1 (Month) (Day) (Year)

7. AGE 35 yrs. mos. ds. IF LESS than 1 day how many hrs. or mins.?

8. OCCUPATION (a) Trade, profession or particular kind of work Miner (b) General nature of industry business, or establishment in which employed (or employer)

9. BIRTHPLACE (State or Country) Italy

10. NAME OF FATHER Pietro Pedrini

11. BIRTHPLACE OF FATHER (State or Country) Italy

12. MAIDEN NAME OF MOTHER Anna Sciuchetti

13. BIRTHPLACE OF MOTHER (State or Country) Italy

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE (Informant) Andrea Gini (Address) Clayton, Ida.

15. Filed 6/12 1913 Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH June 10th or 11th 1913. 191 (Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from 191, to 191, that I last saw h alive on 191, and that death occurred on the date stated above, at M.

The CAUSE OF DEATH* was as follows: This man was found dead in bed at his prospect. I investigated and found no suspicious circumstances. No post was held. yrs. mos. ds. Contributory (Secondary) (Duration) yrs. mos. ds. (Signed) M. D. 19 (Address) Challis, Ida.

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death yrs. mos. days. In the State yrs. mos. days.

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL DATE OF BURIAL Clayton 6/13, 13 191

20. UNDERTAKER ADDRESS Friends Clayton.

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Form V. S. No. 5. 12½ M. 7-24-11

1. PLACE OF DEATH. Registration District No. 2723
County of Croyle Primary Registration District No. 30
City of Dhampur (No. _____, _____ St.)

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics
File No. 3200
Registered No. 7

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Mary Ellen Nugent

If death occurred in a hospital, institution or camp give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX Female 4. COLOR OR RACE White 5. SINGLE, MARRIED, WIDOWED OR DIVORCED. Married
(Write the word.)

6. DATE OF BIRTH Nov 7 1849
(Month) (Day) (Year)

7. AGE 64 yrs. 8 mos. 10 ds. IF LESS than 1 day how many _____ hrs. or _____ min?

8. OCCUPATION
(a) Trade, profession or particular kind of work. House work
(b) General nature of industry business or establishment in which employed (or employer)

9. BIRTHPLACE Canada
(State or Country)

10. NAME OF FATHER Do not know

11. BIRTHPLACE OF FATHER England
(State or Country)

12. MAIDEN NAME OF MOTHER Do not know

13. BIRTHPLACE OF MOTHER England
(State or Country)

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) W. Whitta
(Address) Dhampur Idaho

15. Filed July 10 1913 T. D. Jones
Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH July 10 1913
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from June 20 1913, to July 10 1913
that I last saw him alive on July 10 1913
and that death occurred on the date stated above, at 2:45 P.M.
The CAUSE OF DEATH* was as follows:
Measles & Septicemia

X (Duration) _____ yrs. _____ mos. 20 ds.
Contributory (Secondary) none

(Duration) _____ yrs. _____ mos. _____ ds.
(Signed) T. D. Jones M. D.
July 10 1913 (Address) Dhampur Idaho

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place _____ In the _____
of death _____ yrs. _____ mos. _____ ds. State _____ yrs. _____ mos. _____ ds.
Where was disease contracted,
If not at place of death? _____
Former or
usual residence _____

19. PLACE OF BURIAL OR REMOVAL DATE OF BURIAL
Public Cemetery at Dhampur Idaho July 12 1913

20. UNDERTAKER ADDRESS
John Grote Silver City Idaho

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Form V. S. No. 5 20M.1-16-12

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH.

Registration District No. 30-12County of KootenaiPrimary Registration District No. 2051City of Arbut

(No. _____ St.)

File No. 520Registered No. 299

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

Ray Clemmuth Stayton

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX

M

4. COLOR OR RACE

W

5. SINGLE, MARRIED, WIDOWED OR DIVORCED.

S

(Write the word.)

6. DATE OF BIRTH

June11903

(Month)

(Day)

(Year)

7. AGE

10 yrs. 15 mos. 15 ds.IF LESS than 1 day
how many hrs. or
mins.?

8. OCCUPATION

(a) Trade, profession or particular kind of work

Boy

(b) General nature of industry business, or establishment in which employed (or employer)

9. BIRTHPLACE

(State or Country)

O.K.

10. NAME OF FATHER

Henry Stayton

11. BIRTHPLACE OF FATHER

(State or Country)

O.K.

12. MAIDEN NAME OF MOTHER

Lulu B Stayton

13. BIRTHPLACE OF MOTHER

(State or Country)

Idaho

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

Henry Stayton

(Address)

Arbut

15.

Filed

7/101913S. D. Greenman

Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH

June161913

(Month)

(Day)

(Year)

17. I HEREBY CERTIFY, That I attended deceased from

May 161913June 161913that I last saw him alive on " 16 1913and that death occurred on the date stated above, at 6 P.M.

The CAUSE OF DEATH* was as follows:

Pneumonia & abscess lungOpium(Duration) yrs. 1 mos. 15 ds.

Contributory

(Secondary)

(Duration) yrs. 1 mos. 15 ds.

(Signed)

S. D. Greenman

M. D.

6/17/1913

(Address)

Arbut

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place

of death

yrs.

mos.

days.

In the

State

yrs.

mos.

days.

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

Arbut6/17 1913

20. UNDERTAKER

ADDRESS

KlopfAr

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIAN should state CAUSE OF DEATH in plain terms, so that it may be properly classified. state-ment OCCUPATION is very important. See instructions on back of certificate.

Form V. S. No. 5. 12½ M.

1. PLACE OF DEATH
County of Rushmore Primary Registration District No. 2051
City of Rushmore (No., St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

Vernon L. Kanitsch

of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics
File No. 520
Registered No. 298
If death occurred in a hospital, institution or camp give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX male 4. COLOR OR RACE white 5. SINGLE, MARRIED, WIDOWED OR DIVORCED. single
(Write the word.)

6. DATE OF BIRTH May 15 1913
(Month) (Day) (Year)

7. AGE — yrs. — mos. 19 ds. IF LESS than 1 day how many hrs. or min?

8. OCCUPATION

(a) Trade, profession or particular kind of work. none
(b) General nature of industry business or establishment in which employed (or employer)

9. BIRTHPLACE Rushmore Co. Ida.
(State or Country)

10. NAME OF FATHER J. L. Kanitsch

11. BIRTHPLACE OF FATHER Minn.
(State or Country)

12. MAIDEN NAME OF MOTHER Edith L. Kanitsch

13. BIRTHPLACE OF MOTHER Iowa
(State or Country)

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) J. L. Kanitsch
(Address) Rushmore

15. Filed 17-16 1913 Rushmore
Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH June 2 1913
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from May 29 1913, to June 2 1913 that I last saw him alive on June 1 1913 and that death occurred on the date stated above, at 6 A. M.

The CAUSE OF DEATH* was as follows:

Acute Peritonitis

(Duration) — yrs. — mos. 5 ds.

Contributory (Secondary)

(Duration) — yrs. — mos. — ds.

(Signed) Frank M. D.
6/2 1913 (Address) Rushmore

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place In the
of death yrs. mos. ds. State yrs. mos. ds.
Where was disease contracted,
If not at place of death?
Former or
usual residence.

19. PLACE OF BURIAL OR REMOVAL DATE OF BURIAL

Rushmore 6/3 1913

20. UNDERTAKER ADDRESS

Babe Rushmore

Idaho State Board of Health

BUREAU OF VITAL STATISTICS

BOISE, Nov. 14, 1913.

Dr. Frank Wenz,

Rathdrum, Idaho.

Dear Doctor:

We have received at this office, a death certificate filed by you June 2, 1913, for Vernon Lu Kanitsh in which the cause of death is given as "peritonitis." We are rather at a loss how to classify this. Will you kindly advise us whether this resulted as a consequence of hernia, perforating ulcer of the stomach or bowels or appendicitis, or whether the case was a traumatic one?

I enclose copy of "Physicians' Pocket Reference to the International List of Causes of Death." Our Vital Statistics Law, as amended at the 1913 Session of the Legislature, provides for the use of the International List by physicians.

Thanking you in advance for the courtesy of an early reply, I am

Yours truly,

Ralph Falk
State Registrar.

M.D.

RF/FM
Enc. 3

Dear Sir:

The above "peritonitis," was an acute attack, following and almost coincident with an attack of acute Entero-Colitis. The age of the patient to be considered, as this type of Peritonitis is rarely found in adults.

Yours truly F. Wenz.

*Rathdrum, Ida
11/17-13*

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PLACES should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Form V. S. No. 5. 12½ M. 7-24-11

CERTIFICATE OF DEATH

State of Idaho

BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH.

Registration District No. 12

County of Boothney

Primary Registration District No. 2051

City of Boothney

(No. _____, _____ St.)

File No. 5209

Registered No. 300

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

Martin Andrew Westrom

If death occurred in a hospital, institution or camp give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX

Male

4. COLOR OR RACE

White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED.

Married
(Write the word.)

6. DATE OF BIRTH

Nov. 10th 1882
(Month) (Day) (Year)

7. AGE

30 yrs. _____ mos. _____ ds.

IF LESS than 1 day
how many _____ hrs. or
_____ min?

8. OCCUPATION

(a) Trade, profession or particular kind of work....

Carpenter

(b) General nature of industry business or establishment in which employed (or employer)

9. BIRTHPLACE

(State or Country)

Sweden

10. NAME OF FATHER

Andrew Westrom

11. BIRTHPLACE OF FATHER

(State or Country)

Sweden

12. MAIDEN NAME OF MOTHER

Emma Mary Lindstrom

13. BIRTHPLACE OF MOTHER

(State or Country)

Sweden

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

(Address)

Norman Westrom
Spokane Wash.

15.

Filed 7-10 - 1913

J. D. Brennan
Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH

June 23rd 1913
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from

1913, to 1913

that I last saw h. _____ alive on _____ 1913

and that death occurred on the date stated above, at 10:20 P. M.

The CAUSE OF DEATH* was as follows:

Successes of pneumonia

_____ (Duration) _____ yrs. _____ mos. _____ ds.

Contributory
(Secondary)

_____ (Duration) _____ yrs. _____ mos. _____ ds.

(Signed) No Physician M. D.

_____ 19 _____ (Address)

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place _____ In the _____ State _____ yrs. _____ mos. _____ ds.

Where was disease contracted, _____

If not at place of death? _____

Former or _____

usual residence. _____

19. PLACE OF BURIAL OR REMOVAL DATE OF BURIAL

Spokane, Wash June 26th 1913

20. UNDERTAKER ADDRESS

J. D. Buchanan Spokane, Wash

Idaho State Board of Health

BUREAU OF VITAL STATISTICS

BOISE, Nov. 14, 1913.

Dr. D. D. Drennan,
Local Registrar.
Rathdrum, Idaho.

Dear Doctor:

We have received at this office, a death certificate filed by you June 23, 1913, for Martin D. Webster in which the cause of death is given as "tuberculosis." We are rather at a loss how to classify this. Will you kindly advise me whether this was tuberculosis of the lungs, or of other organs?

I enclose copy of "Physicians' Pocket Reference to the International List of Causes of Death." Our Vital Statistics Law, as amended at the 1913 Session of the Legislature, provides for the use of the International list by physicians.

Thanking you in advance for the courtesy of an early reply, I am

Yours very truly,

Ralph Falk
State Registrar.

M.D.

RF/FM
Enc. 3

*In Dr. my copy of the death
of Martin (A. Weston) #300. Death on Sub
June 23-1913. Cause Tuberculosis of the
Lung. No Doctor attending. Was given
by Undertaker Buchanan Co.
Ralph D. Drennan*

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY in PLAIN
CLANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified.
ment of OCCUPATION is very important. See instructions on back of certificate.

V. S. No. 5 20M.1-16-12

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

PLACE OF DEATH.

Registration District No. 2

File No. 0210

County of Ada

Primary Registration District No. 1004

Registered No. 1356

City of Boise

(No. 410 State St.)

If death occurs away from usual residence, give facts called for under special information. 2. FULL NAME Katherine L. Buckley

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX

Female White

4. COLOR OR RACE

5. SINGLE, MARRIED, WID-
OWED OR DIVORCED.

Widow
(Write the word.)

6. DATE OF BIRTH

Oct 13 1868
(Month) (Day) (Year)

7. AGE

44 yrs. 7 mos. 25 ds.

IF LESS than 1 day
how many hrs. or
..... mins.?

8. OCCUPATION

(a) Trade, profession or
particular kind of work

Housekeeper

(b) General nature of industry
business, or establishment in
which employed (or employer)

9. BIRTHPLACE

(State or Country)

Quebec Canada

10. NAME OF
FATHER

not obtainable

11. BIRTHPLACE
OF FATHER

(State or Country)

not obtainable

12. MAIDEN NAME
OF MOTHER

not obtainable

13. BIRTHPLACE
OF MOTHER

(State or Country)

not obtainable

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

Mrs. M. White

(Address)

Boise, Idaho.

15.

Filed

6-2

1913

M. S. Parker

Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH

May 31st 1913
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from

May 23 1913, to May 31 1913,

that I last saw her alive on May 31 1913,

and that death occurred on the date stated above, at 5 P.M.

The CAUSE OF DEATH* was as follows:

Carcinoma of lung - (left)

(Duration) yrs. mos. ds.

Contributory
(Secondary)

(Duration) yrs. mos. ds.

(Signed)

Marcellus J. Hallman M. D.

6-2-1913 (Address) Boise, Idaho

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death yrs. mos. days. In the State yrs. mos. days.

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

St. Johns Cemetery 6/3 1913

20. UNDERTAKER

ADDRESS

Schreiber & Sidenfaden, Boise, Idaho

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Form V. S. No. 5. 10M. 6-20-11.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH.
County of Ada
City of Boise

Registration District No. 2
Primary Registration District No. 10048
(No. 377) Sanford St. Luke's Hosp

File No. 5211
Registered No. 136

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Holden Baby No I

If death occurred in a hospital, institution or camp give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX Female 4. COLOR OR RACE White 5. SINGLE, MARRIED, WIDOWED OR DIVORCED. Single
(Write the word.)

6. DATE OF BIRTH June 2 1913
(Month) (Day) (Year)

7. AGE 1 yrs. 1 mos. 0 ds.
IF LESS than 1 day how many 1 hrs. or 0 min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work None
(b) General nature of industry business or establishment in which employed (or employer)

9. BIRTHPLACE (State or Country) Idaho

10. NAME OF FATHER Arthur C Holden

11. BIRTHPLACE OF FATHER (State or Country) Colorado

12. MAIDEN NAME OF MOTHER Ave Spensler

13. BIRTHPLACE OF MOTHER (State or Country) Nebraska

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Arthur C Holden
(Address) 311 Barnard St

15. Filed 6-2 1913 M.S. Parker
Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH June 2 1913
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from June 2 1913, to June 2 1913
that I last saw her alive on June 2 1913,
and that death occurred on the date stated above, at 8²⁰ AM.

The CAUSE OF DEATH* was as follows:
Premature Birth

(Duration) 0 yrs. 0 mos. 0 ds.

Contributory (Secondary)

(Duration) 0 yrs. 0 mos. 0 ds.
(Signed) Edward J. Gurn M. D.
June 2 1913 (Address) 208 Cornhill Bldg

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death..... yrs..... mos..... ds. In the State..... yrs..... mos..... ds.
Where was disease contracted,
If not at place of death?
Former or usual residence.

19. PLACE OF BURIAL OR REMOVAL Cremation DATE OF BURIAL June 2 1913

20. UNDERTAKER St Luke's Hospital ADDRESS

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Form V. S. No. 5. 10M. 6-20-11.

CERTIFICATE OF DEATH

1. PLACE OF DEATH.
County of Ada
City of Boise

Registration District No. 2
Primary Registration District No. 1st
(No. St. Luke's Hospital)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Holden Baby No. 11

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics
File No. 5212
Registered No. 137

If death occurred in a hospital, institution or camp give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX Female 4. COLOR OR RACE White 5. SINGLE, MARRIED, WIDOWED OR DIVORCED. Single
(Write the word.)

6. DATE OF BIRTH June 2 1913
(Month) (Day) (Year)

7. AGE 4 IF LESS than 1 day
how many 4 hrs. or
min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work None
(b) General nature of industry business or establishment in which employed (or employer)

9. BIRTHPLACE Idaho
(State or Country)

10. NAME OF FATHER Arthur C. Holden

11. BIRTHPLACE OF FATHER Colorado
(State or Country)

12. MAIDEN NAME OF MOTHER Ava Spencer

13. BIRTHPLACE OF MOTHER Nebraska
(State or Country)

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Arthur C. Holden
(Address) No 311 Bancroft St

15. Filed 6-2 1913 M. S. Parker
Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH June 2 1913
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from June 2 1913, to June 2 1913
that I last saw her alive on June 2 1913,
and that death occurred on the date stated above, at 11:30 AM.

The CAUSE OF DEATH* was as follows:
Premature Birth

(Duration) yrs. mos. ds.

Contributory (Secondary)

(Signed) Edward D. Bink M. D.
June 2 1913 (Address) 208 Sonne Bldg

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death yrs. mos. ds. In the State yrs. mos. ds.
Where was disease contracted,
If not at place of death?
Former or usual residence

19. PLACE OF BURIAL OR REMOVAL Cremation DATE OF BURIAL June 2 1913

20. UNDERTAKER St. Luke's Hospital ADDRESS

Form V. S. No. 5 20M.1-16-12

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH.

Registration District No. 2County of AdaPrimary Registration District No. 1004City of Boise(At Saint Luke's Hospital St.)File No. 5212Registered No. 138

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

Starling Eugene Harper

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX

Male

4. COLOR OR RACE

White American

5. SINGLE, MARRIED, WIDOWED OR DIVORCED.

Single
(Write the word.)

6. DATE OF BIRTH

Sep 30 1982
(Month) (Day) (Year)

7. AGE

10 yrs. 8 mos. 7 ds.IF LESS than 1 day
how many hrs. or
..... mins.?

8. OCCUPATION

(a) Trade, profession or particular kind of work

Student

(b) General nature of industry, business, or establishment in which employed (or employer)

9. BIRTHPLACE

(State or Country)

Kansas

10. NAME OF FATHER

E E Harper

11. BIRTHPLACE OF FATHER

(State or Country)

Nebraska

12. MAIDEN NAME OF MOTHER

Josephine Johnson

13. BIRTHPLACE OF MOTHER

(State or Country)

Nebraska

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

R E Harper

(Address)

Roosevelt Id.

15.

Filed 6/7 1983

Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH

June 7 1983
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from

June 6 1983 to June 7 1983that I last saw him alive on June 7 1983and that death occurred on the date stated above, at 6:30 P. M.

The CAUSE OF DEATH* was as follows:

Septicemia
Retrocaecal abscess.

(Duration) yrs. mos. ds.

Contributory

(Secondary)

(Duration) yrs. mos. ds.

(Signed) J S Springer M. D.

19. (Address)

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death yrs. mos. days. In the State yrs. mos. days.

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

Parma Id. June 8 1983

20. UNDERTAKER

ADDRESS

Joy Summers Boise Id.

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY.
CIVILIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Example of OCCUPATION is very important. See instructions on back of certificate.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

PLACE OF DEATH
Ada
City
If death occurred in a residence, give address.
If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

Registration District No. *2*
Primary Registration District No. *1004*
(No. *1605 W. 18* St.)

File No. *531*
Registered No. *139*

FULL NAME *Martha A. Harvey*

PERSONAL AND STATISTICAL PARTICULARS

3. SEX *Female* 4. COLOR OR RACE *White* 5. SINGLE, MARRIED, WIDOWED OR DIVORCED. *Married*
(Write the word.)

6. DATE OF BIRTH *June 18 1848*
(Month) (Day) (Year)

7. AGE *64* yrs. *11* mos. *11* ds.
IF LESS than 1 day how many hrs. or mins.?

8. OCCUPATION
(a) Trade, profession or particular kind of work *Hon. Secy.*
(b) General nature of industry, business, or establishment in which employed (or employer)

9. BIRTHPLACE *Ky.*
(State or Country)

10. NAME OF FATHER *Edgar Bennett*

11. BIRTHPLACE OF FATHER *Ky.*
(State or Country)

12. MAIDEN NAME OF MOTHER *Lizzie Bennett*

13. BIRTHPLACE OF MOTHER *Ky.*
(State or Country)

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) *G. P. Harvey*
(Address) *Boise*

15. Filed *6-9* 1913 *W. S. Parker*
Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH *June 7 1913*
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from *June 2* 1913, to *June 7* 1913, that I last saw him alive on *June 7* 1913, and that death occurred on the date stated above, at *M.*

The CAUSE OF DEATH* was as follows:
Acute nephritis

(Duration) yrs. mos. ds.
Contributory (Secondary)
(Duration) yrs. mos. ds.
(Signed) *Geo. Callahan* M. D.
19 (Address)

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death yrs. mos. days. In the State yrs. mos. days.

Where was disease contracted if not at place of death?
Former or usual residence

19. PLACE OF BURIAL OR REMOVAL DATE OF BURIAL
Dry Creek Cemetery June 9 1913

20. UNDERTAKER ADDRESS
Schreiber & Sons Boise

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Form V. S. No. 5 20M.1-16-12

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH.

Registration District No.

County of *Ada*

Primary Registration District No.

City of *Boise*

Boise Ada County St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

Abraham B. Chorn

File No. *4778 5215*

Registered No. *140*

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX

Male

4. COLOR OR RACE

White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED.

Married
(Write the word.)

6. DATE OF BIRTH

Oct.

18

1844

(Month)

(Day)

(Year)

7. AGE

63 yrs.

7 mos.

11 ds.

IF LESS than 1 day
how many hrs. or
..... mins.?

8. OCCUPATION

(a) Trade, profession or particular kind of work

Retired

(b) General nature of industry business, or establishment in which employed (or employer)

9. BIRTHPLACE

(State or Country)

Mo.

10. NAME OF FATHER

James K. Chorn

11. BIRTHPLACE OF FATHER

(State or Country)

Ky.

12. MAIDEN NAME OF MOTHER

Sarah Russell

13. BIRTHPLACE OF MOTHER

(State or Country)

Ky.

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

O. M. Chorn

(Address)

Boise

15.

Filed

6 - 9

191*3*

M. S. Parker

Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH

June

6

191*3*

(Month)

(Day)

(Year)

17. I HEREBY CERTIFY, That I attended deceased from

191*3*, to

191*3*,

that I last saw him alive on *June 6* 191*3*,

and that death occurred on the date stated above, at *M.*

The CAUSE OF DEATH* was as follows:

Pulmonary Tuberculosis

(Duration)

yrs.

mos.

ds.

Contributory
(Secondary)

(Duration)

yrs.

mos.

ds.

(Signed)

J. S. Springer M. D.

19

(Address)

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place

of death

yrs.

mos.

days.

In the

State

yrs.

mos.

days.

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

Morris Hill Cemetery

6/9

191*3*

20. UNDERTAKER

ADDRESS

Schreiber & Chidney *Boise, Ida*

Springer

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Form V. S. No. 5 20M.1-16-12

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics
File No. 521
Registered No. 142

1. PLACE OF DEATH.

Registration District No.

County of Ada

Primary Registration District No. 1004

City of Newburg

(No. , St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

Chas. A. Sloper

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX

Male

4. COLOR OR RACE

White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED.

married
(Write the word.)

6. DATE OF BIRTH

Oct. 18 1869
(Month) (Day) (Year)

7. AGE

44 yrs. 8 mos. 20 ds.

IF LESS than 1 day
how many hrs. or mins.?

8. OCCUPATION

(a) Trade, profession or particular kind of work

Carpenter

(b) General nature of industry, business, or establishment in which employed (or employer)

9. BIRTHPLACE

(State or Country)

Boise Valley

10. NAME OF FATHER

J. C. Sloper

11. BIRTHPLACE OF FATHER

(State or Country)

Ida.

12. MAIDEN NAME OF MOTHER

Mary Miller

13. BIRTHPLACE OF MOTHER

(State or Country)

Ida.

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

G. N. Wood.

(Address)

Boise

15.

Filed

6-10

1913

M. S. Parker

Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH

June 8 1913
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from

dead saw
1913-8-1913-1913-
that I last saw h. alive on 1913-
and that death occurred on the date stated above, at 6 P. M.

The CAUSE OF DEATH* was as follows:

Gunsight Wound
Suicide

(Duration) yrs. mos. ds.

Contributory
(Secondary)

(Duration) yrs. mos. ds.

(Signed)

Adolph Schreier, M.D.
19 (Address) Boise, Idaho

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death yrs. mos. days. In the State yrs. mos. days.

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

Morris Hill Cemetery June 10 1913

20. UNDERTAKER

ADDRESS

Schreier & Widengren Boise

MARGIN RESERVED FOR BINDING
WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Form V. S. No. 5 20M.1-16-12

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH.

Registration District No.

County of

Primary Registration District No.

City of

(No. *Danah Hotel* St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME *Walter Sydney Barbour*

File No.

5218

Registered No.

143

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX

4. COLOR OR RACE

5. SINGLE, MARRIED, WIDOWED OR DIVORCED.

Male

White Canadian

Married
(Write the word.)

6. DATE OF BIRTH

Dec 22 1851
(Month) (Day) (Year)

7. AGE

62 yrs. *6* mos. *12* ds.

IF LESS than 1 day
how many hrs. or
..... mins.

8. OCCUPATION

(a) Trade, profession or particular kind of work

Attorney at Law

(b) General nature of industry business, or establishment in which employed (or employer)

9. BIRTHPLACE

(State or Country)

London Canada

10. NAME OF FATHER

James A. Barbour

11. BIRTHPLACE OF FATHER

(State or Country)

Vermont

12. MAIDEN NAME OF MOTHER

Emily Sutton

13. BIRTHPLACE OF MOTHER

(State or Country)

Canada

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

H. T. Barbour

(Address)

Boise Idaho 8314

15.

Filed

6-11

191 *3*

M. S. Parker

Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH

June 10 1913
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from

April 1912 to *April 1913*

that I last saw him alive on *June 8 1913*

and that death occurred on the date stated above, at *9 P. M.*

The CAUSE OF DEATH* was as follows:

Cancer of bowels & liver

1 (Duration) *1* yrs. *3* mos. ds.

Contributory
(Secondary)

(Duration) yrs. mos. ds.

(Signed) *L. P. McCall* M. D.

19 (Address) *Boise Idaho*

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death yrs. *2* mos. days. In the State yrs. *2* mos. days.

Where was disease contracted if not at place of death? *Dillon Montana*

Former or usual residence. *Dillon Montana*

19. PLACE OF BURIAL OR REMOVAL DATE OF BURIAL

Dillon Illinois June 16 1913

20. UNDERTAKER

ADDRESS

Joy Summers Boise Idaho

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.—
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Form V. S. No. 5 20M.1-16-12

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH.

Registration District No. _____

County of AdaPrimary Registration District No. 1004.City of Boise(No. 910 Ellis ave St.)File No. 5210Registered No. 145

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

Thomas Painter

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX

Male

4. COLOR OR RACE

White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED.

Widower
(Write the word.)

6. DATE OF BIRTH

Jan 5 1846
(Month) (Day) (Year)

7. AGE

67 yrs. 5 mos. 7 ds.

IF LESS than 1 day
how many hrs. or
..... mins.?

8. OCCUPATION

(a) Trade, profession or
particular kind of work

Druggist

(b) General nature of industry
business, or establishment in
which employed (or employer)

9. BIRTHPLACE

(State or Country)

Muncy, Penn

10. NAME OF FATHER

W. P. P. Painter

11. BIRTHPLACE OF FATHER

(State or Country)

Penn

12. MAIDEN NAME OF MOTHER

Sabine Muesch.

13. BIRTHPLACE OF MOTHER

(State or Country)

Penn

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

Mrs. P. E. Shoemaker

(Address)

Boise, Idaho

15.

Filed 6-13 1917

M. S. Parker

Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH

June 12 1913
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from

May 1 1913, to June 11 1913

that I last saw him alive on June 11 1913

and that death occurred on the date stated above, at 9:30 a.m.

The CAUSE OF DEATH* was as follows:

Tuberculosis
(Pulmonary)

(Duration) 3 yrs. 0 mos. 0 ds.

Contributory
(Secondary)

(Duration) yrs. mos. ds.

(Signed)

J. Springer M. D.

June 13 1913 (Address) Boise

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death yrs. mos. days. In the State yrs. mos. days.

Where was disease contracted
if not at place of death?

Former or

usual residence 910 Ellis Ave. Boise, Idaho

19. PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

Muncy, Penn.6/15 1913

20. UNDERTAKER

ADDRESS

Schreiber & Lidenfaden Boise, Idaho

Idaho State Board of Health

BUREAU OF VITAL STATISTICS

BOISE, Nov. 14, 1913.

Dr. J. S. Springer,

Boise, Idaho.

Dear Doctor:

We have received at this office, a death certificate filed by you June 12, 1913 for Thomas Painter, in which the cause of death is given as "tuberculosis." We are rather at a loss how to classify this. Will you kindly advise me whether this was tuberculosis of the lungs, or of other organs?

I enclose copy of "Physicians' Pocket Reference to the International List of Causes of Death." Our Vital Statistics Law, as amended at the 1912 Session of the Legislature, provides for the use of the International list by physicians.

Thanking you in advance for the courtesy of an early reply, I am

Yours very truly,

Ralph Falk
Secretary.

M. D.

RF/FM
Enc. 3

This man had Pulmonary Tuberculosis for over 40 years - during the last years of his life he had a complication of the glands - also bowels -

RECEIVED

NOV 1 1913

OFFICE
HEALTH

J S Springer M.D.

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Form V. S. No. 5 20M.1-16-12

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH.

Registration District

County of Ada

Primary Registration District No.

City of Boise

(No. 10040) St. Ann's Hospital

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME John A. Morrison

File No. 5229

Registered No. 146

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX

4. COLOR OR RACE

5. SINGLE, MARRIED, WIDOWED OR DIVORCED.

Male American Single (Write the word.)

6. DATE OF BIRTH

Apr 2 1867
(Month) (Day) (Year)

7. AGE

46 yrs. 7 mos. 15 ds.

IF LESS than 1 day
how many hrs. or
..... mins.?

8. OCCUPATION

(a) Trade, profession or particular kind of work

(b) General nature of industry business, or establishment in which employed (or employer)

Farmer

9. BIRTHPLACE

(State or Country)

Illinois

10. NAME OF FATHER

John A. Morrison

11. BIRTHPLACE OF FATHER

(State or Country)

Maryland

12. MAIDEN NAME OF MOTHER

Hattie Bradshaw

13. BIRTHPLACE OF MOTHER

(State or Country)

Illinois

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) R. L. Morrison

(Address) Boise, Idaho

15.

Filed 6-18 1913

Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH

June 17
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from

June 3 1913, to June 17 1913

that I last saw him alive on June 17 1913,

and that death occurred on the date stated above, at 7 P. M.

The CAUSE OF DEATH* was as follows:

Procuria - following
Erysipelas

(Duration) yrs. mos. 14 ds.

Contributory (Secondary)

(Duration) yrs. mos. ds.

(Signed) O. E. Blount, M. D.

19 (Address) Eagle, Idaho

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death yrs. mos. days. In the State yrs. mos. days.

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

Caldwell, Ida June 19 1913

20. UNDERTAKER

ADDRESS

Fry & Summers Boise, Idaho

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PREGNANTS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exactment of OCCUPATION is very important. See instructions on back of certificate.

Form V. S. No. 5 20M.1416.12

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH

Registration District No.

County of Ada

Primary Registration District No. 1004

City of Boise

(No. 412, State Idaho St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Edward Trechsel Boone

File No. 5221
Registered No. 147

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX | 4. COLOR OR RACE | 5. SINGLE, MARRIED, WIDOWED OR DIVORCED.

Male | White | Married (See word.)

6. DATE OF BIRTH

December 26 1872
(Month) (Day) (Year)

7. AGE

40 yrs. 5 mos. 22 ds.

IF LESS than 1 day
how many hrs. or
mins.?

8. OCCUPATION

(a) Trade, profession or particular kind of work.
(b) General nature of industry, business, or establishment in which employed (or employer)

Farmer

9. BIRTHPLACE

(State or Country) Pennsylvania

10. NAME OF FATHER

Amos G. Boone

11. BIRTHPLACE OF FATHER

(State or Country) Pennsylvania

12. MAIDEN NAME OF MOTHER

Mary Trechsel

13. BIRTHPLACE OF MOTHER

(State or Country) Switzerland

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Amos G. Boone

(Address) 409 Beech St Portland Ore.

15.

Filed 6-18 1913 M. S. Parker

Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

June 17 1913
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from

about 6-10 1913, to 6-17 1913,

that I last saw him alive on 6-17 1913,

and that death occurred on the date stated above, at 1 P.M.

The CAUSE OF DEATH* was as follows:

Neuritis

(Duration) Several days yrs. mos. ds.

Contributory (Secondary) under my care

(Duration) unknown yrs. mos. ds.

(Signed) L. L. Bensen M. D.

19 (Address)

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL OR HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death St. Albans Hospital In the State Idaho yrs. mos. days.

Where was disease contracted if not at place of death?

Former or usual residence. near Eagle Idaho

19. PLACE OF BURIAL OR REMOVAL | DATE OF BURIAL

Morris Hill Cemetery June 20 1913

20. UNDERTAKER

ADDRESS

Schreibers Undertakers Boise, Idaho

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Form V. S. No. 5 20M.1-16-12

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics
File No. 5229
Registered No. 149

1. PLACE OF DEATH.

Registration District No.

County of Ada

Primary Registration District No.

City of Boise(No. 1301, N. 20 St. St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

Augusta H. Paulson

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX

4. COLOR OR RACE

5. SINGLE, MARRIED, WIDOWED OR DIVORCED.

Female WhiteMarried
(Write the word.)

6. DATE OF BIRTH

Aug 3 1861
(Month) (Day) (Year)

7. AGE

57 yrs. 10 mos. 21 ds.IF LESS than 1 day
how many hrs. or
..... mins.?

8. OCCUPATION

(a) Trade, profession or particular kind of work.

Housewife

(b) General nature of industry business, or establishment in which employed (or employer).

9. BIRTHPLACE

(State or Country)

Illinois

10. NAME OF FATHER

Julius Hauttelt

11. BIRTHPLACE OF FATHER

(State or Country)

Germany

12. MAIDEN NAME OF MOTHER

Nancy Kracht

13. BIRTHPLACE OF MOTHER

(State or Country)

Germany

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

Carl H. Paulson(Address) 1301 N. 20th St. Boise

15.

Filed 6-24 1913M. S. Parker

Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH

June 24 1913
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from

June 13 1913, to June 24 1913,that I last saw her alive on June 23 1913and that death occurred on the date stated above, at 8 a M.

The CAUSE OF DEATH* was as follows:

Chronic parenchymatous nephritis(Duration) 2 yrs. mos. ds.

Contributory (Secondary)

Mitral insufficiency(Duration) 2 yrs. mos. ds.(Signed) Marion Henry Talbot M. D.6/24 1913. (Address) Boise, Idaho

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death yrs. mos. days. In the State yrs. mos. days.

Where was disease contracted if not at place of death?

Former or usual residence.....

19. PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

Morris Hill Cemetery June 25 1913

20. UNDERTAKER

ADDRESS

Trux Summerson Boise, Idaho

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Form V. S. No. 5 20M.1-16-12

CERTIFICATE OF DEATH

1. PLACE OF DEATH.

Registration District No. 2

County of Ada

Primary Registration District No. 1004

City of Boise, Idaho

(No. 112, E. Baumgardner St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

Lawrence Christensen

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

File No. 5223

Registered No. 151

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX

Male

4. COLOR OR RACE

White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED.

Single
(Write the word.)

6. DATE OF BIRTH

Sept 1st 1881
(Month) (Day) (Year)

7. AGE

31 yrs. 9 mos. 22 ds.

IF LESS than 1 day
how many hrs. or mins.?

8. OCCUPATION

(a) Trade, profession or particular kind of work

R. R. Laborer

(b) General nature of industry business, or establishment in which employed (or employer)

9. BIRTHPLACE

(State or Country)

Denmark

10. NAME OF FATHER

Andrew Christensen

11. BIRTHPLACE OF FATHER

(State or Country)

Denmark

12. MAIDEN NAME OF MOTHER

not obtainable

13. BIRTHPLACE OF MOTHER

(State or Country)

not obtainable

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

T. M. Jensen

(Address)

Harshoe Bend, Ida

15.

Filed

6-26 1913

M. S. Parker

Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH

June 22nd 1913
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from

June 1913, to June 22 1913,

that I last saw him alive on June 22 1913,

and that death occurred on the date stated above, at 7:30 PM.

The CAUSE OF DEATH* was as follows:

Thromb

(Duration) yrs. mos. ds.

Contributory
(Secondary)

(Duration) yrs. mos. ds.

(Signed)

June 24 1913

(Address)

Boise, Idaho

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents)

At place of death St. Luke's Hospital
yrs. mos. days. In the State yrs. mos. days.

Where was disease contracted if not at place of death? May Harshoe Bend, Idaho

Former or usual residence Harshoe Bend, Idaho

19. PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

Harshoe Bend

6-26 1913

20. UNDERTAKER

ADDRESS

Schreiber & Schenckel Boise,

D. Smith

Form V. S. No. 5 20M.1-16-12

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH.

Registration District No. 2County of AdaPrimary Registration District No. 1004City of Bonne(No. 1903 N. E. St St.)File No. 5224Registered No. 152

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

Sarah G. Austin

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX

4. COLOR OR RACE

5. SINGLE, MARRIED, WIDOWED OR DIVORCED.

Female WhiteWidowed
(Write the word.)

6. DATE OF BIRTH

Mar. 16 1883
(Month) (Day) (Year)

7. AGE

75 yrs. 3 mos. 10 ds.IF LESS than 1 day
how many hrs. or
..... mins.

8. OCCUPATION

(a) Trade, profession or particular kind of work

(b) General nature of industry, business, or establishment in which employed (or employer)

Housework

9. BIRTHPLACE

(State or Country)

Vermont

10. NAME OF FATHER

James Case

11. BIRTHPLACE OF FATHER

(State or Country)

England

12. MAIDEN NAME OF MOTHER

Emily Barber

13. BIRTHPLACE OF MOTHER

(State or Country)

Vermont

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

Harry E. Austin(Address) 1903 N. E. St.

15.

Filed 6-26 1913M. S. Parker

Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH

6 26 1913
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from

Mar. 16 1913, to June 25 1913that I last saw her alive on June 25 1913and that death occurred on the date stated above, at 2:14 M.

The CAUSE OF DEATH* was as follows:

Complicating apoplexy
(Duration) yrs. mos. ds.

Contributory

(Secondary)

(Duration) yrs. mos. ds.

(Signed) Fred A. Pittenger M. D.6/26 1913 (Address) Talk Bldg

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death yrs. mos. days. In the State yrs. mos. days.

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

Morris HillJun. 27 1913

20. UNDERTAKER

ADDRESS

Fry & Summers Bonne

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Form V. S. No. 5 20M.1-16-12

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH.

Registration District No.

County of

Primary Registration District No.

City of

(No. 410, State

St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

File No.

Registered No.

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX

4. COLOR OR RACE

5. SINGLE, MARRIED, WID-OWED OR DIVORCED.

6. DATE OF BIRTH

7. AGE

IF LESS than 1 day
how many hrs. or mins.

8. OCCUPATION

(a) Trade, profession or particular kind of work

(b) General nature of industry business, or establishment in which employed (or employer)

9. BIRTHPLACE

(State or Country)

10. NAME OF FATHER

11. BIRTHPLACE OF FATHER

(State or Country)

12. MAIDEN NAME OF MOTHER

13. BIRTHPLACE OF MOTHER

(State or Country)

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

(Address)

15.

Filed

1913

Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

17. I HEREBY CERTIFY, That I attended deceased from

that I last saw him alive on

and that death occurred on the date stated above, at

The CAUSE OF DEATH* was as follows:

(Duration) yrs. mos. ds.

Contributory (Secondary)

(Duration) yrs. mos. ds.

(Signed)

(Address)

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death yrs. mos. days. In the State yrs. mos. days.

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

20. UNDERTAKER

ADDRESS

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Form V. S. No. 5 20M.1-16-12		CERTIFICATE OF DEATH		State of Idaho BOARD OF HEALTH Bureau of Vital Statistics	
1. PLACE OF DEATH.		Registration District No. _____		File No. 522	
County of Ada		Primary Registration District No. 1004		Registered No. 155	
City of Boise		(No. 410, State St.)		If death occurred in a hospital, institution or camp, give its NAME instead of street and number.	
If death occurs away from usual residence, give facts called for under special information.		2. FULL NAME		Cora E. Bassett.	
PERSONAL AND STATISTICAL PARTICULARS					
3. SEX		4. COLOR OR RACE		5. SINGLE, MARRIED, WIDOWED OR DIVORCED.	
Female		White		Married (Write the word.)	
6. DATE OF BIRTH					
March 16 1872 (Month) (Day) (Year)					
7. AGE					
41 yrs. 3 mos. 10 ds. IF LESS than 1 day how many hrs. or mins.?					
8. OCCUPATION					
(a) Trade, profession or particular kind of work Landlady of Hotel. (b) General nature of industry business, or establishment in which employed (or employer)					
9. BIRTHPLACE					
(State or Country) Albion Illinois					
10. NAME OF FATHER					
Bradford Gilb.					
11. BIRTHPLACE OF FATHER					
Ill.					
12. MAIDEN NAME OF MOTHER					
Miss Emma Smith					
13. BIRTHPLACE OF MOTHER					
Albion Illinois					
14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE					
(Informant) Finlay Mackenzie (Address) Rockville Oregon					
15.					
Filed 6-27 1913 M. S. Parker Local Registrar					
MEDICAL CERTIFICATE OF DEATH.					
16. DATE OF DEATH					
June 26 1913 (Month) (Day) (Year)					
17. I HEREBY CERTIFY, That I attended deceased from June 20 1913, to June 26 1913, that I last saw her alive on June 24 1913, and that death occurred on the date stated above, at 1 P. M.					
The CAUSE OF DEATH* was as follows: Puerperal infection.					
(Duration) yrs. mos. 4 ds.					
Contributory Anemia: Suffusion (Secondary) of urine:					
(Duration) yrs. mos. ds.					
(Signed) L. D. McCall M. D.					
6/27 1913 (Address) Boise Idaho					
*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.					
18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)					
At place of death St. Alphonsus yrs. mos. days. In the State yrs. mos. days.					
Where was disease contracted if not at place of death?					
Former or usual residence Jordan Valley Oregon.					
19. PLACE OF BURIAL OR REMOVAL					
Albion Illinois					
20. UNDERTAKER					
Schreiber & Vidensfaden Boise					
DATE OF BURIAL					
6/27 1913					
ADDRESS					

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Form V. S. No. 5 20M.1-16-12

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH.

Registration District No.

County of AdaPrimary Registration District No. 1004File No. 522City of Boise(No. 1308, N. 21)

St.)

Registered No. 156

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Harriett M. Dorsey

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX

4. COLOR OR RACE

5. SINGLE, MARRIED, WIDOWED OR DIVORCED.

Female WhiteMarried
(Write the word.)

6. DATE OF BIRTH

May 30 1885
(Month) (Day) (Year)

7. AGE

55 yrs. — 29 mos. 29 ds.

IF LESS than 1 day
how many hrs. or
..... mins.?

8. OCCUPATION

(a) Trade, profession or particular kind of work
(b) General nature of industry, business, or establishment in which employed (or employer)

Housework

9. BIRTHPLACE

(State or Country)

Illinois

10. NAME OF FATHER

Michael Slaght

11. BIRTHPLACE OF FATHER

(State or Country)

Canada

12. MAIDEN NAME OF MOTHER

Helen Davis

13. BIRTHPLACE OF MOTHER

(State or Country)

Virginia

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

(Address)

Helen Davis
1308 N. 21

15.

Filed

6-301913M. S. Parker

Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH

June 29 1913
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from May 20 1913, to June 29 1913, that I last saw her alive on June 29 1913, and that death occurred on the date stated above, at 5 P. M.

The CAUSE OF DEATH* was as follows:

Carcinoma of Intestines

(Duration) yrs. mos. ds.

Contributory (Secondary)

(Duration) yrs. mos. ds.

(Signed)

June 30, 1913 (Address) Boise, Ida

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death yrs. mos. days. In the State yrs. mos. days.

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL DATE OF BURIAL

Morris Hill Cemetery July 5 1913

20. UNDERTAKER

ADDRESS

Wm. J. Summers Boise, Ida

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Form V. S. No. 5. 10M. 6-20-11.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics
File No. 5228

1. PLACE OF DEATH. Registration District No. 22
County of Gooding. Primary Registration District No. 2018
City of Wendell. (No. , St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Carl Burner

Registered No. _____
If death occurred in a hospital, institution or camp give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX 4. COLOR OR RACE 5. SINGLE, MARRIED, WIDOWED OR DIVORCED.

Male. White Single
(Write the word.)

6. DATE OF BIRTH

Jan. 25 25 1913
(Month) (Day) (Year)

7. AGE

0 yrs. 0 mos. 2 ds.

IF LESS than 1 day
how many hrs. or min.?

8. OCCUPATION

(a) Trade, profession, or particular kind of work
(b) General nature of industry, business, or establishment in which employed (or employer)

9. BIRTHPLACE

(State or Country)

Gooding Co. Idaho

10. NAME OF FATHER

Allan Burner

11. BIRTHPLACE OF FATHER

(State or Country)

Kentucky

12. MAIDEN NAME OF MOTHER

Louise Eaton

13. BIRTHPLACE OF MOTHER

(State or Country)

Iowa

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

(Address)

Allen Burner

Wendell Idaho

15.

Filed

July 17 1913

H. B. Lamm
Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

Jan - 28 1913
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from

date of birth 191 to Jan 28 1913

that I last saw him alive on Jan 28 1913

and that death occurred on the date stated above, at 2 P. M.

The CAUSE OF DEATH* was as follows:

Abelactasis?

(Duration) yrs. mos. ds.

Contributory (Secondary)

(Duration) yrs. mos. ds.

(Signed) J. B. Abrahamson M. D.

19 (Address) Wendell Ida.

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place In the
of death yrs. mos. ds. State yrs. mos. ds.

Where was Disease contracted,
If not at place of death?
Former or usual residence.

19. PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

Wendell Idaho Jan 29 1913

20. UNDERTAKER

ADDRESS

name Wendell Idaho

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Form V. S. No. 5. 12½ M. 7-24-11

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics
File No. 4 5229
Registered No. 4

1. PLACE OF DEATH. Registration District No. 245
County of Lewia Primary Registration District No. 2125
City of Tamiah (No. _____, St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Peter Wallace Parsons

If death occurred in a hospital, institution or camp give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX Male 4. COLOR OR RACE Indian 5. SINGLE, MARRIED, WIDOWED OR DIVORCED. married
(Write the word.)

6. DATE OF BIRTH _____
(Month) (Day) (Year)

7. AGE 54 yrs. _____ mos. _____ ds. IF LESS than 1 day
how many _____ hrs. or _____ min?

8. OCCUPATION Farmer
(a) Trade, profession or particular kind of work
(b) General nature of industry business or establishment in which employed (or employer)

9. BIRTHPLACE Idaho
(State or Country)

10. NAME OF FATHER Do not know

11. BIRTHPLACE OF FATHER Do not know
(State or Country)

12. MAIDEN NAME OF MOTHER Obbie

13. BIRTHPLACE OF MOTHER Idaho
(State or Country)

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) J. M. Parsons
(Address) Tamiah, Idaho

15. Filed July 1 1913 E. Taylor
Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH 6 / 20 1913
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from June 20th 1913, to same 1913
that I last saw him alive on 6/20 1913
and that death occurred on the date stated above, at 5 P. M.
The CAUSE OF DEATH* was as follows:
Phthisis Pulmonalis

(Duration) 7 yrs. _____ mos. _____ ds.
Contributory (Secondary)

(Duration) _____ yrs. _____ mos. _____ ds.
(Signed) Walter F. Hammond M. D.
June 24, 1913 (Address) Tamiah

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place _____ In the _____
of death _____ yrs. _____ mos. _____ ds. State _____ yrs. _____ mos. _____ ds.
Where was disease contracted,
If not at place of death?
Former or
usual residence.

19. PLACE OF BURIAL OR REMOVAL DATE OF BURIAL

Indian Cemetery June 21st 1913
20. UNDERTAKER ADDRESS
G. Johnson Tamiah, Idaho

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Form V. S. No. 5. 12½ M. 7-24-11

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics
File No. **5230**
Registered No. _____

1. PLACE OF DEATH
County of Bear Lake
City of Montpelier
Registration District No. 24
Primary Registration District No. 2098
(No. _____, St. _____)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME James Perry Howland

If death occurred in a hospital, institution or camp give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX Male 4. COLOR OR RACE White 5. SINGLE, MARRIED, WIDOWED OR DIVORCED.
Married
(Write the word.)

6. DATE OF BIRTH April 27 1846
(Month) (Day) (Year)

7. AGE 67 yrs. 1 mos. 13 ds. IF LESS than 1 day
how many _____ hrs. or _____ min.

8. OCCUPATION
(a) Trade, profession or particular kind of work Farming
(b) General nature of industry business or establishment in which employed (or employer) _____

9. BIRTHPLACE
(State or Country) Michigan

10. NAME OF FATHER Don't know

11. BIRTHPLACE OF FATHER
(State or Country) Irish (Ireland)

12. MAIDEN NAME OF MOTHER Hall

13. BIRTHPLACE OF MOTHER
(State or Country) Don't know

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) J. H. Nelson
(Address) Coalville, Utah

15. Filed June 10th 1913
Local Registrar W. H. Nelson

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH June 9 1913
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from May 7 1913, to June 9 1913
that I last saw him alive on June 4th 1913
and that death occurred on the date stated above, at 10 P. M.

The CAUSE OF DEATH* was as follows: Broncho-pneumonia superinduced by Organic Heart trouble
(Duration) _____ yrs. _____ mos. _____ ds.

Contributory (Secondary) _____
(Duration) _____ yrs. _____ mos. _____ ds.
(Signed) J. H. Nelson M. D.
June 11 1913 (Address) Montpelier, Utah

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place _____ In the _____
of death _____ yrs. _____ mos. _____ ds. State 30 yrs. _____ mos. _____ ds.
Where was disease contracted, _____
If not at place of death? _____
Former or _____
usual residence _____

19. PLACE OF BURIAL OR REMOVAL DATE OF BURIAL
Single Idaho June 12 1913
ADDRESS _____

20. UNDERTAKER none

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Form V. S. No. 5. 12½ M. 7-24-11

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH. Registration District No. 24
County of Bear Lake Primary Registration District No. 2098
City of Montpelier (No. _____ St.)

File No. 5233
Registered No. _____

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

S. Predroff

If death occurred in a hospital, institution or camp give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX Male 4. COLOR OR RACE Male 5. SINGLE, MARRIED, WIDOWED OR DIVORCED. Single
(Write the word.)

6. DATE OF BIRTH May 23rd 1875
(Month) (Day) (Year)

7. AGE 38 yrs. _____ mos. _____ ds. IF LESS than 1 day how many _____ hrs. or _____ min?

8. OCCUPATION
(a) Trade, profession or particular kind of work. Laborer
(b) General nature of industry business or establishment in which employed (or employer)

9. BIRTHPLACE Bulgaria
(State or Country)

10. NAME OF FATHER Don't Know

11. BIRTHPLACE OF FATHER Bulgaria
(State or Country)

12. MAIDEN NAME OF MOTHER Don't Know

13. BIRTHPLACE OF MOTHER Bulgaria
(State or Country)

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) S. Predroff
(Address) (Autopsy Statement)

15. Filed June 9th 1913 S. J. H. H. H. H.
Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH June 7th 1913
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from June 7th 1913 to June 7th 1913
that I last saw h. in alive on June 7th 1913
and that death occurred on the date stated above, at 4^{PM} M.

The CAUSE OF DEATH* was as follows:
Guns shot Wounds in Abdomen
(Homicidal)

(Duration) _____ yrs. _____ mos. _____ ds.

Contributory (Secondary) _____

(Duration) _____ yrs. _____ mos. _____ ds.

(Signed) S. J. H. H. H. M. D.
June 9th 1913 (Address) Montpelier, Id.

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place _____ In the _____
of death _____ yrs. _____ mos. _____ ds. State _____ yrs. _____ mos. _____ ds.
Where was disease contracted, _____
If not at place of death? _____
Former or _____
usual residence _____

19. PLACE OF BURIAL OR REMOVAL Montpelier DATE OF BURIAL June 9th 1913

20. UNDERTAKER Unrent Bros. ADDRESS Montpelier

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Form V, S. No. 5. 12½M.7-24-11

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics
File No. 5233
Registered No.

1. PLACE OF DEATH. Registration District No. 24
County of Bear Lake Primary Registration District No. 2098
City of Montpelier (No. St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

John Bunney

If death occurred in a hospital, institution or camp give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX 4. COLOR OR RACE 5. SINGLE, MARRIED, WIDOWED OR DIVORCED.

Male White Married (Write the word.)

6. DATE OF BIRTH

Oct 15 1827
(Month) (Day) (Year)

7. AGE

85 yrs. 7 mos. 7 ds.

IF LESS than 1 day
how many hrs. or min?

8. OCCUPATION

(a) Trade, profession or particular kind of work.

Farmer

(b) General nature of industry business or establishment in which employed (or employer)

9. BIRTHPLACE

(State or Country)

Corwall, England

10. NAME OF FATHER

John Bunney

11. BIRTHPLACE OF FATHER

(State or Country)

Corwall, England

12. MAIDEN NAME OF MOTHER

Grace White

13. BIRTHPLACE OF MOTHER

(State or Country)

Corwall, England

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

John Bunney

(Address)

Montpelier, Idaho

15.

Filed June 23 1913

Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH

June 27 1913
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from June 18 1913, to June 27 1913

that I last saw him alive on June 27 1913

and that death occurred on the date stated above, at 3 P. M.

The CAUSE OF DEATH* was as follows:

Pneumonia (Catarrhal)

(Duration) yrs. mos. 4 ds.

Contributory (Secondary)

(Duration) yrs. mos. ds.

(Signed) John Bunney M. D.

19 (Address) Montpelier, Idaho

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death 59 yrs. mos. ds. State 59 yrs. mos. ds.

Where was disease contracted,

If not at place of death?

Former or

usual residence Montpelier, Idaho

19. PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

Montpelier, Ida. June 23 1913

20. UNDERTAKER

ADDRESS

None

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Form V. S. No. 5. 12½ M. 7-24-11

CERTIFICATE OF DEATH

1. PLACE OF DEATH
County of Bear Lake
City of Montpelier
Registration District No. 24
Primary Registration District No. 2098
(No. _____ St.)

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics
File No. 5234

Registered No. _____

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

Baby Neilson

If death occurred in a hospital, institution or camp give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX Female 4. COLOR OR RACE White 5. SINGLE, MARRIED, WIDOWED OR DIVORCED. Single
(Write the word.)

6. DATE OF BIRTH June 17 1913
(Month) (Day) (Year)

7. AGE _____ yrs. _____ mos. 1 ds.
IF LESS than 1 day
how many _____ hrs. or _____ min?

8. OCCUPATION None
(a) Trade, profession or particular kind of work
(b) General nature of industry business or establishment in which employed (or employer)

9. BIRTHPLACE Idaho
(State or Country)

10. NAME OF FATHER Frank Nelson

11. BIRTHPLACE OF FATHER Boylau city Utah
(State or Country)

12. MAIDEN NAME OF MOTHER Margaret Anna E. Haskin

13. BIRTHPLACE OF MOTHER Blackfoot - Idaho
(State or Country)

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Frank Nelson
(Address) Montpelier Ida

15. Filed 6/19/1913 Notified

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH June 18 1913
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from June 17 1913, to June 18 1913, that I last saw her alive on June 18 1913, and that death occurred on the date stated above, at 4 P. M.
The CAUSE OF DEATH* was as follows: Unknown
Premature Birth

(Duration) _____ yrs. _____ mos. _____ ds.
Contributory (Secondary) _____

(Duration) _____ yrs. _____ mos. _____ ds.
(Signed) Tom Rydman M. D.
19 _____ (Address) Montpelier Idaho

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death _____ yrs. _____ mos. 1 ds. In the State _____ yrs. _____ mos. 1 ds.
Where was disease contracted, v. _____
If not at place of death? _____
Former or usual residence _____

19. PLACE OF BURIAL OR REMOVAL Montpelier DATE OF BURIAL 6-19-1913

20. UNDERTAKER None ADDRESS _____

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
MARGIN RESERVED FOR BINDING

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Form V. S. No. 5 20M.1-16-12

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics
File No. **5235**
Registered No. _____

1. PLACE OF DEATH _____

Registration District No. **27**

County of **Franklin**

Primary Registration District No. **2119**

City of **Grifton**

(No. _____ St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

Laura Hansen

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX

Female

4. COLOR OR RACE

White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED.

Married
(Write the word.)

6. DATE OF BIRTH

July 17 1867
(Month) (Day) (Year)

7. AGE

50 yrs. 10 mos. 22 ds.

IF LESS than 1 day
how many _____ hrs. or
_____ mins.?

8. OCCUPATION

(a) Trade, profession or particular kind of work

House Wife

(b) General nature of industry, business, or establishment in which employed (or employer)

9. BIRTHPLACE

(State or Country)

Brigham City Utah

10. NAME OF FATHER

James Johnson

11. BIRTHPLACE OF FATHER

(State or Country)

Denmark

12. MAIDEN NAME OF MOTHER

Not known

13. BIRTHPLACE OF MOTHER

(State or Country)

Denmark

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

Mr. [Redacted] Johnson

(Address)

Grifton R. 2119

15.

Filed

6/1

1912

Alfred C.

Local H

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

June 4 1913
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from

some time in 1911, to June 4 1913,

that I last saw her alive on **June 4 1913,**

and that death occurred on the date stated above, at **7 P.M.**

The CAUSE OF DEATH* was as follows:

**Valvular insufficiency
& dilatation of heart
with exsanguination**

(Duration) **2 yrs. 8 mos.** ds.

Contributory

galactaria

(Secondary)

(Duration) **1 yr. 8 mos.** ds.

(Signed)

Alfred C. [Redacted] M. D.

19

(Address)

Grifton

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place

of death _____ yrs. _____ mos. _____ days.

In the

State _____ yrs. _____ mos. _____ days.

Where was disease contracted if not at place of death?

Former or

usual residence _____

19. PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

Grifton

June 8 1913

20. UNDERTAKER

G. J. Hansen

ADDRESS

Grifton

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Form V. S. No. 5 20M.1-16-12

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH.

Registration District No. 2119

County of Franklin

Primary Registration District No. _____

City of Riverdale

(No. _____, St.)

File No. 8236

Registered No. 90

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Lugran Nealey

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX

Male White

4. COLOR OR RACE

5. SINGLE, MARRIED, WIDOWED OR DIVORCED.

(Write the word.)

6. DATE OF BIRTH

April 24 1913
(Month) (Day) (Year)

7. AGE

_____ yrs. 1 mos. 22 ds.

IF LESS than 1 day
how many _____ hrs. or
_____ mins.?

8. OCCUPATION

- (a) Trade, profession or particular kind of work _____
(b) General nature of industry, business, or establishment in which employed (or employer) _____

9. BIRTHPLACE

(State or Country) Riverdale

10. NAME OF FATHER

L. G. Nealey

11. BIRTHPLACE OF FATHER

(State or Country) Franklin Idaho

12. MAIDEN NAME OF MOTHER

Erans

13. BIRTHPLACE OF MOTHER

(State or Country) Idaho Heber

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) A. M. Nealey

(Address) Riverdale Ida

15.

Filed June 8th 1913 Allen Kleuter
Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

June 26 1913
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from

June 20 1913, to June 26 1913,
that I last saw him alive on June 20 1913,
and that death occurred on the date stated above, at 6 A.M.

The CAUSE OF DEATH* was as follows:

Bronchial Pneumonia

(Duration) _____ yrs. _____ mos. 2 ds.

Contributory Whooping Cough
(Secondary)

(Duration) _____ yrs. _____ mos. _____ ds.

(Signed) Allen Kleuter M. D.

19 (Address) Preston Idaho

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death _____ yrs. _____ mos. _____ days. In the State _____ yrs. _____ mos. _____ days.

Where was disease contracted if not at place of death? _____

Former or usual residence _____

19. PLACE OF BURIAL OR REMOVAL

Riverdale June 22 1913

20. UNDERTAKER

D. L. Hansen Preston

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Form V. S. No. 5 20M.1-16-12

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH.

Registration District No. 19

County of Minidoka

Primary Registration District No. _____

City of Rupert

(No. _____)

(St. _____)

File No. 5237

Registered No. 3

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

W E Chitty

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX

Male

4. COLOR OR RACE

White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED
Married
(Write the word.)

6. DATE OF BIRTH

Unknown

(Month)

(Day)

(Year)

7. AGE

33 apparently
yrs. mos. ds.

IF LESS than 1 day
how many hrs. or
mins.?

8. OCCUPATION

(a) Trade, profession or particular kind of work

Police Officer

(b) General nature of industry, business, or establishment in which employed (or employer)

9. BIRTHPLACE

(State or Country)

10. NAME OF FATHER

11. BIRTHPLACE OF FATHER

(State or Country)

12. MAIDEN NAME OF MOTHER

13. BIRTHPLACE OF MOTHER

(State or Country)

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

(Address)

J Heyman
Calderwell

15.

Filed

June 30 1913

Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

June 30 1913
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from

191 , to 191 ,
that I last saw h alive on 191 ,

and that death occurred on the date stated above, at M.

The CAUSE OF DEATH* was as follows:

Electrocuted accident

(Duration) yrs. mos. ds.

Contributory
(Secondary)

(Duration) yrs. mos. ds.

(Signed)

6/30 1913 (Address) Rupert, M. D.

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MANNER OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death. yrs. mos. days. In the State. yrs. mos. days.

Where was disease contracted if not at place of death?

Former or usual residence.

19. PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

Oklahoma City

191

20. UNDERTAKER

ADDRESS

W E Goodman

Rupert

Form V. S. No. 5 20M.1-16-12

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH.

Registration District No. 19

County of

Primary Registration District No.

File No.

City of

(No.

St.)

Registered No.

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX

4. COLOR OR RACE

5. SINGLE, MARRIED, WIDOWED OR DIVORCED.

(Write the word.)

6. DATE OF BIRTH

7. AGE

IF LESS than 1 day
how many hrs. or
mins.?

8. OCCUPATION

(a) Trade, profession or particular kind of work

(b) General nature of industry business, or establishment in which employed (or employer)

9. BIRTHPLACE

(State or Country)

10. NAME OF FATHER

11. BIRTHPLACE OF FATHER

(State or Country)

12. MAIDEN NAME OF MOTHER

13. BIRTHPLACE OF MOTHER

(State or Country)

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

(Address)

15.

Filed

1913

Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH

(Month)

(Day)

1913 (Year)

17. I HEREBY CERTIFY, That I attended deceased from

1913, to

1913,

that I last saw him alive on 1913,

and that death occurred on the date stated above, at M.

The CAUSE OF DEATH* was as follows:

Electrocuted accident
(Duration) 10 yrs. 10 mos. ds.Contributory
(Secondary)

(Duration) 10 yrs. 10 mos. ds.

(Signed)

J. H. Scott M. D.
June 30, 1913 (Address) Rupert

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place

of death. yrs. mos. days.

In the

State. yrs. mos. days.

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

Burial Co. 1913

20. UNDERTAKER

ADDRESS

W. E. Goodman Rupert

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. PHYSI-
 N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. Exact state-
 CIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. See instructions on back of certificate.
 -ment of OCCUPATION is very important.

Form V. S. No. 5. 10M. 6-20-11.

CERTIFICATE OF DEATH

 State of Idaho
 BOARD OF HEALTH
 Bureau of Vital Statistics

1. PLACE OF DEATH.

Registration District No. 19County of Mundaka

Primary Registration District No. _____

City of Rupert

(No. _____, St.)

File No. 5239Registered No. 3

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

Rud Olson

If death occurred in a hospital, institution or camp give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX

Male4. COLOR OR RACE 5. SINGLE, MARRIED, WID-
OWED OR DIVORCED.WhiteInfant
(Write the word.)

6. DATE OF BIRTH

June211913

(Month)

(Day)

(Year)

7. AGE

yrs.

mos.

65

ds.

 IF LESS than 1 day
 how many hrs. or
 min. ?

8. OCCUPATION

- (a) Trade, profession or particular kind of work
 (b) General nature of industry business or establishment in which employed (or employer)

home

9. BIRTHPLACE

(State or Country)

Rupert Idaho

10. NAME OF FATHER

Leo Smith

11. BIRTHPLACE OF FATHER

(State or Country)

Utah

12. MAIDEN NAME OF MOTHER

Florence Olson

13. BIRTHPLACE OF MOTHER

(State or Country)

Utah

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

Miss Florence Olson

(Address)

Rupert Idaho

15.

Filed

June 27 1913C. H. Scott

Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

June

(Month)

25

(Day)

1913

(Year)

17. I HEREBY CERTIFY, That I attended deceased from

191

to

191that I last saw him alive on June 22 1913and that death occurred on the date stated above, at 8 A M.

The CAUSE OF DEATH* was as follows:

accidental suffocation

(Duration)

yrs.

mos.

ds.

Contributory
(Secondary)

(Duration)

yrs.

mos.

ds.

(Signed)

June 27 1913

(Address)

Rupert

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place

In the

of death yrs. mos. ds. State yrs. mos. ds.

Where was disease contracted.

If not at place of death?

Former or

usual residence.

19. PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

Rupert CemeteryJune 27 1913

20. UNDERTAKER

ADDRESS

W. G. GormanRupert

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Form V. S. No. 5. 10M. 6-20-11.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics
File No. 5240
Registered No. 2

1. **PLACE OF DEATH.** Registration District No.
County of Minidoka Primary Registration District No.
City of Rupert (No. St.)

If death occurs away from usual residence, give facts called for under special information. 2. **FULL NAME** Still Born

If death occurred in a hospital, institution or camp give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. **SEX** 4. **COLOR OR RACE** 5. **SINGLE, MARRIED, WIDOWED OR DIVORCED.**

Male White (Write the word)

6. **DATE OF BIRTH**
June 5 1913
(Month) (Day) (Year)

7. **AGE** IF LESS than 1 day how many . . . hrs. or min.?
..... yrs. . . . mos. 2 hrs. ds. . . . min.?

8. **OCCUPATION**
(a) Trade, profession or particular kind of work . . . Infant
(b) General nature of industry business or establishment in which employed (or employer) . . .

9. **BIRTHPLACE**
(State or Country) Rupert Idaho

10. **NAME OF FATHER** Louis Hite

11. **BIRTHPLACE OF FATHER**
(State or Country) Mo

12. **MAIDEN NAME OF MOTHER** Hessie Evans

13. **BIRTHPLACE OF MOTHER**
(State or Country) Mo

14. **THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE**
(Informant) Henry Hite
(Address) Rupert

15. **Filed** July 3 1913 C. H. Scott
Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. **DATE OF DEATH**
May 5 1913
(Month) (Day) (Year)

17. **I HEREBY CERTIFY**, That I attended deceased from
..... 191..... to 191.....
that I last saw h..... alive on 191.....
and that death occurred on the date stated above, at M.
The CAUSE OF DEATH* was as follows:

Still born
(Duration) yrs. mos. ds.

Contributory (Secondary)
(Signed) J. B. Kennedy M. D.
6/5 1913 (Address) Rupert

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. **LENGTH OF RESIDENCE** (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death..... yrs. mos. ds. In the State..... yrs. mos. ds.
Where was disease contracted, If not at place of death?.....
Former or usual residence.....

19. **PLACE OF BURIAL OR REMOVAL** Rupert **DATE OF BURIAL** June 5 1913
20. **UNDERTAKER** W. A. Goodman **ADDRESS** Rupert

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. PHYSICIAN'S should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Form V. S. No. 5. 10M. 6-20-11.

CERTIFICATE OF DEATH

 State of Idaho
 BOARD OF HEALTH
 Bureau of Vital Statistics

1. PLACE OF DEATH.

Registration District No.

County of

Primary Registration District No.

City of

(No. St.)

File No. 5241

Registered No. 1

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

Matilda Mc Vean

If death occurred in a hospital, institution or camp give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX

4. COLOR OR RACE 5. SINGLE, MARRIED, WIDOWED OR DIVORCED.

Female White White (Married)

6. DATE OF BIRTH

 Nov 18 18 1885
 (Month) (Day) (Year)

7. AGE

55 yrs. 7 mos. 3 ds. IF LESS than 1 day how many hrs. or min.

8. OCCUPATION

 (a) Trade, profession or particular kind of work
 (b) General nature of industry business or establishment in which employed (or employer)

House Wife

9. BIRTHPLACE

(State or Country)

Sweden

10. NAME OF FATHER

11. BIRTHPLACE OF FATHER

(State or Country)

Sweden

12. MAIDEN NAME OF MOTHER

13. BIRTHPLACE OF MOTHER

(State or Country)

Sweden

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

Chas Mc Vean

(Address)

Rupert - Idaho

15.

Filed

July 3 1913

Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

 June 21 1913
 (Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from

June 10 1913, to June 20 1913

That I last saw her alive on June 20 1913,

and that death occurred on the date stated above, at 8 P. M.

The CAUSE OF DEATH* was as follows:

 Carcinoma of Uterus following
 (Duration) yrs. 3 mos. ds.

Contributory (Secondary)

(Duration) yrs. mos. ds.

(Signed) J. B. Kennedy M. D.

6/20 1913 (Address) Rupert

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

 At place of death. Salt Lake In the Holy Cross
 yrs. mos. ds. State yrs. mos. ds.

 Where was disease contracted, -
 If not at place of death? -
 Former or usual residence.

19. PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

Rupert

6/25 1913

20. UNDERTAKER

ADDRESS

W. A. Goodman

Rupert

Form V. S. No. 5. 10M. 6-20-11.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital StatisticsFile No. 5242

1. PLACE OF DEATH.

Registration District No. 38County of BlainePrimary Registration District No. 2138City of Blaine

(No. _____, _____ St.)

Registered No. _____

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

Unmarried Shonk

If death occurred in a hospital, institution or camp give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX

4. COLOR OR RACE 5. SINGLE, MARRIED, WIDOWED OR DIVORCED.

Male WhiteSingle
(Write the word.)

6. DATE OF BIRTH

July 13 1913
(Month) (Day) (Year)

7. AGE

IF LESS than 1 day
how many _____ hrs. or
_____ yrs. _____ mos. 3 ds. _____ min.

8. OCCUPATION

- (a) Trade, profession, or particular kind of work
-
- (b) General nature of industry, business, or establishment in which employed (or employer)

9. BIRTHPLACE

(State or Country)

Ida

10. NAME OF FATHER

J. B. Shonk

11. BIRTHPLACE OF FATHER

(State or Country)

Ida

12. MAIDEN NAME OF MOTHER

Evelyn Mitchell

13. BIRTHPLACE OF MOTHER

(State or Country)

Ida

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

(Address)

J. B. Shonk
Blaine, Ida

15.

Filed July 4 1913Deelett P. Hagg
Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

July 13 1913
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from

_____ 191____, to _____ 191____
that I last saw h_____ alive on _____ 191____and that death occurred on the date stated above, at 10³⁰ A. M.

The CAUSE OF DEATH* was as follows:

Premature and lived only a few minutes

(Duration) _____ yrs. _____ mos. _____ ds.

Contributory (Secondary)

(Duration) _____ yrs. _____ mos. _____ ds.

(Signed) Deelett P. Hagg M. D.7-13 1913 (Address) Blaine, Ida

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place _____ In the _____
of death _____ yrs. _____ mos. _____ ds. State _____ yrs. _____ mos. _____ ds.Where was Disease contracted,
If not at place of death? _____Former or
usual residence _____

19. PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

On Farm 7-13 1913

20. UNDERTAKER

ADDRESS

Ralph Smith buried Blaine Ida
D. P. Hagg

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Form V. S. No. 5. 10M. 6-20-11.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics
File No. 5243

1. PLACE OF DEATH.
County of Blaine
City of Blaine

Registration District No. 58
Primary Registration District No. 2138
(No. _____, _____ St.)

Registered No. _____
If death occurred in a hospital, institution or camp give its NAME instead of street and number.

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Unnamed, Shank

PERSONAL AND STATISTICAL PARTICULARS

3. SEX Male 4. COLOR OR RACE White 5. SINGLE, MARRIED, WIDOWED OR DIVORCED. Single
(Write the word.)

6. DATE OF BIRTH July 13 1913
(Month) (Day) (Year)

7. AGE _____ yrs. _____ mos. 10 ds.
IF LESS than 1 day how many _____ hrs. or _____ min.

8. OCCUPATION
(a) Trade, profession, or particular kind of work
(b) General nature of industry, business, or establishment in which employed (or employer)

9. BIRTHPLACE (State or Country) Idaho

10. NAME OF FATHER J. B. Shank

11. BIRTHPLACE OF FATHER (State or Country) Idaho

12. MAIDEN NAME OF MOTHER Priscilla Mitchell

13. BIRTHPLACE OF MOTHER (State or Country) Idaho

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) J. B. Shank
(Address) _____

15. Filed July 24 1913 Dee L. O'Neil
Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH July 23 1913
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from _____ 1913, to _____ 1913, that I last saw him alive on July 23 1913, and that death occurred on the date stated above, at 4 P. M.

The CAUSE OF DEATH* was as follows:
Inanition a Premature birth
(Duration) _____ yrs. _____ mos. 10 ds.

Contributory (Secondary) _____
(Duration) _____ yrs. _____ mos. _____ ds.
(Signed) Dee L. O'Neil M. D.
July 23 1913 (Address) Blaine

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL,

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place _____ In the _____
of death _____ yrs. _____ mos. _____ ds. State _____ yrs. _____ mos. _____ ds.
Where was Disease contracted, _____
If not at place of death? _____
Former or _____
usual residence. _____

19. PLACE OF BURIAL OR REMOVAL On Ranch DATE OF BURIAL July 24 1913

20. UNDERTAKER Elgin Stroka ADDRESS Blaine Idaho

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

County of <u>Canyon</u>		Primary Registration District No. <u>2216</u>		File No. <u>5244</u>
City of <u>Payette</u>		(No. _____ St.)		Registered No. <u>7</u>
If death occurs away from usual residence, give facts called for under special information.				
2. FULL NAME <u>Alice Martha Hart</u>				
PERSONAL AND STATISTICAL PARTICULARS				
3. SEX <u>Female</u>	4. COLOR OR RACE <u>White</u>	5. SINGLE, MARRIED, WIDOWED OR DIVORCED. <u>Widowed</u> (Write the word.)		
6. DATE OF BIRTH <u>November 7 1886</u> (Month) (Day) (Year)				
7. AGE <u>46</u> yrs. <u>5</u> mos. _____ ds.		IF LESS than 1 day how many _____ hrs. or _____ min?		
8. OCCUPATION (a) Trade, profession or particular kind of work. <u>Housewife</u> (b) General nature of industry business or establishment in which employed (or employer) _____				
9. BIRTHPLACE (State or Country) <u>Idaho-Canyon Co</u>				
10. NAME OF FATHER <u>Samuel Applegate</u>				
11. BIRTHPLACE OF FATHER (State or Country) <u>Indiana-Scott Co</u>				
12. MAIDEN NAME OF MOTHER <u>Delia F Landreth</u>				
13. BIRTHPLACE OF MOTHER (State or Country) <u>Missouri-Linn Co</u>				
14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE (Informant) <u>J. R. McInnes</u> (Address) <u>Payette Idaho</u>				
15. Filed <u>July 7 1913</u> <u>J. R. Woodward</u> Local Registrar				
MEDICAL CERTIFICATE OF DEATH.				
16. DATE OF DEATH <u>July 7 1913</u> (Month) (Day) (Year)				
17. I HEREBY CERTIFY, That I attended deceased from <u>Mar 1 1912</u> , to <u>July 6 1913</u> that I last saw her alive on <u>July 6 1913</u> and that death occurred on the date stated above, at <u>12:00</u> M. The CAUSE OF DEATH* was as follows: <u>Carcinoma of Liver</u>				
(Duration) _____ yrs. <u>6</u> mos. _____ ds.				
Contributory (Secondary) _____				
(Duration) _____ yrs. _____ mos. _____ ds.				
(Signed) <u>J. R. Woodward</u> M. D. <u>July 7 1913</u> (Address) <u>Payette, Idaho</u>				
(*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.				
18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.) At place _____ In the _____ of death _____ yrs. _____ mos. _____ ds. State _____ yrs. _____ mos. _____ ds. Where was disease contracted, _____ If not at place of death? _____ Former or _____ usual residence _____				
19. PLACE OF BURIAL OR REMOVAL <u>Payette</u> DATE OF BURIAL <u>July 8 1913</u>				
20. UNDERTAKER <u>W. C. Woodward</u> ADDRESS <u>Payette Idaho</u>				

Form V. S. No. 5 20M.1-16-12

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH.

Registration District No. 41County of LewiaPrimary Registration District No. 2116City of Sahman

(No. _____, _____ St.)

File No. 5245Registered No. 1

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Dr. Rachel Miller

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX

4. COLOR OR RACE

5. SINGLE, MARRIED, WIDOWED OR DIVORCED.

FemaleWhiteMarried
(Write the word.)

6. DATE OF BIRTH

May 27

(Month)

(Day)

1895

(Year)

7. AGE

18

yrs.

1

mos.

13

ds.

IF LESS than 1 day
how many _____ hrs. or
_____ mins.?

8. OCCUPATION

(a) Trade, profession or particular kind of work

(b) General nature of industry business, or establishment in which employed (or employer)

House wife

9. BIRTHPLACE

(State or Country)

Iowa

10. NAME OF FATHER

J. V. Leuchs

11. BIRTHPLACE OF FATHER

(State or Country)

Do not know

12. MAIDEN NAME OF MOTHER

Ors Rachel Wee

13. BIRTHPLACE OF MOTHER

(State or Country)

Iowa

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

J. E. Miller

(Address)

Sahman Ida.

15.

Filed 7-15

1913

Helena L. Smith
Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH

July 13th

(Month)

July

(Day)

13

1913

(Year)

17. I HEREBY CERTIFY, That I attended deceased from

July 1

1913, to

July 13th

1913,

July 13th

1913,

that I last saw him alive on

July 15th

1913,

July 15th

1913,

and that death occurred on the date stated above, at 5-45 M.

The CAUSE OF DEATH* was as follows:

German measles following
childbirth on July 1st

(Duration)

yrs.

mos.

ds.

Contributory Exophthalmic Goiter
(Secondary)

(Duration)

yrs.

mos.

ds.

(Signed)

W. C. Whitwell

M. D.

19

(Address)

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place

of death.

yrs.

mos.

days.

In the

State.

yrs.

mos.

days.

Where was disease contracted if not at place of death?

Former or usual residence.

19. PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

Sahman CemeteryJuly 15 1913

20. UNDERTAKER

ADDRESS

W. C. WhitwellSahmanIda

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Form V. S. No. 5 20M.1-16-12

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH.

Registration District No. 41

County of Lemhi

Primary Registration District No. 2116

City of Frank Lemhi

(No. _____ St.)

File No. 5246

Registered No. 2

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

John Chapman

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX

4. COLOR OR RACE

5. SINGLE, MARRIED, WIDOWED OR DIVORCED.

Male

White

Single
(Write the word.)

6. DATE OF BIRTH

(Month) (Day) (Year)

7. AGE

65 yrs. ____ mos. ____ ds.

IF LESS than 1 day
how many ____ hrs. or
____ mins.?

8. OCCUPATION

(a) Trade, profession or particular kind of work

(b) General nature of industry, business, or establishment in which employed (or employer)

Quartz Miner

9. BIRTHPLACE

(State or Country)

England

10. NAME OF FATHER

Do not know

11. BIRTHPLACE OF FATHER

(State or Country)

England

12. MAIDEN NAME OF MOTHER

Do not know

13. BIRTHPLACE OF MOTHER

(State or Country)

Do not know

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

W. C. Jaebble

(Address)

Salmon Ida

15.

Filed

July 31 1913

Helen L. Smith
Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH

July-26"

1913
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from

_____, 191____, to _____, 191____,
that I last saw h_____ alive on _____, 191____,

and that death occurred on the date stated above, at _____ M.

The CAUSE OF DEATH* was as follows:

Natural
causes due to chronic
valvular heart disease

_____, (Duration) ____ yrs. ____ mos. ____ ds.

Contributory
(Secondary)

_____, (Duration) ____ yrs. ____ mos. ____ ds.

(Signed) W. C. Jaebble

July 26 1913 (Address) Salmon Ida

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death ____ yrs. ____ mos. ____ days. In the State ____ yrs. ____ mos. ____ days.

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

Salmon Cemetery

July 30 1913

20. UNDERTAKER

ADDRESS

W. C. Jaebble

Salmon
Ida

MARGIN RESERVED FOR BINDING

WRITE PAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Form V. S. No. 5 20M.1-16-12

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics
File No. 524
Registered No. 3
If death occurred in a
stitution or camp, give
instead of street and nu

1. PLACE OF DEATH.

Registration District No. 41

County of Lemhi

Primary Registration District No. 2116.

City of Tendency, Ida

(No.)

If death occurs away from usual residence, give facts called for under special information.

FULL NAME Earnest R Morris

PERSONAL AND STATISTICAL PARTICULARS

3. SEX

4. COLOR OR RACE

5. SINGLE, MARRIED, WIDOWED OR DIVORCED.

Male white

(Write the word.) Single

6. DATE OF BIRTH

(Month)

(Day)

(Year)

7. AGE

32

yrs. mos. ds.

IF LESS than 1 day
how many hrs. or mins.

8. OCCUPATION

- (a) Trade, profession or particular kind of work
(b) General nature of industry business, or establishment in which employed (or employer)

Farmer

9. BIRTHPLACE

(State or Country)

Illinois

10. NAME OF FATHER

Robert Morris

11. BIRTHPLACE OF FATHER

(State or Country)

Ohio

12. MAIDEN NAME OF MOTHER

Kathleen Spornick

13. BIRTHPLACE OF MOTHER

(State or Country)

Illinois

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

E. R. Morris

(Address)

Tendency, Ida

15.

Filed August 1st 1913

Walter Smith

Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH

July 29

(Month)

(Day)

17. I HEREBY CERTIFY, That I attended decea

191., to

that I last saw h alive on

and that death occurred on the date stated above, at

The CAUSE OF DEATH* was as follows:

Self injury
With suicidal intent

(Duration)

yrs.

mos.

Contributory
(Secondary)

(Duration)

yrs.

mos.

(Signed)

July 29 1913

(Address)

Wm C Daebler

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSE MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL

18. LENGTH OF RESIDENCE (For Hospitals, Institutions or Recent Residents.)

At place

of death yrs. mos. days.

In the

State yrs. mos.

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF DEATH OR REMOVAL

DATE OF BURIAL

Marango, Illinois

Aug 1st

20. UNDERTAKER

ADDRESS

Wm C Daebler

Sakma Ida

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Form V. S. No. 5 20M.1-16-12

CERTIFICATE OF DEATH

 State of Idaho
 BOARD OF HEALTH
 Bureau of Vital Statistics

1. PLACE OF DEATH.

Registration District No. HCounty of LemhiPrimary Registration District No. 2116City of Salmon

(No. _____ St.)

File No. 5248Registered No. 4

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME R. L. Davis

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX

Male

4. COLOR OR RACE

White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED.

Single
(Write the word.)

6. DATE OF BIRTH

Do not know
(Month) (Day) (Year)

7. AGE

37

yrs. mos. ds.

 IF LESS than 1 day
 how many hrs. or mins.?

8. OCCUPATION

(a) Trade, profession or particular kind of work

Farmer

(b) General nature of industry business, or establishment in which employed (or employer)

9. BIRTHPLACE

(State or Country)

Illinois

10. NAME OF FATHER

J. K. Davis

11. BIRTHPLACE OF FATHER

(State or Country)

Phil Pen

12. MAIDEN NAME OF MOTHER

Ester Brundage

13. BIRTHPLACE OF MOTHER

(State or Country)

Ohio

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

Mr Kelly

(Address)

Salmon Ida

15.

Filed

August 4 1913

Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH

August 31913

(Month)

(Day)

(Year)

17. I HEREBY CERTIFY, That I attended deceased from

July 30 1913 to Aug 3 1913that I last saw him alive on Aug 3 1913and that death occurred on the date stated above, at 4 A.M.

The CAUSE OF DEATH* was as follows:

Fracture and dislocation of 6th cervical vertebra(Duration) yrs. mos. 3 1/2 ds.

Contributory

(Secondary)

(Duration) yrs. mos. ds.

(Signed)

Chas. F. Hammer

M. D.

2-4-1913 (Address) Salmon Ida

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death. yrs. mos. days. In the State. yrs. mos. days.

Where was disease contracted if not at place of death?

Former or usual residence.

19. PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

Cameron Mount1913

20. UNDERTAKER

ADDRESS

Wm C. DaublerSalmonIda

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Form V. S. No. 5 20M.1-16-12

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH.

Registration District No. 41

County of Lemhi

Primary Registration District No. 2116

City of Salmon

(No. _____, _____ St.)

File No. 5249

Registered No. 5

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Elanor Matilda Erickson

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX

f.

4. COLOR OR RACE

white

5. SINGLE, MARRIED, WIDOWED OR DIVORCED.

single
(Write the word.)

6. DATE OF BIRTH

Sept
(Month)

18
(Day)

1891
(Year)

7. AGE

22 yrs. 10 mos. 10 ds.

IF LESS than 1 day
how many _____ hrs. or
_____ mins.?

8. OCCUPATION

(a) Trade, profession or particular kind of work

Housekeeper

(b) General nature of industry business, or establishment in which employed (or employer)

9. BIRTHPLACE

(State or Country)

Idaho

10. NAME OF FATHER

John E. Erickson

11. BIRTHPLACE OF FATHER

(State or Country)

Sweden

12. MAIDEN NAME OF MOTHER

Hilda Whatman

13. BIRTHPLACE OF MOTHER

(State or Country)

Sweden

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

John E. Erickson

(Address)

Salmon Idaho

15.

Filed August 7 1913

Robert Smith
Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH

August
(Month)

7
(Day)

1913
(Year)

17. I HEREBY CERTIFY, That I attended deceased from

Aug 2 1913, to Aug 6 1913,

that I last saw her alive on Aug 6 about 1913,

and that death occurred on the date stated above, at, 2 AM.

The CAUSE OF DEATH* was as follows:

Pericarditis with effusion

(Duration) _____ yrs. about 4 ds.

Contributory Phlegmonous tonsillitis
(Secondary)

(Duration) _____ yrs. 6 mos. 6 ds.

(Signed) Chas. F. Hennessey M. D.

19 (Address) Salmon Ida

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death _____ yrs. _____ mos. _____ days. In the State _____ yrs. _____ mos. _____ days.

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

Salmon Cemetery

Aug-8 1913

20. UNDERTAKER

ADDRESS

W. C. Joehls

Salmon Ida

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Form V. S. No. 5 20M.1-16-12

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics
File No. **5258**

1. PLACE OF DEATH.

County of Lemhi
City of Gibbonsville

Registration District No. 41

Primary Registration District No. 2116

(No. St.)

Registered No. 6

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Herry Allen

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX

Male

4. COLOR OR RACE

White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED.

Single
(Write the word.)

6. DATE OF BIRTH

September 1883
(Month) (Day) (Year)

7. AGE

29 yrs. 10 mos. 10 ds.

IF LESS than 1 day
how many hrs. or
..... mins.)

8. OCCUPATION

(a) Trade, profession or particular kind of work

Farmer

(b) General nature of industry business, or establishment in which employed (or employer)

9. BIRTHPLACE

(State or Country)

Oregon

10. NAME OF FATHER

Joseph Allen

11. BIRTHPLACE OF FATHER

(State or Country)

Oregon

12. MAIDEN NAME OF MOTHER

Do not know

13. BIRTHPLACE OF MOTHER

(State or Country)

Oregon

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

Frank Allen

(Address)

Gibbonsville, Ida

15.

Filed August 2 1913

Helen Smith
Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH

August 7 1913
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from made one visit June 2 1913
that I last saw him alive on June 2 1913
and that death occurred on the date stated above, at 12:30 A.M.

The CAUSE OF DEATH* was as follows:

Pulmonary Tuberculosis

(Duration) 2 yrs. mos. ds.

Contributory
(Secondary)

(Duration) yrs. mos. ds.

(Signed)

B. Stratton M. D.
8/8 1913 (Address) Sakima, Ida.

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death yrs. mos. days. In the State yrs. mos. days.

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL DATE OF BURIAL

Gibbonsville, Ida Aug-9 1913

20. UNDERTAKER

ADDRESS

None such

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Form V. S. No. 5. 12½M.7-24-11

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics
File No. 5251
Registered No. 42

1. PLACE OF DEATH. Registration District No. 11
County of Blaine Primary Registration District No. 2647
City of McCammer (No. , St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

Mrs. Ida Lewis

If death occurred in a hospital, institution or camp give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX Female 4. COLOR OR RACE White 5. SINGLE, MARRIED, WIDOWED OR DIVORCED. Married
(Write the word.)

6. DATE OF BIRTH 12 - 11 - 1870
(Month) (Day) (Year)

7. AGE 44 yrs. — mos. — ds. IF LESS than 1 day how many... hrs. or min?

8. OCCUPATION
(a) Trade, profession or particular kind of work Housewife
(b) General nature of industry business or establishment in which employed (or employer)

9. BIRTHPLACE
(State or Country) Indiana

10. NAME OF FATHER David Reggins

11. BIRTHPLACE OF FATHER
(State or Country) Indiana

12. MAIDEN NAME OF MOTHER Reggins

13. BIRTHPLACE OF MOTHER
(State or Country) Indiana

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) W. W. Wakes
(Address) McCammer, Idaho

15. Filed Aug 14 1913 Edis K. Carey
Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH July 13 1913
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from January 2 1913, to July 13 1913 that I last saw h. a. alive on July 13 1913 and that death occurred on the date stated above, at 8 P. M.
The CAUSE OF DEATH* was as follows:

Abscess Gall Bladder
(Duration) yrs. 2 mos. — ds.

Contributory (Secondary)
(Duration) yrs. — mos. — ds.
(Signed) W. W. Wakes M. D.
19 (Address) McCammer, Idaho

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place In the
of death yrs. — mos. — ds. State yrs. — mos. — ds.
Where was disease contracted,
If not at place of death?
Former or
usual residence

19. PLACE OF BURIAL OR REMOVAL DATE OF BURIAL

McCammer Aug 15 1913

20. UNDERTAKER ADDRESS

W. W. Wakes Camden, Mo.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Form V. S. No. 5 20M.1-16-12

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH.

Registration District No. 11County of BannockPrimary Registration District No. 2046City of Marsh Center

(No. _____, St.)

File No. 5252Registered No. 41

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

No NameAt Home

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX

Female

4. COLOR OR RACE

white

5. SINGLE, MARRIED, WIDOWED OR DIVORCED.

Infant
(Write the word.)

6. DATE OF BIRTH

July
(Month)18
(Day)1913
(Year)

7. AGE

yrs. mos. 10 ds.IF LESS than 1 day
how many hrs. or mins.

8. OCCUPATION

(a) Trade, profession or particular kind of work
(b) General nature of industry, business, or establishment in which employed (or employer)Infant

9. BIRTHPLACE

(State or Country)

Franklin Id

10. NAME OF FATHER

Joe Morrison

11. BIRTHPLACE OF FATHER

(State or Country)

Franklin

12. MAIDEN NAME OF MOTHER

Mary Ross Whitehead

13. BIRTHPLACE OF MOTHER

(State or Country)

Franklin

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

N S Coffin

(Address)

Armed

15.

Filed

Aug. 16,1913Edis Carey
Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH

July 29
(Month) (Day) (Year)1913

17. I HEREBY CERTIFY, That I attended deceased from

July 28 1913, to July 29 1913,
that I last saw her alive on July 28 1913,
and that death occurred on the date stated above, at 1 a.m.

The CAUSE OF DEATH* was as follows:

Pneumonia (Bronchi)(Duration) yrs. mos. 3 ds.Contributory
(Secondary)(Duration) yrs. mos. ds.(Signed) N S Coffin M. D.Aug. 1, 1913 (Address) Armed

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death yrs. mos. days. In the State yrs. mos. days.

Where was disease contracted if not at place of death?

Former or usual residence.

19. PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

Marsh CenterJuly 30 1913

20. UNDERTAKER

ADDRESS

N S CoffinArmed

-SUPPLEMENTARY DEATH CERTIFICATE-

(Please reply on this sheet to
the registrar of Vital Statistics)

Death Certificate No. 5252

Name Infant of Jas. Morrison

Date of Death July 29, 1913.

Cause of Death *Broncho-pneumonia*

Contributory Cause of death *none*

(Sign here) *Carroll* M.D.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Form V. S. No. 5 20M.1-16-12

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics
File No. 525

1. PLACE OF DEATH. Registration District No. 11
County of Bannock Primary Registration District No. 2046
City of Orford (No. _____ St.)

Registered No. 39

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME William Hadley

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX M 4. COLOR OR RACE W 5. SINGLE, MARRIED, WIDOWED OR DIVORCED. Single
(Write the word.)

6. DATE OF BIRTH Aug 3 1913
(Month) (Day) (Year)

7. AGE 1 yrs. 3 mos. 3 ds. IF LESS than 1 day how many _____ hrs. or _____ mins.?

8. OCCUPATION
(a) Trade, profession or particular kind of work Child
(b) General nature of industry business, or establishment in which employed (or employer)

9. BIRTHPLACE (State or Country) Orford Idaho

10. NAME OF FATHER Fay William Hadley

11. BIRTHPLACE OF FATHER (State or Country) Willard Utah

12. MAIDEN NAME OF MOTHER Violet Carlsson

13. BIRTHPLACE OF MOTHER (State or Country) Clifton Idaho

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Walter Hatch
(Address) Orford Idaho

15. Filed Aug 1 1913 Ellis Hadley
Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH Aug 28 1913
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from 1913 to 1913, that I last saw him alive on 1913, and that death occurred on the date stated above, at M.

The CAUSE OF DEATH* was as follows:

Pneumonia
(Duration) _____ yrs. _____ mos. _____ ds.
Contributory (Secondary) _____
(Duration) _____ yrs. _____ mos. _____ ds.
(Signed) Had no Physician M. D.
19 _____ (Address) _____

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death _____ yrs. _____ mos. _____ days. In the State _____ yrs. _____ mos. _____ days.
Where was disease contracted if not at place of death? _____

Former or usual residence _____

19. PLACE OF BURIAL OR REMOVAL Orford Idaho DATE OF BURIAL Aug 6 1913

20. UNDERTAKER Walter Hatch ADDRESS Orford

1. PLACE OF DEATH.		Registration District No. <u>2048</u>		Bureau of Vital Statistics	
County of <u>Bennett</u>		Primary Registration District No. <u>2048</u>		File No. <u>5255</u>	
City of <u>Perry Idaho</u>		(No. _____, St.)		Registered No. <u>28</u>	
If death occurs away from usual residence, give facts called for under special information.		2. FULL NAME <u>None</u>		If death occurred in a hospital, institution or camp give its NAME instead of street and number.	

PERSONAL AND STATISTICAL PARTICULARS			MEDICAL CERTIFICATE OF DEATH.		
3. SEX <u>Boy</u>	4. COLOR OR RACE <u>White</u>	5. SINGLE, MARRIED, WIDOWED OR DIVORCED. <u>Single</u> (Write the word.)	16. DATE OF DEATH <u>July</u> <u>24</u> 191 <u>3</u> (Month) (Day) (Year)		
6. DATE OF BIRTH <u>July</u> <u>23</u> 191 <u>3</u> (Month) (Day) (Year)			17. I HEREBY CERTIFY, That I attended deceased from 191 <u> </u> , to 191 <u> </u> that I last saw him alive on <u>July 23</u> 191 <u>3</u> and that death occurred on the date stated above, at <u>8 A.M.</u> The CAUSE OF DEATH* was as follows: <u>Premature Birth</u>		
7. AGE _____ yrs. _____ mos. <u>27</u> ds. IF LESS than 1 day how many <u>24</u> hrs. or _____ min?			_____ (Duration) _____ yrs. _____ mos. _____ ds.		
8. OCCUPATION (a) Trade, profession or particular kind of work. <u>None</u> (b) General nature of industry business or establishment in which employed (or employer) _____			Contributory (Secondary) _____ _____ (Duration) _____ yrs. _____ mos. _____ ds.		
9. BIRTHPLACE (State or Country) <u>Perry Idaho</u>			(Signed) <u>Mary Lundgreen</u> M. D. <u>Aug 1</u> 191 <u>3</u> (Address) <u>Tremonton</u>		
10. NAME OF FATHER <u>Frank Homer</u>			*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; (2) whether ACCIDENTAL, SUICIDAL OR HOMICIDAL.		
11. BIRTHPLACE OF FATHER (State or Country) <u>Trenton Utah</u>			18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.) At place _____ In the _____ of death _____ yrs. _____ mos. _____ ds. State _____ yrs. _____ mos. _____ ds.		
12. MAIDEN NAME OF MOTHER <u>Amey Emilie Jones</u>			Where was disease contracted, _____ If not at place of death? _____ Former or _____ usual residence _____		
13. BIRTHPLACE OF MOTHER (State or Country) <u>Perry Idaho</u>			19. PLACE OF BURIAL OR REMOVAL <u>Perry Idaho</u> DATE OF BURIAL <u>July 24</u> 191 <u>3</u>		
14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE (Informant) <u>Mary Lundgreen</u> (Address) <u>Tremonton Idaho</u>			20. UNDERTAKER <u>By Larson</u> ADDRESS <u>Blended</u>		
15. Filed <u>Aug 10</u> 191 <u>3</u> <u>Reisbach</u> Local Registrar					

WRITE PLAINLY, WITH UNFADING INK--THIS IS A PERMANENT RECORD.
N. B.--Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Form V. S. No. 5 20M.1-16-12

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH

Registration District No. 19

County of

Primary Registration District No. 10.02

City of

(No. 1150, V. Harrison St.)

File No. 2 525

Registered No. 66

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

Bernard Grant

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX

Male

4. COLOR OR RACE

White

5. SINGLE, MARRIED, WID-
OWED OR DIVORCED.

Widowed
(Write the word.)

6. DATE OF BIRTH

Dec.

26

1827

(Month)

(Day)

(Year)

7. AGE

85 yrs. 6 mos. 25 ds.

IF LESS than 1 day
how many hrs. or
mins.?

8. OCCUPATION

(a) Trade, profession or
particular kind of work

Retired

(b) General nature of industry
business, or establishment in
which employed (or employer)

9. BIRTHPLACE

(State or Country)

Ireland

10. NAME OF
FATHER

11. BIRTHPLACE
OF FATHER

(State or Country)

12. MAIDEN NAME
OF MOTHER

13. BIRTHPLACE
OF MOTHER

(State or Country)

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

M. A. Burlingame

(Address)

1150 V. Harrison Ave

15.

Filed

June 21 1913

O. B. Steady

Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

June

20

1913

(Month)

(Day)

(Year)

17. I HEREBY CERTIFY, That I attended deceased from

June 18" 1913, to June 20 1913,

that I last saw him alive on June 20 1913,

and that death occurred on the date stated above, at 10.10 P. M.

The CAUSE OF DEATH* was as follows:

Empyema + Pneumonia

(Duration) yrs. mos. ds.

Contributory
(Secondary)

refractive - stenocardia

(Duration) 10 yrs. mos. ds.

(Signed)

H. A. Castle

M. D.

June 20 1913 (Address) Bocatello Id

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death yrs. mos. days. In the State yrs. mos. days.

Where was disease contracted
if not at place of death?

Former or
usual residence

19. PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

Luna, Mont

June

1913

20. UNDERTAKER

ADDRESS

H. H. Walker Bocatello

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Form V. S. No. 5 20M.1-16-12

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH
County of *Blaine*
City of *Pocatello*

Registration District No. *19*
Primary Registration District No. *10202*
(No. *Commercial Hotel* St.)

File No. *52572*
Registered No. *64*

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME *John W. Loney*

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX *Male* 4. COLOR OR RACE *White* 5. SINGLE, MARRIED, WIDOWED OR DIVORCED. *Single*
(Write the word.)

6. DATE OF BIRTH *1894*
(Month) (Day) (Year)

7. AGE *19* yrs. *19* mos. *19* ds.
IF LESS than 1 day how many hrs. or mins.?

8. OCCUPATION *Paucher*
(a) Trade, profession or particular kind of work
(b) General nature of industry business, or establishment in which employed (or employer)

9. BIRTHPLACE *Ohio*
(State or Country)

10. NAME OF FATHER *George B. Loney*

11. BIRTHPLACE OF FATHER *Ohio*
(State or Country)

12. MAIDEN NAME OF MOTHER *Laura A. Hudnicker*

13. BIRTHPLACE OF MOTHER *Ohio*
(State or Country)

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) *R. F. Loney*
(Address) *Mt Pleasant Mich*

15. Filed *June 6 1913*

Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH *June 6 1913*
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from *June 6 1913* to *June 6 1913*, that I last saw him alive on *June 6 1913*, and that death occurred on the date stated above, at *7:30 A.M.*

The CAUSE OF DEATH* was as follows:
Pulmonary Tuberculosis

(Duration) *19* yrs. *19* mos. *19* ds.
Contributory (Secondary) *Hemorrhage*

(Signed) *A. J. Newton* M. D.
June 6 1913 (Address) *Pocatello Idaho*

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death *19* yrs. *19* mos. *19* days. In the State *19* yrs. *19* mos. *19* days.

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL DATE OF BURIAL

Mt Pleasant Mich June 6 1913
20. UNDERTAKER *R. F. Loney* ADDRESS *Pocatello Idaho*

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Form V. S. No. 5 20M.1-16-12

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH

Registration District No. 19

County of

Primary Registration District No. 1002

City of

(No. H. Buchanan

St.)

File No. 2 525

Registered No. 63

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

Alfred H. Bagshaw

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX

Male

4. COLOR OR RACE

White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED.

(Write the word.) Single

6. DATE OF BIRTH

May 8 1913

(Month)

(Day)

(Year)

7. AGE

— yrs. — mos. 25 ds.

IF LESS than 1 day
how many hrs. or
..... mins.?

8. OCCUPATION

(a) Trade, profession or particular kind of work

None

(b) General nature of industry business, or establishment in which employed (or employer)

9. BIRTHPLACE

(State or Country)

Pocatello

10. NAME OF FATHER

Arnold Windon

11. BIRTHPLACE OF FATHER

(State or Country)

Beaver City Utah

12. MAIDEN NAME OF MOTHER

Zella Bagshaw

13. BIRTHPLACE OF MOTHER

(State or Country)

Beaver City Utah

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

Zella Della Bagshaw

(Address)

Pocatello

15.

Filed

June 4 1913

1913

O. B. Seely

Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH

June 2 1913

(Month)

(Day)

(Year)

17. I HEREBY CERTIFY, That I attended deceased from

May 25 1913, to June 2 1913,

that I last saw him alive on June 2 1913,

and that death occurred on the date stated above, at 8:45 P.M.

The CAUSE OF DEATH* was as follows:

Pertussis

(Duration)

— yrs. — mos. 25 ds.

Contributory
(Secondary)

Convulsions

(Duration)

— yrs. — mos. 2 ds.

(Signed)

W. F. Howard, M. D.

6/2 1913 (Address) Pocatello

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place

of death yrs. mos. days.

In the

State yrs. mos. days.

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

Mt. View Cemetery

June 4 1913

20. UNDERTAKER

ADDRESS

M. M. Meller

Pocatello

MARGIN RESERVED FOR BINDING
WRITE PLAINLY, WITH UNFADING INK.—THIS IS A PERMANENT RECORD.
N. B.—Every item of information should be carefully supplied. If the cause of death should be stated EXACTLY. If the cause of death is not stated, it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Form V. S. No. 5 20M.1-16-12

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics
File No. 2525
Registered No. 65

1. PLACE OF DEATH. Registration District No. 19
County of Blaine Primary Registration District No. 1007
City of Pocatello (No. Japanese Market St.)
If death occurs away from usual residence, give facts called for under special information. 2. FULL NAME J. Ochi

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX Male 4. COLOR OR RACE Mongolian 5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.)

6. DATE OF BIRTH 1883
(Month) (Day) (Year)

7. AGE 30 yrs. mos. ds. IF LESS than 1 day how many hrs. or mins.?

8. OCCUPATION (a) Trade, profession or particular kind of work Laborer (b) General nature of industry business, or establishment in which employed (or employer)

9. BIRTHPLACE Japan (State or Country)

10. NAME OF FATHER

11. BIRTHPLACE OF FATHER

12. MAIDEN NAME OF MOTHER

13. BIRTHPLACE OF MOTHER (State or Country)

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) M. M. Marku (Address) Pocatello

15. Filed June 9 1913 J. Ochi Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH June 7 1913
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from January 3 1913, to June 7 1913, that I last saw him alive on June 7 1913, and that death occurred on the date stated above, at 11 P.M. The CAUSE OF DEATH* was as follows:
Tuberculosis
(Duration) 1 yrs. 4 mos. 3 ds.
Contributory (Secondary)
(Duration) yrs. mos. ds.
(Signed) J. Ochi M. D.
June 7 1913 (Address) Pocatello Idaho

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death yrs. mos. days. In the State yrs. mos. days.

Where was disease contracted if not at place of death?

Former or usual residence.

19. PLACE OF BURIAL OR REMOVAL Japanese Cemetery DATE OF BURIAL June 9 1913

20. UNDERTAKER M. M. Marku ADDRESS Pocatello

DR. O. B. STEELY
POCATELLO, IDAHO

Pocatello, Idaho, Nov. 17, 1913.

Dr. Ralph Falk,

Secy State Board of Health, Boise, Idaho.

Dear Doctor:

In reference to the cause of death of J. Oichi I will state that I am not absolutely sure of cause of peritonitis.

He was under treatment for an extremely vicious attack of luteal disease at the time, when peritonitis developed suddenly and the patient died in twelve hours from the initial symptoms of inflammation.

I believe it was perforating ulcer of the bowels.

Yours truly,



RECEIVED

NOV 18 1913

SECRETARY'S OFFICE
STATE BOARD OF HEALTH

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Form V. S. No. 5 20M.1-16-12

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH.

Registration District No.

County of

Primary Registration District No.

City of

(No. 259, 15. 2nd ave. St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

Albert C. Draper

File No.

2 5260

Registered No.

66

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX

Male

4. COLOR OR RACE

White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED.

Married

6. DATE OF BIRTH

Dec

13

1840

(Month)

(Day)

(Year)

7. AGE

77 yrs. 6 mos. 10 ds.

IF LESS than 1 day how many hrs. or mins.?

8. OCCUPATION

(a) Trade, profession or particular kind of work

Merchant

(b) General nature of industry business, or establishment in which employed (or employer)

9. BIRTHPLACE

(State or Country)

10. NAME OF FATHER

11. BIRTHPLACE OF FATHER

(State or Country)

12. MAIDEN NAME OF MOTHER

13. BIRTHPLACE OF MOTHER

(State or Country)

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

Albert C. Draper

(Address)

Procatello Ida

15.

Filed

June 7 5

1913

AP Draper

Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH

June

23

1913

(Month)

(Day)

(Year)

17. I HEREBY CERTIFY, That I attended deceased from

June 16 1913 to June 23 1913

that I last saw him alive on June 23 1913

and that death occurred on the date stated above, at 4:30 P.M.

The CAUSE OF DEATH* was as follows:

Coronary
Stomach.

(Duration) yrs. mos. ds.

Contributory

(Secondary)

(Duration) yrs. mos. ds.

(Signed)

Wm. H. W. Draper M. D.

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death yrs. mos. days. In the State yrs. mos. days.

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

At New cemetery June 26 1913

20. UNDERTAKER

ADDRESS

W. Draper Procatello Ida

Form V. S. No. 5 20M.1-16-12

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH.

Registration District No. 19

County of

Primary Registration District No. 1002

City of

(No. 227, Do 7 Ave. St.)

File No. 2 5261

Registered No. 65

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

Charles Mortimer White

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX

Male

4. COLOR OR RACE

White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED.

Married
(Write the word)

6. DATE OF BIRTH

Dec

28

1823

(Month)

(Day)

(Year)

7. AGE

89 yrs.

5 mos.

24 ds.

IF LESS than 1 day
how many hrs. or
mins.?

8. OCCUPATION

(a) Trade, profession or particular kind of work

Attorney at Law.

(b) General nature of industry business, or establishment in which employed (or employer)

9. BIRTHPLACE

(State or Country)

Fayetteville N. Y.

10. NAME OF FATHER

11. BIRTHPLACE OF FATHER

(State or Country)

12. MAIDEN NAME OF MOTHER

13. BIRTHPLACE OF MOTHER

(State or Country)

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

Caleb L. White

(Address)

Pocatello Idaho

15.

Filed

June 23d 1913

O. B. Steady
Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH

June

22

1913

(Month)

(Day)

(Year)

17. I HEREBY CERTIFY, That I attended deceased from

June 9th 1913, to June 22nd 1913

that I last saw him alive on June 22nd 1913

and that death occurred on the date stated above, at 4:30 A.M.

The CAUSE OF DEATH* was as follows:

Cardiac dilatation due to senile atheroma

(Duration) 3 yrs. mos. ds.

Contributory Cause
(Secondary)

(Duration) yrs. mos. ds.

(Signed)

O. B. Steady M. D.

6-23, 1913 (Address) Pocatello, Idaho

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death. yrs. mos. days. In the State. yrs. mos. days.

Where was disease contracted if not at place of death?

Former or usual residence.

19. PLACE OF BURIAL OR REMOVAL DATE OF BURIAL

Cavanaugh Mts June 25 1913

20. UNDERTAKER

ADDRESS

W. M. Warner Pocatello Ida

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Form V. S. No. 5. 10M. 6-20-11.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics
File No. 5200

1. PLACE OF DEATH.

Registration District No. 34

County of Elmore

Primary Registration District No. 2020

City of Mountain Home

(No. St.)

Registered No. 17

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

J. R. Marchbanks

If death occurred in a hospital, institution or camp give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX

Male

4. COLOR OR RACE

White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED.

Married
(Write the word.)

6. DATE OF BIRTH

(Month) (Day) (Year)

7. AGE

40 yrs. — mos. — ds.

IF LESS than 1 day
how many..... hrs. or
min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work
(b) General nature of industry business or establishment in which employed (or employer)

Stockgrower

9. BIRTHPLACE

(State or Country)

Oregon

10. NAME OF FATHER

J. R. Marchbanks

11. BIRTHPLACE OF FATHER

(State or Country)

don't know

12. MAIDEN NAME OF MOTHER

don't know

13. BIRTHPLACE OF MOTHER

(State or Country)

don't know

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

Mrs. Lillie H. Gniel

(Address)

Mountain Home

15.

Filed June 26th 1913

B. W. Mather
Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

June 26th 1913
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from

June 25th 1913, to June 26th 1913
that I last saw him alive on June 26th 1913,
and that death occurred on the date stated above, at 7:30 A.M.

The CAUSE OF DEATH* was as follows:

Rupture bladder, internal hemorrhage. Run away accident

(Duration) yrs. mos. ds.

Contributory (Secondary)

Shock - post operative

(Duration) yrs. mos. ds.

(Signed) B. W. Mather M. D.

June 26th 1913 (Address) Mountain Home

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death..... yrs..... mos..... ds. State..... yrs..... mos..... ds.

Where was disease contracted,

If not at place of death?

Former or

usual residence

19. PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

Buried in Idaho June 28 1913

20. UNDERTAKER

ADDRESS

J. M. Corlew M. H. Horn

MARGIN RESERVED FOR BINDING
WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Form V. S. No. 5. 12½ M. 7-24-11

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics
File No. 326
Registered No.

1. PLACE OF DEATH. Registration District No.
County of Boise Primary Registration District No.
City of Ministry Sweet (No., St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Thomas William Carlock

If death occurred in a hospital, institution or camp give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX 4. COLOR OR RACE 5. SINGLE, MARRIED, WIDOWED OR DIVORCED.

Male White Single
(Write the word.)

6. DATE OF BIRTH

March 22 1909
(Month) (Day) (Year)

7. AGE

9 yrs. 3 mos. 11 ds.

IF LESS than 1 day
how many hrs. or
min?

8. OCCUPATION

(a) Trade, profession or particular kind of work
(b) General nature of industry business or establishment in which employed (or employer)

Boy

9. BIRTHPLACE

(State or Country)

Idaho

10. NAME OF FATHER

Richard C. Carlock

11. BIRTHPLACE OF FATHER

(State or Country)

Missouri

12. MAIDEN NAME OF MOTHER

Mary ~~W. Schenck~~

13. BIRTHPLACE OF MOTHER

(State or Country)

Idaho

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

Mary Carlock

(Address)

Sweet Idaho

15.

Filed 191

A. G. Ryan
Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH

July 3 1913
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from

May 25 1913, to July 3 1913

that I last saw him alive on July 3 1913

and that death occurred on the date stated above, at 10 P. M.

The CAUSE OF DEATH* was as follows:

Typhoid Fever

..... (Duration) yrs. 1 mos. 8 ds.

Contributory pharyngitis
(Secondary)

..... (Duration) yrs. mos. 1 ds.

(Signed) A. G. Ryan M. D.

..... 19..... (Address)

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place In the
of death yrs. mos. ds. State yrs. mos. ds.

Where was disease contracted,

If not at place of death?

Former or

usual residence.....

19. PLACE OF BURIAL OR REMOVAL DATE OF BURIAL

At a Idaho July 5 1913

20. UNDERTAKER

ADDRESS

E. L. Buckner

MA
IN

WRITE PLAINLY, WITH UNFADING INK. THIS IS A PERMANENT RECORD.
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Form V. S. No. 5. 12½ M. 7-24-11

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics
File No. **5264**
Registered No. _____

1. PLACE OF DEATH. Registration District No. _____
County of Boise Primary Registration District No. _____
City of Vicinity of Sweet (No. _____, _____ St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Bessie La Grande Klinger

If death occurred in a hospital, institution or camp give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX M. 4. COLOR OR RACE W. 5. SINGLE, MARRIED, WIDOWED OR DIVORCED. Single
(Write the word.)

6. DATE OF BIRTH October 17 1913
(Month) (Day) (Year)

7. AGE 1 yrs. 8 mos. 1 ds. IF LESS than 1 day how many _____ hrs. or _____ min?

8. OCCUPATION
(a) Trade, profession or particular kind of work. Infant
(b) General nature of industry business or establishment in which employed (or employer) Infant

9. BIRTHPLACE
(State or Country) Near Sweet Idaho

10. NAME OF FATHER E. H. Klinger

11. BIRTHPLACE OF FATHER
(State or Country) Michigan

12. MAIDEN NAME OF MOTHER Anna Klinger

13. BIRTHPLACE OF MOTHER
(State or Country) Michigan

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Mrs. A. Klinger
(Address) Sweet Idaho

15. Filed July 9, 1913
Local Registrar A. G. Byrd

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH June 18 1913
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from June 18th 1913, to _____ 191____
that I last saw h _____ alive on _____ 191____
and that death occurred on the date stated above, at about 4 P. M.

The CAUSE OF DEATH* was as follows:
Accidental Drowning

_____ (Duration) _____ yrs. _____ mos. _____ ds.
Contributory (Secondary) None

_____ (Duration) _____ yrs. _____ mos. _____ ds.
(Signed) A. G. Byrd M. D.
July 9 1913 (Address) Sweet Idaho

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place _____ In the _____
of death _____ yrs. _____ mos. _____ ds. State _____ yrs. _____ mos. _____ ds.
Where was disease contracted, _____
If not at place of death? _____
Former or _____
usual residence _____

19. PLACE OF BURIAL OR REMOVAL Sweet DATE OF BURIAL June 19, 1913

20. UNDERTAKER Tabley Bros acting for C. D. Buckenish of Emmett Idaho. ADDRESS _____

A stillbirth must be registered both as a birth and death. The date of death should be the date of delivery and the death certificate should further state, if known, the cause of the stillbirth and the period of utero gestation in months.

STATEMENT OF OCCUPATION.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer, Physician, Stenographer, Compositor, Architect, Locomotive engineer, Civil engineer, Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner*, (b) *Cotton mill*; (a) *Salesman*, (b) *Grocery*; (a) *Foreman*, (b) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification, as *Day laborer, Farm laborer, Laborer—Coal mine*, etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers*, who receive a definite salary), may be entered as *Housewife, Housework*, or *At home*, and children, not gainfully employed, as *At school* or *At home*. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer (retired, 6 yrs.)*. For persons who have no occupation whatever, write *None*.

STATEMENT OF CAUSE OF DEATH.—Name, first the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebro-*

spinal fever (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid Pneumonia") *Lobar pneumonia; Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritoneum*, etc., *Carcinoma, Sarcoma*, etc., of (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent affection need not be stated unless important. Example: *Measles* (disease causing death), 29 ds.; *Bronchopneumonia* (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "Asthenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility, (Congenital)," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Haemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uraemia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify as "PUERPERAL, septicemia", "PUERPERAL peritonitis," etc., all diseases resulting from childbirth or miscarriage. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as probably such, if impossible to determine definitely. Examples: *Accidental drowning; Struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "Contributory."

2 # 2

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Form V, B. No. 5, 2004-1-10-12		CERTIFICATE OF DEATH		STATE OF ILLINOIS BOARD OF HEALTH Bureau of Vital Statistics	
PLACE OF DEATH		Registration District No.		File No. 5269	
County of <i>Peoria</i>		Primary Registration District No.		Registered No.	
City of <i>Roseburg</i> (No. _____) St. _____		FULL NAME <i>Bridget Cynthia McPherson</i>		If death occurred in a hospital, institution or camp, give its NAME instead of street and number.	
If death occurs away from usual residence, give facts called for under special information. 2.					
PERSONAL AND STATISTICAL PARTICULARS					
3. SEX <i>M</i>	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.)			
6. DATE OF BIRTH <i>January 5, 1895</i> Month (Day) (Year)					
7. AGE <i>38</i> yrs. <i>5</i> mos. <i>5</i> ds.		IF LESS than 1 day how many hrs. or mins.?			
8. OCCUPATION (a) Trade, profession or particular kind of work <i>Housewife (formerly)</i> (b) General nature of industry, business, or establishment in which employed (or employer)					
9. BIRTHPLACE (State or Country) <i>Davenport Iowa</i>					
10. NAME OF FATHER <i>John Dawson</i>					
11. BIRTHPLACE OF FATHER (State or Country) <i>Ohio</i>					
12. MAIDEN NAME OF MOTHER <i>Loomis</i>					
13. BIRTHPLACE OF MOTHER (State or Country) <i>Ohio</i>					
14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE (Informant) _____ (Address) _____					
15. Filed _____ 191 <i>U. S. Brydman</i> Local Registrar					
MEDICAL CERTIFICATE OF DEATH.					
16. DATE OF DEATH <i>June 27, 1913</i> (Month) (Day) (Year)					
17. I HEREBY CERTIFY, That I attended deceased from <i>May 27, 1913</i> , to <i>June 2nd, 1913</i> , that I last saw her alive on <i>June 2nd, 1913</i> , and that death occurred on the date stated above, at <i>10 P.M.</i>					
The CAUSE OF DEATH* was as follows: <i>Chronic interstitial Nephritis</i> <i>History of many years treatment</i> <i>of kidney by many Physicians</i> (Duration) yrs. mos. ds. Contributory <i>Chronic Valvular Heart Disease</i> (Secondary) <i>arteriosclerosis</i> (Duration) yrs. mos. ds. (Signed) <i>J. H. Conpton</i> M. D. 10 (Address)					
*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.					
18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.) At place of death yrs. mos. days. In the State yrs. mos. days. Where was disease contracted if not at place of death? _____ Former or usual residence. _____					
19. PLACE OF BURIAL OR REMOVAL				DATE OF BURIAL _____ 191	
20. UNDERTAKER				ADDRESS	

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Form 100-5 20M.1-16-12

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. CAUSE OF DEATH.

Registration District No.

County Boise

Primary Registration District No.

City of Roseburg

(No., St.)

Registered No.

If death occurred from usual residence, state facts called for under information.

2. FULL NAME Unborn - Stewart

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX 4. COLOR OR RACE 5. SINGLE, MARRIED, WID-
OWED OR DIVORCEDMale White Infant
(Write the word.)

6. DATE OF BIRTH

Dec. 28th 1913
(Month) (Day) (Year)

7. AGE

IF LESS than 1 day
how many hrs. or
..... mins.?
..... yrs. mos. 3 ds. 15

8. OCCUPATION

(a) Trade, profession or
particular kind of work
(b) General nature of industry
business, or establishment in
which employed (or employer)Infant

9. BIRTHPLACE

(State or Country) Boise Co. Ida10. NAME OF
FATHERJames F. Stewart11. BIRTHPLACE
OF FATHER(State or Country) Ind: Miami Co12. MAIDEN NAME
OF MOTHEROllie E. Henderson13. BIRTHPLACE
OF MOTHER(State or Country) Neb. Cass Co

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

(Address)

15. .

Filed 191

A. G. Ryan
Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH

April 12 1913
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from

April 7th 1913, to April 12 1913,that I last saw him alive on April 12 1913,and that death occurred on the date stated above, at 11:30 M.

The CAUSE OF DEATH* was as follows:

Bronchopneumonia(Duration) yrs. mos. 5 ds.Contributory Bronchitis
(Secondary)(Duration) yrs. mos. 15 ds.(Signed) J. H. Compton M. D.1913 (Address) Roseburg Idaho

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death yrs. mos. days. In the State yrs. mos. days.

Where was disease contracted
if not at place of death?Former or
usual residence

19. PLACE OF BURIAL OR REMOVAL DATE OF BURIAL

191

20. UNDERTAKER

ADDRESS

STATE OF IDAHO
Board of Health--Bureau of Vital Statistics

The enclosed certificate is defective for the reason that.....

.....Signature of undertaker and informant?.....
.....

Please correct and return immediately, together with this card in the accompanying stamped envelope.

See # 5278

RALPH FALK, M. D.,
State Registrar.

Make a copy of this card and return to the State Registrar.

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Form V. S. No. 5 20M.1-16-12

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH. Registration District No. 26
County of Oneida Primary Registration District No. 2071
City of Halbrook (No. _____ St.)

File No. 5271
Registered No. 63

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Emeline Baker

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX Female 4. COLOR OR RACE White 5. SINGLE, MARRIED, WIDOWED OR DIVORCED. Widowed
(Write the word.)

6. DATE OF BIRTH June 17 1844
(Month) (Day) (Year)

7. AGE 68 yrs 11 mos 27 ds.
IF LESS than 1 day how many hrs. or mins.?

8. OCCUPATION
(a) Trade, profession or particular kind of work Housewife
(b) General nature of industry, business, or establishment in which employed (or employer)

9. BIRTHPLACE Winto Run West Vir.
(State or Country)

10. NAME OF FATHER Steven Kendall

11. BIRTHPLACE OF FATHER Virginia
(State or Country)

12. MAIDEN NAME OF MOTHER Anna Watson

13. BIRTHPLACE OF MOTHER West Virginia
(State or Country)

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Ira Baker

(Address) Halbrook, Ida.

15. Filed June 18 1913 W.C. Ray
Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH June 14 1913
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from 191... to 191...
that I last saw h..... alive on 191...
and that death occurred on the date stated above, at 6:00 M.

The CAUSE OF DEATH* was as follows:

acute myocardial
no doctor in attendance
except after telephone
(Duration) yrs. mos. ds.

Contributory (Secondary)

(Signed) W.C. Ray M. D.
6/15 1913 (Address) Malad Ida.

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death yrs. mos. days. In the State yrs. mos. days.

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL Bountiful Utah DATE OF BURIAL June 17 1913
20. UNDERTAKER W.S. Johnson ADDRESS Malad Ida.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Form V, S. No. 5. 12½ M. 7-24-11

CERTIFICATE OF DEATH

1. PLACE OF DEATH. Registration District No. 26
County of Oneida Primary Registration District No. 2069
City of Malad (No. _____, _____ St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

Robert J. Rose

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics
File No. 5273
Registered No. 64

If death occurred in a hospital, institution or camp give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX Male 4. COLOR OR RACE White 5. SINGLE, MARRIED, WIDOWED OR DIVORCED. Single
(Write the word.)

6. DATE OF BIRTH Nov. 8 1904
(Month) (Day) (Year)

7. AGE 3 yrs. 8 mos. 8 ds. IF LESS than 1 day how many _____ hrs. or _____ min?

8. OCCUPATION

- (a) Trade, profession or particular kind of work
(b) General nature of industry business or establishment in which employed (or employer)

Child.

9. BIRTHPLACE

(State or Country)

Oneida Co. Ida.

10. NAME OF FATHER

G. L. Rose

11. BIRTHPLACE OF FATHER

(State or Country)

England

12. MAIDEN NAME OF MOTHER

Mary A. Brooks

13. BIRTHPLACE OF MOTHER

(State or Country)

England

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

(Address)

A. L. Rose
Malad Ida.

15.

Filed

June 17 1913

D. C. Ray

Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH

June 16 1913
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from June 15 1913, to June 16 1913 that I last saw him alive on June 16 1913 and that death occurred on the date stated above, at 2:00 P. M.

The CAUSE OF DEATH* was as follows:

Loss of the circulation

(Duration) _____ yrs. _____ mos. 3 ds.

Contributory
(Secondary)

(Duration) _____ yrs. _____ mos. _____ ds.

(Signed)

J. M. Thomas M. D.
6/17 1913 (Address) Malad Ida.

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place _____ In the _____
of death _____ yrs. _____ mos. _____ ds. State _____ yrs. _____ mos. _____ ds.
Where was disease contracted,
If not at place of death?
Former or
usual residence _____

19. PLACE OF BURIAL OR REMOVAL DATE OF BURIAL

Saint John Ida June 18 1913

20. UNDERTAKER

ADDRESS

W. S. Johnson Malad Ida.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Form V. S. No. 5. 20M.1-16-12

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics
File No. **5273**
Registered No. **68**

1. PLACE OF DEATH.

Registration District No. **26**County of **Oneida**Primary Registration District No. **2069**City of **Malak**

(No.)

St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

Wallace K. Burnham

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX

male

4. COLOR OR RACE

white

5. SINGLE, MARRIED, WIDOWED OR DIVORCED.

married
(Write the word.)

6. DATE OF BIRTH

Jan**24****1838**

(Month)

(Day)

(Year)

7. AGE

73 yrs. **4** mos. **23** ds.IF LESS than 1 day
how many hrs. or
..... mins.?

8. OCCUPATION

(a) Trade, profession or particular kind of work

(b) General nature of industry business, or establishment in which employed (or employer)

farmer

9. BIRTHPLACE

(State or Country)

Illinois

10. NAME OF FATHER

James L Burnham

11. BIRTHPLACE OF FATHER

(State or Country)

Vermont

12. MAIDEN NAME OF MOTHER

Mary Ann Humbley

13. BIRTHPLACE OF MOTHER

(State or Country)

Vermont

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

James L Burnham

(Address)

Richmond Utah

15.

Filed

June 18191 **3****D C Ray**

Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH

June**17****1913**

(Month)

(Day)

(Year)

17. I HEREBY CERTIFY, That I attended deceased from

191... to **June 17** 191**3**,
that I last saw him **alive on** **June 17** 191**3**,
died **10 minutes after** **3:15 P.M.**and that death occurred on the date stated above, at **3:15 P.M.**

The CAUSE OF DEATH* was as follows:

apoplexy

(Duration) yrs. mos. ds.

Contributory
(Secondary)

(Duration) yrs. mos. ds.

(Signed)

D C Ray

M. D.

6-18 1913 (Address) **Malak City Idaho**

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death yrs. mos. days. In the State yrs. mos. days.

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

Richmond Utah**June 22 1913**

20. UNDERTAKER

ADDRESS

August S. Schow**Richmond Utah**

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH.

Registration District No. 26County of OneidaPrimary Registration District No. 2069City of Malad

(No. _____ St.)

File No. 5217Registered No. 66

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

Gottlieb Nieffmeger

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX

Male

4. COLOR OR RACE

White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED.

Widowed

6. DATE OF BIRTH.

Sept 14 1832
(Month) (Day) (Year)

7. AGE

80 Yrs. 9 Mos. 10 ds.IF LESS than 1 day
how many hrs. or
..... min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work...
(b) General nature of industry, business, or establishment in which employed (or employer).....Farmer

9. BIRTHPLACE

(State or Country)

Switzerland

10. NAME OF FATHER

Don't know

11. BIRTHPLACE OF FATHER

(State or Country)

Switzerland

12. MAIDEN NAME OF MOTHER

Don't know

13. BIRTHPLACE OF MOTHER

(State or Country)

Switzerland

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant)

Henry Nieffmeger

(Address)

Malad

15.

Filed

6-261913J. C. Ray

Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

June 24 1913
(Month) (Day) (Year)17. I HEREBY CERTIFY, That I attended deceased from May 4 1913 to June 24 1913, that I last saw him alive on June 20 1913, and that death occurred on the date stated above, at 5 A M.

The CAUSE OF DEATH* was as follows:

Carcinoma of Stomach

(Duration) _____ Yrs. _____ mos. _____ ds.

Contributory (Secondary)

(Duration) _____ Yrs. _____ mos. _____ ds.

(Signed)

6/26/13 (Address) J. F. H. M. D.

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death.....yrs.....mos.....days. In the State.....yrs.....mos.....days

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

Saint John IdaJune 27 1913

20. UNDERTAKER

W. S. Johnson

ADDRESS

Malad Ida

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Form V. S. No. 5 20M.1-16-12

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH

Registration District No.

County of *Twins Falls*Primary Registration District No. *20 55*City of *" "*(No. *" "* St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

Albert Vurro Larsen

Registered No.

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX

4. COLOR OR RACE

5. SINGLE, MARRIED, WIDOWED OR DIVORCED.

Male *White* *Single*
(Write the word.)

6. DATE OF BIRTH

Sept. 28 1900
(Month) (Day) (Year)

7. AGE

13 yrs. *8* mos. *19* ds.IF LESS than 1 day
how many hrs. or
mins.

8. OCCUPATION

(a) Trade, profession or particular kind of work
(b) General nature of industry, business, or establishment in which employed (or employer)*School boy*

9. BIRTHPLACE

(State or Country)

Utah

10. NAME OF FATHER

Albert E. Larsen

11. BIRTHPLACE OF FATHER

(State or Country)

Utah

12. MAIDEN NAME OF MOTHER

Elizabeth M. Behrman

13. BIRTHPLACE OF MOTHER

(State or Country)

Utah

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

Albert Larsen

(Address)

Holister Ida.

15.

Filed

*6-17*191 *3**John G. Gault*
Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH

June 16 1913
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from

June 13 1913, to June 16 1913,
that I last saw him alive on *June 16 1913,*and that death occurred on the date stated above, at *1 A.M.*

The CAUSE OF DEATH* was as follows:

Appendicitis

(Duration) yrs. mos. ds.

Contributory
(Secondary)

(Duration) yrs. mos. ds.

(Signed)

W. B. Boyd

M. D.

June 17 1913 (Address) *Twins Falls, Idaho*

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death yrs. mos. days. In the State yrs. mos. days.

Where was disease contracted if not at place of death?

Former or usual residence.

19. PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

*Twins Falls**June 18 1913*

20. UNDERTAKER

ADDRESS

J. J. Groesman *Twins Falls*

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Form V. S. No. 5 20M.1-16-12

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH. Registration District No. 3
County of Twin Falls Primary Registration District No. 2085
City of " (No. " St.)

File No. 527

Registered No. _____

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Jose. H. McCabe

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX Male 4. COLOR OR RACE White 5. SINGLE, MARRIED, WIDOWED OR DIVORCED Single

6. DATE OF BIRTH

June 3 1913
(Month) (Day) (Year)

7. AGE

_____ yrs. _____ mos. 11 ds.

IF LESS than 1 day
how many _____ hrs. or
_____ mins.?

8. OCCUPATION

(a) Trade, profession or particular kind of work

(b) General nature of industry business, or establishment in which employed (or employer)

9. BIRTHPLACE

(State or Country) Idaho.

10. NAME OF FATHER Roy McCabe

11. BIRTHPLACE OF FATHER

(State or Country) Washington

12. MAIDEN NAME OF MOTHER Anna Elger.

13. BIRTHPLACE OF MOTHER

(State or Country)

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Walter McCabe

(Address) Twin Falls

15.

Filed 6-15191 3

John J. Coughlin
Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH

June 14 1913
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from

June 12 1913, to June 14 1913,
that I last saw h. alive on June 14 1913,
and that death occurred on the date stated above, at 7 P.M.

The CAUSE OF DEATH* was as follows:

Pneumonia
Brandt (See letter attached)
to 5158.

_____ (Duration) _____ yrs. _____ mos. _____ ds.

Contributory
(Secondary)

_____ (Duration) _____ yrs. _____ mos. _____ ds.

(Signed) J. P. Morgan M. D.

June 17 1913 (Address) Twin Falls

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death _____ yrs. _____ mos. _____ days. In the State _____ yrs. _____ mos. _____ days.

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL DATE OF BURIAL

Twin Falls June 15 1913

20. UNDERTAKER ADDRESS

J. P. Morgan Twin Falls

MARGIN RESERVED FOR BINDING
WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Form V. S. No. 5 20M.1-16-12

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH. Registration District No. 23
County of Twin Falls Primary Registration District No. 2085
City of Twin Falls (No. _____, _____ St.)

File No. 524
Registered No. _____

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Wm. Refior

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX 4. COLOR OR RACE 5. SINGLE, MARRIED, WIDOWED OR DIVORCED.

Male White Married (the word.)

6. DATE OF BIRTH

Nov. 29, 1873
(Month) (Day) (Year)

7. AGE

39 yrs. 6 mos. 17 ds.

IF LESS than 1 day
how many _____ hrs. or
_____ mins.?

8. OCCUPATION

(a) Trade, profession or particular kind of work Farmer
(b) General nature of industry, business, or establishment in which employed (or employee).

9. BIRTHPLACE

(State or Country) Lee Co. Iowa.

10. NAME OF FATHER

Deceased, no records & unknown.

11. BIRTHPLACE OF FATHER

(State or Country) Germany

12. MAIDEN NAME OF MOTHER

Deceased, no records & unknown.

13. BIRTHPLACE OF MOTHER

(State or Country) Germany.

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) May G. Refior
(Address) Twin Falls

15.

Filed 6-16 1913 John H. Engelen
Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH

June 15 1913
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from

May 27 1913, to June 15 1913,
that I last saw him alive on June 15 1913,
and that death occurred on the date stated above, at 5:20 M.

The CAUSE OF DEATH* was as follows:

Acute attack on Chronic
Nephritis Interstitial
Acute attack 3 to 4 weeks
(Duration) _____ yrs. _____ mos. _____ ds.

Contributory Chronic Fibroid Pleurisy
(Secondary)

(Duration) 51 yrs. _____ mos. _____ ds.
(Signed) Blueson & Abraham M. D.

June 19, 1913 (Address) Twin Falls, Id.

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death _____ yrs. _____ mos. _____ days. In the State _____ yrs. _____ mos. _____ days.

Where was disease contracted if not at place of death? _____

Former or usual residence Burial Twin Falls Signature

19. PLACE OF BURIAL OR REMOVAL DATE OF BURIAL

Burial Twin Falls June 17 1913

20. UNDERTAKER

O. Crosby ADDRESS Twin Falls

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
 N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Form V. S. No. 5 20M.1-16-12

CERTIFICATE OF DEATH

 State of Idaho
 BOARD OF HEALTH
 Bureau of Vital Statistics

1. PLACE OF DEATH

Registration District No. 23County of Twin FallsPrimary Registration District No. 2085City of(No. St.)File No. 5281Registered No.

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

Baby Muir

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX

4. COLOR OR RACE

5. SINGLE, MARRIED, WIDOWED OR DIVORCED.

6. DATE OF BIRTH

7. AGE

 IF LESS than 1 day
 how many hrs. or
 mins.?

8. OCCUPATION

(a) Trade, profession or particular kind of work

(b) General nature of industry business, or establishment in which employed (or employer)

9. BIRTHPLACE

(State or Country)

10. NAME OF FATHER

11. BIRTHPLACE OF FATHER

(State or Country)

12. MAIDEN NAME OF MOTHER

13. BIRTHPLACE OF MOTHER

(State or Country)

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

(Address)

15.

Filed

191

Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH

17. I HEREBY CERTIFY, That I attended deceased from

June 9 1913, to June 10 1913,

that I last saw her alive on June 9 1913,

and that death occurred on the date stated above, at 3 A.M.

The CAUSE OF DEATH* was as follows:

Premature birth* mening

(Duration) yrs. mos. ds.

Contributory

(Secondary)

(Duration) yrs. mos. ds.

(Signed)

J. R. Morgan

M. D.

June 10 1913 (Address) Twin Falls, Idaho

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death yrs. mos. days. In the State yrs. mos. days.

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

Twin FallsJune 10 1913

20. UNDERTAKER

ADDRESS

J. H. Groesman Twin Falls

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Form V. S. No. 5 20M.1-16-12

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics
File No. 5281

1. PLACE OF DEATH. Registration District No. 23
County of Twin Falls Primary Registration District No. 2085
City of (No. St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Emma May Cryder

Registered No. If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX Female 4. COLOR OR RACE white 5. SINGLE, MARRIED, WIDOWED OR DIVORCED. Married (Write the word.)

6. DATE OF BIRTH Oct. 1st 1895 (Month) (Day) (Year)

7. AGE 27 yrs. 8 mos. 18 ds. IF LESS than 1 day how many hrs. or mins.?

8. OCCUPATION (a) Trade, profession or particular kind of work House wife (b) General nature of industry business, or establishment in which employed (or employer)

9. BIRTHPLACE Wisconsin (State or Country)

10. NAME OF FATHER John Stiles

11. BIRTHPLACE OF FATHER New York (State or Country)

12. MAIDEN NAME OF MOTHER Cora Meigs

13. BIRTHPLACE OF MOTHER Wis. (State or Country)

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) C. P. Meigs

(Address) Twin Falls, Ida

15. Filed 6-20 1913 John H. Ogden Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH June 19 1913 (Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from June 7 1913, to June 19 1913 that I last saw her alive on June 17 1913 and that death occurred on the date stated above, at 5:30 am M.

The CAUSE OF DEATH* was as follows:

Acute Endocarditis

(Duration) yrs. mos. 12 ds.

Contributory Inflammatory Rheumatism (Secondary)

(Duration) yrs. mos. 16 ds.

(Signed) H. Wilson M. D.

June 19 1913 (Address) Twin Falls, Ida

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death. yrs. mos. days. In the State. yrs. mos. days.

Where was disease contracted if not at place of death?

Former or usual residence.

19. PLACE OF BURIAL OR REMOVAL DATE OF BURIAL

Twin Falls June 22 1913

20. UNDERTAKER ADDRESS

J. F. Grosvenor Twin Falls

MARGIN RESERVED FOR BUREAU OF VITAL RECORDS. WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Form V. S. No. 5 20M.1-16-12

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH.

Registration District No. 23

County of Bonanza

Primary Registration District No. 2085

City of

(No. 11 St.)

Registered No.

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

Mrs. Harriett M. Kinsley

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX

4. COLOR OR RACE

5. SINGLE, MARRIED, WIDOWED OR DIVORCED.

Female

White

Widow

6. DATE OF BIRTH

Sept 9th

1856

(Month)

(Day)

(Year)

7. AGE

56 yrs 9 mos 18 ds.

IF LESS than 1 day how many hrs. or mins.?

8. OCCUPATION

(a) Trade, profession or particular kind of work

Housewife

(b) General nature of industry, business, or establishment in which employed (or employer)

9. BIRTHPLACE

(State or Country)

Puttenberg Iowa

10. NAME OF FATHER

Adolf Schrum

11. BIRTHPLACE OF FATHER

(State or Country)

Germany

12. MAIDEN NAME OF MOTHER

Unknown

13. BIRTHPLACE OF MOTHER

(State or Country)

Germany

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

E. L. Friedlein

(Address)

Levittown, Mont.

15.

Filed

June 28 1913

John H. Hughes

Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH

June 26 1913
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from

June 25 1913, to June 26 1913, that I last saw him alive on June 25 1913,

and that death occurred on the date stated above, at 5:30 P.M.

The CAUSE OF DEATH* was as follows:

Epilepsy

(Duration) yrs. mos. 28 hrs.

Contributory (Secondary)

(Duration) yrs. mos. ds.

(Signed)

D. O. Boyd

M. D.

June 25 1913 (Address) 2014 So. 2nd St.

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death yrs. mos. days. In the State yrs. mos. days.

Where was disease contracted if not at place of death?

Former or usual residence.

19. PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

Puttenberg Ia.

1913

20. UNDERTAKER

ADDRESS

Stroby

2014 So. 2nd St.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Form V. S. No. 5 20M.1-16-12

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics
File No. 5283

1. PLACE OF DEATH Registration District No. 23
County of Twin Falls Primary Registration District No. 2085
City of (No. St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

Henry Roy Smith

Registered No.
If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX Male 4. COLOR OR RACE White 5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.)

6. DATE OF BIRTH June 6 - 1913
(Month) (Day) (Year)

7. AGE yrs. 16 mos. ds. IF LESS than 1 day how many hrs. or mins.?

8. OCCUPATION

(a) Trade, profession or particular kind of work
(b) General nature of industry, business, or establishment in which employed (or employer)

9. BIRTHPLACE Twin Falls County
(State or Country)

10. NAME OF FATHER Newton Smith

11. BIRTHPLACE OF FATHER Virginia
(State or Country)

12. MAIDEN NAME OF MOTHER Kate Rose

13. BIRTHPLACE OF MOTHER Virginia
(State or Country)

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Newton Smith
(Address) Twin Falls R.F.D. 1

15. Filed June 23 1913 Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH June 22 1913
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from June 6 1913, to June 22 1913, that I last saw him alive on June 22 1913, and that death occurred on the date stated above, at 11 P.M.
The CAUSE OF DEATH* was as follows:

Bronchopneumonia

(Duration) yrs. 8 mos. ds.
Contributory (Secondary) Whooping Cough

(Duration) yrs. 12 mos. ds.
(Signed) H. M. Alexander M.D.
6/20/13 (Address) Twin Falls, Idaho

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death yrs. mos. days. In the State yrs. mos. days.

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL DATE OF BURIAL
Twin Falls 6-23 1913

20. UNDERTAKER ADDRESS
C. J. Crosby Twin Falls

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Form V. S. No. 5 20M.1-16-12

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics
File No. **5281**

1. PLACE OF DEATH.

Registration District No. **23**County of **Twin Falls**Primary Registration District No. **2086**

City of _____

(No. _____)

St.) _____

Registered No. _____

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

Lula Grace Davis

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX

F

4. COLOR OR RACE

W

5. SINGLE, MARRIED, WIDOWED OR DIVORCED.

married
(Write the word.)

6. DATE OF BIRTH

May 7**1877**

(Month)

(Day)

(Year)

7. AGE

36

yrs.

mos.

28

ds.

IF LESS than 1 day
how many hrs. or
..... mins.?

8. OCCUPATION

(a) Trade, profession or particular kind of work

(b) General nature of industry business, or establishment in which employed (or employer)

9. BIRTHPLACE

(State or Country)

Mo. Vernon Co

10. NAME OF FATHER

J T Barber

11. BIRTHPLACE OF FATHER

(State or Country)

Mo

12. MAIDEN NAME OF MOTHER

Less Morgan

13. BIRTHPLACE OF MOTHER

(State or Country)

Indiana

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

R L Davis

(Address)

Tiler Ida

15.

Filed

June 5 1913**John C. Bagley**
Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH

June 4

(Month)

(Day)

1913

(Year)

17. I HEREBY CERTIFY, That I attended deceased from

191., to

191.,

that I last saw h. alive on

191.

and that death occurred on the date stated above, at **2:50 P.M.**

The CAUSE OF DEATH* was as follows:

Shock from Lightning Stroke(Duration) **Sudden Death** yrs. mos. ds.Contributory
(Secondary)

(Duration) yrs. mos. ds.

(Signed)

A A Newberry M. D.**6-4-1913**(Address) **Filer, Ida**

*State the DISEASE CAUSING DEATH; or in death from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents)

At place of death yrs. mos. days. In the State yrs. mos. days.

Where was disease contracted if not at place of death?

Former or usual residence.

19. PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

Filer, Ida**June 6 1913**

20. UNDERTAKER

ADDRESS

A. Crosby**Filer, Ida**

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Form V. S. No. 5 20M.1-16-12

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH.

Registration District No. 22County of CanyonPrimary Registration District No. 2008File No. 5285City of Payette

(No. _____)

St.) _____

Registered No. 93-

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Margaret Thomas

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX Female4. COLOR OR RACE White5. SINGLE, MARRIED, WIDOWED OR DIVORCED. Single
(Write the word.)6. DATE OF BIRTH Sept 11 1912
(Month) (Day) (Year)7. AGE 9 yrs. 9 mos. — ds.IF LESS than 1 day
how many hrs. or
..... mins.?

8. OCCUPATION

(a) Trade, profession or particular kind of work Infant

(b) General nature of industry business, or establishment in which employed (or employer) _____

9. BIRTHPLACE Idaho

(State or Country)

10. NAME OF FATHER George Thomas11. BIRTHPLACE OF FATHER Wis

(State or Country)

12. MAIDEN NAME OF MOTHER Nellie Jerome13. BIRTHPLACE OF MOTHER Mich

(State or Country)

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Geo. Thomas(Address) Payette Ida

15.

Filed June 11 1913

1913

J. R. W. Thomas
Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH June 10 1913
(Month) (Day) (Year)17. I HEREBY CERTIFY, That I attended deceased from May 22 1913, to June 10 1913,that I last saw her alive on June 10 1913,and that death occurred on the date stated above, at 6 P. M.

The CAUSE OF DEATH* was as follows:

Bronch pneumonia(Duration) yrs. mos. 4 ds.Contributory Enteritis
(Secondary)(Duration) yrs. mos. 19 ds.(Signed) O. H. Avery M. D.6/11/1913 (Address) Payette Ida

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death yrs. mos. days. In the State yrs. mos. days.

Where was disease contracted if not at place of death? _____

Former or usual residence _____

19. PLACE OF BURIAL OR REMOVAL Ontario Ore DATE OF BURIAL June 12 191320. UNDERTAKER J. W. UdanADDRESS Payette Ida

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Form V. S. No. 5 20M.1-16-12

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH.

Registration District No. 22

County of Canyon

Primary Registration District No. 2005

City of Payette

(No. 1)

(St.)

File No. 5286

Registered No. 74

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

Infant Fergusson

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX

4. COLOR OR RACE

5. SINGLE, MARRIED, WIDOWED OR DIVORCED.

Male

White

Single (Write the word.)

6. DATE OF BIRTH

June 6

1913

(Month)

(Day)

(Year)

7. AGE

2 yrs. 2 mos. 2 ds.

IF LESS than 1 day how many hrs. or mins.?

8. OCCUPATION

(a) Trade, profession or particular kind of work

(b) General nature of industry business, or establishment in which employed (or employer)

Infant

9. BIRTHPLACE

(State or Country)

Payette

10. NAME OF FATHER

Father not known

11. BIRTHPLACE OF FATHER

(State or Country)

12. MAIDEN NAME OF MOTHER

Ida Fergusson

13. BIRTHPLACE OF MOTHER

(State or Country)

not known

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

C. H. Carlisle Payette

(Address)

15.

Filed

June 9 1913

Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH

June 8

1919

(Month)

(Day)

(Year)

17. I HEREBY CERTIFY, That I attended deceased from

June 1 1913, to Ida Fergusson 1913, that I last saw her alive on 11 am June 8 1919

and that death occurred on the date stated above, at 12 M.

The CAUSE OF DEATH* was as follows:

premature birth

(Duration) yrs. mos. ds.

Contributory (Secondary)

(Duration) yrs. mos. ds.

(Signed)

C. H. Carlisle

M. D.

19

(Address) Payette Idaho

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death. yrs. mos. days. In the State. yrs. mos. days.

Where was disease contracted if not at place of death?

Former or usual residence.

19. PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

Payette Idaho June 9 1913

20. UNDERTAKER

ADDRESS

J. A. Hildair Payette Idaho

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Form V. S. No. 5 20M.1-16-12

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics
File No. 528
Registered No. 23

1. PLACE OF DEATH. Registration District No. 27
County of Jeremi Primary Registration District No. 2116
City of Salmou (No. _____, St.)
If death occurs away from usual residence, give facts called for under special information. 2. FULL NAME Frank Hays

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX Male 4. COLOR OR RACE White 5. SINGLE, MARRIED, WIDOWED OR DIVORCED. Single
(Write the word.)

6. DATE OF BIRTH _____
(Month) (Day) (Year)

7. AGE about 50 yrs. mos. ds. IF LESS than 1 day how many hrs. or mins.

8. OCCUPATION
(a) Trade, profession or particular kind of work Day laborer
(b) General nature of industry, business, or establishment in which employed (or employer)

9. BIRTHPLACE
(State or Country) Do not know

10. NAME OF FATHER Do not know

11. BIRTHPLACE OF FATHER
(State or Country) Do not know

12. MAIDEN NAME OF MOTHER Do not know

13. BIRTHPLACE OF MOTHER
(State or Country) Do not know

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) W. C. Daehler, coroner
(Address) Salmou

15. Filed June 6 1913 Kelvin L. Smith
Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH about May 23rd 1913
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from _____ 1913, to _____ 1913,
that I last saw him alive on _____ 1913,
and that death occurred on the date stated above, at _____ M.
The CAUSE OF DEATH* was as follows:

Natural causes
probably Valvular heart
Disease
(Duration) _____ yrs. mos. ds.

Contributory (Secondary) _____
(Duration) _____ yrs. mos. ds.
(Signed) W. C. Daehler, Coroner
6-24 1913 (Address) Salmou Ida.

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death _____ yrs. mos. days. In the State _____ yrs. mos. days.

Where was disease contracted if not at place of death? _____

Former or usual residence _____

19. PLACE OF BURIAL OR REMOVAL Salmou Idaho DATE OF BURIAL June 5th 1913
20. UNDERTAKER W. C. Daehler ADDRESS Salmou Ida

Form V. S. No. 5 20M.1-16-12

CERTIFICATE OF DEATH

 State of Idaho
 BOARD OF HEALTH
 Bureau of Vital Statistics

1. PLACE OF DEATH.

Registration District No. 29

County of Lemhi

Primary Registration District No. 2116

City of Salmon

(No. St.)

File No. 528

Registered No. 28

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME John R. Pond Infant

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX

Male

4. COLOR OR RACE

White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED.

 Single
 (Write the word.)

6. DATE OF BIRTH

 June 24" 1913.
 (Month) (Day) (Year)

7. AGE

yrs. mos. ds.

 IF LESS than 1 day
 how many hrs. or
 mins.?

8. OCCUPATION

(a) Trade, profession or particular kind of work

(b) General nature of industry business, or establishment in which employed (or employer)

9. BIRTHPLACE

(State or Country)

Idaho

10. NAME OF FATHER

Frank J. Pond.

11. BIRTHPLACE OF FATHER

(State or Country)

Colo

12. MAIDEN NAME OF MOTHER

Letha Clark

13. BIRTHPLACE OF MOTHER

(State or Country)

Colo

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

Frank J. Pond.

(Address)

Salmon Ida.

15.

Filed

June 24 1913 Helen L. Smith

Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH

 June 24" 1913.
 (Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from June 24 1913, to June 24 1913, that I last saw him alive on June 24 1913

and that death occurred on the date stated above, at 6 A.M.

The CAUSE OF DEATH* was as follows:

Still born 7 month child

(Duration) yrs. mos. ds.

Contributory (Secondary)

(Duration) yrs. mos. ds.

(Signed)

J. W. Smith M. D.

19 (Address) Salmon Ida

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death yrs. mos. days. In the State yrs. mos. days.

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

Salmon Cemetery June 25" 1913

20. UNDERTAKER

ADDRESS

J. C. Doeble Salmon Ida

Form V. S. No. 5 20M.1-16-12

CERTIFICATE OF DEATH

 State of Idaho
 BOARD OF HEALTH
 Bureau of Vital Statistics

1. PLACE OF DEATH.

Registration District No. 27County of LewinPrimary Registration District No. 2116City of Shoup

(No. _____ St.)

File No. 529Registered No. 27

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

Henry Myers

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX

Male

4. COLOR OR RACE

White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED.

Single
(Write the word.)

6. DATE OF BIRTH

The exact date is not known
(Month) (Day) (Year)

7. AGE

73

yrs. mos. ds.

 IF LESS than 1 day
 how many hrs. or mins.?

8. OCCUPATION

(a) Trade, profession or particular kind of work

Miner Quartz

(b) General nature of industry business, or establishment in which employed (or employer)

9. BIRTHPLACE

(State or Country)

Pennsylvania

10. NAME OF FATHER

Do not know

11. BIRTHPLACE OF FATHER

(State or Country)

Do not know

12. MAIDEN NAME OF MOTHER

Do not know

13. BIRTHPLACE OF MOTHER

(State or Country)

Do not know

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

E. L. Heydorn

(Address)

Shoup, Ida

15.

Filed 6-191913Helen L. Smith
Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH

June 7

(Month)

(Day)

1913
(Year)

17. I HEREBY CERTIFY, That I attended deceased from

1913, to1913,that I last saw him alive on 1913,and that death occurred on the date stated above, at M.

The CAUSE OF DEATH* was as follows:

Natural causes probably heart failure

(Duration) yrs. mos. ds.

Contributory
(Secondary)

(Duration) yrs. mos. ds.

(Signed)

W. C. Dethlefsen M.D.June 7 1913. (Address) Salmon, Idaho

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death. yrs. mos. days. In the State. yrs. mos. days.

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

Shoup IdahoJune 7 1913

20. UNDERTAKER

June 9

ADDRESS

Wm. J. Smith

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Form V. S. No. 5 20M.1-16-12

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH.

Registration District No. 27County of LemhiPrimary Registration District No. 2153City of Juniper

(No. _____, St.)

File No. 5291Registered No. 28

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

Charles Lee

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX

male

4. COLOR OR RACE

White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED.

married
(Write the word.)

6. DATE OF BIRTH

Dec

(Month)

8

(Day)

1859

(Year)

7. AGE

54

yrs.

5

mos.

25

ds.

IF LESS than 1 day
how many _____ hrs. or
_____ mins.?

8. OCCUPATION

(a) Trade, profession or particular kind of work

General labor

(b) General nature of industry business, or establishment in which employed (or employer)

9. BIRTHPLACE

(State or Country)

Ill

10. NAME OF FATHER

Charles Lee

11. BIRTHPLACE OF FATHER

(State or Country)

Kentucky

12. MAIDEN NAME OF MOTHER

Blair da Smith

13. BIRTHPLACE OF MOTHER

(State or Country)

not known

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

Mrs. Alice Lee

(Address)

Idaho Junction

15.

Filed 6-281913R. Klenz Smith

Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH

June 3

(Month)

(Day)

1913
(Year)

17. I HEREBY CERTIFY, That I attended deceased from

191

to

191

that I last saw him _____ alive on _____ 191

and that death occurred on the date stated above, at _____ M.

The CAUSE OF DEATH* was as follows:

Due to Lightning

(Duration) _____ yrs. _____ mos. _____ ds.

Contributory
(Secondary)

(Duration) _____ yrs. _____ mos. _____ ds.

(Signed)

Wm. O. Daubert

19

(Address) Salmon, Ida.

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death _____ yrs. _____ mos. _____ days. In the State _____ yrs. _____ mos. _____ days.

Where was disease contracted if not at place of death?

Former or usual residence.

19. PLACE OF BURIAL OR REMOVAL DATE OF BURIAL

Juniper Ida. June 4- 1913

20. UNDERTAKER

ADDRESS

per George Martin, Leadon, Ida.Wm. O. Daubert

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Form V. S. No. 5 20M.1-16-12

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH.

Registration District No.

County of Lemhi

Primary Registration District No.

City of Salmon Springs

(No. St.)

File No. 5292Registered No. 30

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

John William

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX

Male

4. COLOR OR RACE

White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED
Widowed
(Write the word.)

6. DATE OF BIRTH

Jan 2nd 1850
(Month) (Day) (Year)

7. AGE

63 yrs. 5 mos. 26 ds.

IF LESS than 1 day
how many hrs. or
..... mins.?

8. OCCUPATION

(a) Trade, profession or particular kind of work

(b) General nature of industry, business, or establishment in which employed (or employer)

Day Laborer

9. BIRTHPLACE

(State or Country)

Carmarvon Wales

10. NAME OF FATHER

Do not know

11. BIRTHPLACE OF FATHER

(State or Country)

Wales

12. MAIDEN NAME OF MOTHER

Do not know

13. BIRTHPLACE OF MOTHER

(State or Country)

Wales

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

Mrs Mary Durand

(Address)

Salmon Idaho

15.

Filed 6-281913Helen Smith

Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH

June 27th 1913
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from Feb. 3rd 1913, to June 27th 1913,

that I last saw him alive on June 27th 1913, and that death occurred on the date stated above, at 12³⁰ AM.

The CAUSE OF DEATH* was as follows:

atrophic cirrhosis of liver

(Duration) yrs. mos. ds.

Contributory
(Secondary)

alcoholism

(Duration) yrs. mos. ds.

(Signed)

6/27/1913

(Address)

Salmon, Idaho

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death yrs. mos. days. In the State yrs. mos. days.

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

Salmon CemeteryJune 27th 1913

20. UNDERTAKER

ADDRESS

Wm C TaeblerSalmonIdaho

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Form V. S. No. 5 20M.1-16-12

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics
File No. **5293**
Registered No. **31**

1. PLACE OF DEATH.

Registration District No. **27**

County of **Lemhi**

Primary Registration District No. **2116**

City of **Salmon**

(No. _____ St.)

Registered No. **31**

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME **Marvin A. Eldridge**

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX

4. COLOR OR RACE

5. SINGLE, MARRIED, WIDOWED OR DIVORCED.

Male

White

Single
(Write the word.)

6. DATE OF BIRTH

May 3rd

1913

(Month)

(Day)

(Year)

7. AGE

2 yrs. **2** mos. **2** ds.

IF LESS than 1 day
how many _____ hrs. or
_____ mins.?

8. OCCUPATION

(a) Trade, profession or particular kind of work **none**
(b) General nature of industry, business, or establishment in which employed (or employer)

9. BIRTHPLACE

(State or Country)

Salmon, Ida

10. NAME OF FATHER

James Eldridge

11. BIRTHPLACE OF FATHER

(State or Country)

Libberville, Ida

12. MAIDEN NAME OF MOTHER

May Jones

13. BIRTHPLACE OF MOTHER

(State or Country)

Idaho, Montana

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

James Eldridge

(Address)

Salmon, Idaho

15.

Filed

July 5 **1913**

John L. Smith

Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH

July 5th

1913

(Month)

(Day)

(Year)

17. I HEREBY CERTIFY, That I attended deceased from

191...

to

191...

that I last saw him alive on **191**...

and that death occurred on the date stated above, at **M.**

The CAUSE OF DEATH* was as follows:

Suffocated by accidently being turned on the face

(Duration) _____ yrs. _____ mos. _____ ds.

Contributory

(Secondary)

(Duration) _____ yrs. _____ mos. _____ ds.

(Signed)

J. M. O. Hebb

7-5-1913 (Address **Salmon, Ida, Corcoran**)

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death _____ yrs. _____ mos. _____ days. In the State _____ yrs. _____ mos. _____ days.

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

Salmon Cemetery

July 6th 1913

20. UNDERTAKER

ADDRESS

J. M. O. Hebb
Salmon, Ida

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Form V. S. No. 5 20M.1-16-12

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH. Registration District No. 11
County of Bannock Primary Registration District No. 2046
City of Oxford (No. _____, St.) Registered No. 36

If death occurs away from usual residence, give facts called for under special information. 2. FULL NAME Not Named

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX Male 4. COLOR OR RACE White 5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.)
6. DATE OF BIRTH Feb 11 1913
(Month) (Day) (Year)
7. AGE 5 yrs. 19 mos. 19 ds. IF LESS than 1 day how many hrs. or mins?
8. OCCUPATION
(a) Trade, profession or particular kind of work
(b) General nature of industry business, or establishment in which employed (or employer)
9. BIRTHPLACE (State or Country) Bannock Idaho
10. NAME OF FATHER Amos Howell Lewis
11. BIRTHPLACE OF FATHER (State or Country) Oxford Idaho
12. MAIDEN NAME OF MOTHER Ruth H Parrott
13. BIRTHPLACE OF MOTHER (State or Country) Clifton Idaho
14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Walter Hatch
(Address) Oxford Idaho
15. Eugene
Filed June 30 1913 Walter Hatch
Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH June 30 1913
(Month) (Day) (Year)
17. I HEREBY CERTIFY, That I attended deceased from 191 , to 191 , that I last saw h. alive on 191 , and that death occurred on the date stated above, at 6 AM.
The CAUSE OF DEATH* was as follows:
Spinal meningitis
Had no attending Physician
(Duration) yrs. mos. ds.
Contributory (Secondary)
(Duration) yrs. mos. ds.
(Signed) _____ M. D.
19. (Address) _____
*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.
18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death yrs. mos. days. In the State yrs. mos. days.
Where was disease contracted if not at place of death?
Former or usual residence.
19. PLACE OF BURIAL OR REMOVAL Oxford Idaho DATE OF BURIAL July 1 1913
20. UNDERTAKER Walter Hatch ADDRESS Oxford Idaho

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Form V. S. No. 5 20M.1-16-12

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH

Registration District No. 11

County of Bannock

Primary Registration District No. 20487

City of McCall

(No. _____, _____ St.)

File No. 5205

Registered No. 38

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Mr Reiser

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX

Male

4. COLOR OR RACE

White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED.

(Write the word.)

6. DATE OF BIRTH

May 30 1913
(Month) (Day) (Year)

7. AGE

38 yrs. 7 mos. 20 ds.

IF LESS than 1 day
how many _____ hrs. or
_____ mins.?

8. OCCUPATION

(a) Trade, profession or particular kind of work

Blacksmith and Farmer

(b) General nature of industry business, or establishment in which employed (or employer)

9. BIRTHPLACE

(State or Country)

Germany

10. NAME OF FATHER

William Reiser

11. BIRTHPLACE OF FATHER

(State or Country)

Germany

12. MAIDEN NAME OF MOTHER

Johanna Thal

13. BIRTHPLACE OF MOTHER

(State or Country)

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

A. C. Blanchard

(Address)

Downey

15.

Filed July 10, 1913 Ellis Kasey
Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

5 — 31 — 1913
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from

5/30 — 1913, to 5/31 — 1913,

that I last saw him alive on 5/31 — 1913,

and that death occurred on the date stated above, at 7 P.M.

The CAUSE OF DEATH* was as follows:

Maxillary Abscess

(Duration) _____ yrs. _____ mos. _____ ds.

Contributory
(Secondary)

(Duration) _____ yrs. _____ mos. _____ ds.

(Signed) Hot Corpse — M. D.

19. (Address) Mr. Downey

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (Per Hospitals, Institutions, Transients or Recent Residents.)

At place of death _____ yrs. _____ mos. _____ days. In the State _____ yrs. _____ mos. _____ days.

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL

Arino

DATE OF BURIAL

June 1, 1913

20. UNDERTAKER

By Downey

ADDRESS

Downey

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Form V. S. No. 5 20M.1-16-12

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics
File No. 529

1. PLACE OF DEATH
County of Bannock
City of Cleveland
(No. _____, _____ St.)
Registration District No. 11
Primary Registration District No. 2098

Registered No. 34
If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME James P. Nielsen

PERSONAL AND STATISTICAL PARTICULARS

3. SEX Male 4. COLOR OR RACE White 5. SINGLE, MARRIED, WIDOWED OR DIVORCED. Married
(the word.)

6. DATE OF BIRTH Oct 13 1883
(Month) (Day) (Year)

7. AGE 29 yrs. 8 mos. 21 ds.
IF LESS than 1 day how many _____ hrs. or _____ mins.?

8. OCCUPATION
(a) Trade, profession or particular kind of work Farmer
(b) General nature of industry business, or establishment in which employed (or employer)

9. BIRTHPLACE Cleveland Ida
(State or Country)

10. NAME OF FATHER Peter Nielsen

11. BIRTHPLACE OF FATHER Pesto Denmark
(State or Country)

12. MAIDEN NAME OF MOTHER Mary Larsen

13. BIRTHPLACE OF MOTHER Logan Utah
(State or Country)

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Henry Larsen
(Address) Cleveland Idaho

15. Filed June 16 1913 Earl Karsen
Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH July 4 1913
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from Apr 8 1913 to July 4 1913, that I last saw him alive on May 25 1913, and that death occurred on the date stated above, at 11¹⁵ A.M.

The CAUSE OF DEATH* was as follows:

Pulmonary tuberculosis

(Duration) 1 yrs. 4 mos. 20 ds.

Contributory Mitral disease
(Secondary) from inflammatory rheumatism
(Duration) 10 yrs. 1 mos. 1 ds.

(Signed) J. W. States M. D.
19. (Address) Preston Idaho

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death _____ yrs. _____ mos. _____ days. In the State _____ yrs. _____ mos. _____ days.

Where was disease contracted if not at place of death? _____

Former or usual residence _____

19. PLACE OF BURIAL OR REMOVAL Cleveland Ida DATE OF BURIAL July 6 1913

20. UNDERTAKER P. J. Hansen ADDRESS Preston Idaho

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Form V. S. No. 5 20M.1-16-12

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics
File No. 529
Registered No. 455

1. PLACE OF DEATH

County of WashingtonCity of CambodgeRegistration District No. 26Primary Registration District No. 2114

(No. _____ St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

Cornelius M Ross

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX

Male

4. COLOR OR RACE

White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED.

Single
(Write the word.)

6. DATE OF BIRTH

Jan 9 1860
(Month) (Day) (Year)

7. AGE

33 yrs. 4 mos. 11 ds.

IF LESS than 1 day
how many _____ hrs. or
_____ mins.?

8. OCCUPATION

(a) Trade, profession or
particular kind of work

(b) General nature of industry
business, or establishment in
which employed (or employer)

Rancher

9. BIRTHPLACE

(State or Country)

Codyville Tennessee

10. NAME OF FATHER

J T Ross

11. BIRTHPLACE OF FATHER

(State or Country)

Tennessee

12. MAIDEN NAME OF MOTHER

Elizabeth Charles

13. BIRTHPLACE OF MOTHER

(State or Country)

Tennessee

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

J T Ross

(Address)

Orland, Cal.

15.

Filed

May 201913C E Schmitz

Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

May 20 1913
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from
May 17 1913, to May 20 1913,

that I last saw him alive on May 19 1913,

and that death occurred on the date stated above, at 8 AM.

The CAUSE OF DEATH* was as follows:

fracture of femur, steinum and rupture
of bladder and intestines

(Duration) _____ yrs. _____ mos. 4 ds.

Contributory thrown from a horse
(Secondary)

(Duration) _____ yrs. _____ mos. 4 ds.

(Signed) C E Schmitz M. D.

May 21 1913 (Address) Cambodge Id.

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death _____ yrs. _____ mos. _____ days. In the State _____ yrs. _____ mos. _____ days.

Where was disease contracted
if not at place of death?

Former or
usual residence

19. PLACE OF BURIAL OR REMOVAL DATE OF BURIAL

Cambodge Id. May 21 1913

20. UNDERTAKER ADDRESS

Gas Kudskan Cambodge Id.

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Form V. S. No. 5 20M.1-16-12

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH.

Registration District No. 26

County of Wash.

Primary Registration District No. 10/0

City of Weiser

(No. In. Court & Ninth St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

Mrs. Elvora Adams

File No. 5299

Registered No. 46

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX

Female

4. COLOR OR RACE

White

5. SINGLE, MARRIED, WID-
OWED OR DIVORCED

Widow
(Write the word.)

6. DATE OF BIRTH

July 12

1891
(Month) (Day) (Year)

7. AGE

81 yrs. 10 mos. 23 ds.

IF LESS than 1 day
how many hrs. or
..... mins.

8. OCCUPATION

(a) Trade, profession or
particular kind of work

Housewife

(b) General nature of industry
business, or establishment in
which employed (or employer)

9. BIRTHPLACE

(State or Country)

State of Ohio

10. NAME OF
FATHER

W. C. Clark

11. BIRTHPLACE
OF FATHER

(State or Country)

Ohio

12. MAIDEN NAME
OF MOTHER

Sara B. Clark

13. BIRTHPLACE
OF MOTHER

(State or Country)

Ohio

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

Mrs. John Lemon

(Address)

Weiser, Idaho

15.

Filed

Jun 6 1913

W. R. Howell

Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH

June - 5 - 1913
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from

May 20 1913, to June 5 1913,

that I last saw her alive on June 3 1913,

and that death occurred on the date stated above, at 5:30 A.M.

The CAUSE OF DEATH* was as follows:

Myocardial Insufficiency

(Duration) yrs. mos. 18 ds.

Contributory
(Secondary)

none

(Duration) yrs. mos. ds.

(Signed) address Weiser Idaho M. D.

June 5 1913 (Address) James A. Jones

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death. yrs. mos. days. In the State. yrs. mos. days.

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

Galloway Cemetery June 6 - 1913

20. UNDERTAKER

ADDRESS

W. H. Bowen Weiser, Idaho

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Form V. S. No. 5. 12½ M. 7-24-11

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH.
County of Washington
City of Weiser

Registration District No. 26
Primary Registration District No. 2112
(No. _____, St.)

File No. 530
Registered No. 47

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

Karl Edgar Keys

If death occurred in a hospital, institution or camp give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX Male 4. COLOR OR RACE Wht 5. SINGLE, MARRIED, WIDOWED OR DIVORCED.

(Write the word.)

6. DATE OF BIRTH

June 6 1913
(Month) (Day) (Year)

7. AGE

_____ yrs. _____ mos. 2 ds.
IF LESS than 1 day
how many _____ hrs. or _____ min?

8. OCCUPATION

- (a) Trade, profession or particular kind of work.
(b) General nature of industry business or establishment in which employed (or employer)

9. BIRTHPLACE

(State or Country) Weiser

10. NAME OF FATHER

Karl Llewellyn Keys

11. BIRTHPLACE OF FATHER

(State or Country) Montague, Mich.

12. MAIDEN NAME OF MOTHER

Salma Williams

13. BIRTHPLACE OF MOTHER

(State or Country) Neb.

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Karl Llewellyn Keys
(Address) Weiser, Ida.

15.

Filed June 5 1913

W. R. Hamel
Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH

6 8 1913
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from June 6 1913, to June 8 1913 that I last saw him alive on June 8 1913 and that death occurred on the date stated above, at 2:45 P. M.

The CAUSE OF DEATH* was as follows:

Meningitis

(Duration) _____ yrs. _____ mos. 3 ds.
Contributory injury at birth
(Secondary) Brain hemorrhage
(Duration) _____ yrs. _____ mos. 2 ds.
(Signed) C. R. Phinney M. D.
Weiser 1913 (Address)

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place _____ In the _____
of death _____ yrs. _____ mos. _____ ds. State _____ yrs. _____ mos. _____ ds.
Where was disease contracted,
If not at place of death?
Former or
usual residence _____

19. PLACE OF BURIAL OR REMOVAL DATE OF BURIAL

Weiser Ida June 8 1913

20. UNDERTAKER

ADDRESS

L. C. Norther Weiser Ida

1. Place of Birth Washington County of Washington Primary Registration District No. 1010
 City of Wheat (No. _____ St.)
 Bureau of Vital Statistics
 File No. 5301
 Registered No. 48
 If death occurs away from usual residence, give facts called for under special information. 2. FULL NAME George F. Knight
 If death occurred in a hospital, institution or camp give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX Male 4. COLOR OR RACE Wht 5. SINGLE, MARRIED, WIDOWED OR DIVORCED. single
 (Write the word.)

6. DATE OF BIRTH Oct 6 1893
 (Month) (Day) (Year)

7. AGE 19 yrs. 8 mos. 9 ds. IF LESS than 1 day how many _____ hrs. or _____ min?

8. OCCUPATION
 (a) Trade, profession or particular kind of work Civil Engineer
 (b) General nature of industry business or establishment in which employed (or employer)

9. BIRTHPLACE Kansas
 (State or Country)

10. NAME OF FATHER Jesse S. Knight

11. BIRTHPLACE OF FATHER Indiana
 (State or Country)

12. MAIDEN NAME OF MOTHER Cora Tibbitts

13. BIRTHPLACE OF MOTHER Iowa
 (State or Country)

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
 (Informant) J. S. Knight
 (Address) Wheat

15. Filed June 16 1913 W. R. Russell
 Local

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH June 15th 1913
 (Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from June 4 1913, to June 15 1913
 that I last saw him alive on June 15 1913
 and that death occurred on the date stated above, at 7:20 P.M.

The CAUSE OF DEATH* was as follows:
Tubercular meningitis

_____ (Duration) _____ yrs. _____ mos. 11 ds.

Contributory (Secondary) none

_____ (Duration) _____ yrs. _____ mos. _____ ds.
 (Signed) James A. Young M. D.
June 16 1913 (Address) Wheat

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; (2) whether ACCIDENTAL, SUICIDAL OR HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place _____ In the _____
 of death _____ yrs. _____ mos. _____ ds. State _____ yrs. _____ mos. _____ ds.
 Where was disease contracted,
 If not at place of death? _____
 Former or
 usual residence _____

19. PLACE OF BURIAL OR REMOVAL DATE OF BURIAL
Weiser June 17 1913

20. UNDERTAKER ADDRESS
W. R. Northam Weiser

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Form V. S. No. 5 20M.1-16-12

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics
File No. 5305

1. PLACE OF DEATH.

County of Armstrong
City of Feet

Registration District No. 7Primary Registration District No. 2087

(No. _____, St.)

Registered No. 94

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

Amelia Woods

PERSONAL AND STATISTICAL PARTICULARS

3. SEX

7

4. COLOR OR RACE

White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED.

married
(Write the word.)

6. DATE OF BIRTH

Dec. 6 1881
(Month) (Day) (Year)

7. AGE

31 yrs. 5 mos. 10 ds.

IF LESS than 1 day
how many hrs. or
..... mins.?

8. OCCUPATION

- (a) Trade, profession or particular kind of work
(b) General nature of industry, business, or establishment in which employed (or employer)

Housewife

9. BIRTHPLACE

(State or Country)

Idaho

10. NAME OF FATHER

A. Henderson

11. BIRTHPLACE OF FATHER

(State or Country)

Idaho

12. MAIDEN NAME OF MOTHER

Don't know

13. BIRTHPLACE OF MOTHER

(State or Country)

Idaho

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

E. F. Davis

(Address)

Feet City, Idaho

15.

Filed

May 27 1913 Ray St. H. M.
Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH

May 26 1913
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from
May 25 1913 to May 26 1913

that I last saw her alive on May 26 1913
and that death occurred on the date stated above, at 6 P. M.

The CAUSE OF DEATH* was as follows:

Cerebro-spinal meningitis

(Duration) yrs. mos. ds.

Contributory
(Secondary)

(Duration) yrs. mos. ds.

(Signed)

Dr. S. Keith M. D.
June 30 13 (Address) Driggs

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death yrs. mos. days. In the State yrs. mos. days.

Where was disease contracted if not at place of death?

Former or usual residence.

19. PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

Feet City, Ida. 5/28 1913

20. UNDERTAKEN

ADDRESS

C. Cherrington Driggs

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Form V. S. No. 5 20M.1-16-12

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH.

County of Idaho
City of Victor

Registration District No. 9Primary Registration District No. 2039

(No. _____, St.)

File No. 203Registered No. 95

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

George C. Maullon

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX 4. COLOR OR RACE 5. SINGLE, MARRIED, WIDOWED OR DIVORCED.

M.W.

Married
(Write the word.)

6. DATE OF BIRTH

Dec. 17 1886
(Month) (Day) (Year)

7. AGE

26 yrs. 5 mos. 26 ds.

IF LESS than 1 day
how many _____ hrs. or
_____ mins.?

8. OCCUPATION

- (a) Trade, profession or particular kind of work
(b) General nature of industry business, or establishment in which employed (or employer)

9. BIRTHPLACE

(State or Country)

Utah

10. NAME OF FATHER

George F. Maullon

11. BIRTHPLACE OF FATHER

(State or Country)

Utah

12. MAIDEN NAME OF MOTHER

Ada L. Cluff

13. BIRTHPLACE OF MOTHER

(State or Country)

Utah

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Nellie Madston Hulme(Address) Victor

15.

Filed July 10 1913 Ray H. Hinkley
Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH

June 13 1913
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from

191 , to 191 ,that I last saw him alive on 191 ,and that death occurred on the date stated above, at M.

The CAUSE OF DEATH* was as follows:

Killed by lightning

(Duration) _____ yrs. _____ mos. _____ ds.

Contributory (Secondary) No physician

(Duration) _____ yrs. _____ mos. _____ ds.

(Signed) Ray H. Hinkley M. D.-19 (Address) Regley Idaho

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death _____ yrs. _____ mos. _____ days. In the State _____ yrs. _____ mos. _____ days.

Where was disease contracted if not at place of death?

Former or usual residence _____

19. PLACE OF BURIAL OR REMOVAL DATE OF BURIAL

Victor June 16 1913

20. UNDERTAKER ADDRESS

C. Cherrington Driggs

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Form V. S. No. 5 20M.1-16-12

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH.

Registration District No. 9County of PrincetonPrimary Registration District No. 2039City of Burton

(No. _____) (St. _____)

File No. 5305Registered No. 70

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

Britta Marie Mateau

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX

F.

4. COLOR OR RACE

W.

5. SINGLE, MARRIED, WIDOWED OR DIVORCED.

married
(Write the word.)

6. DATE OF BIRTH

Feb. 12 1884
(Month) (Day) (Year)

7. AGE

79 yrs. 3 mos. 29 ds.IF LESS than 1 day
how many hrs. or
..... mins.?

8. OCCUPATION

- (a) Trade, profession or particular kind of work
(b) General nature of industry, business, or establishment in which employed (or employer)

Housewife

9. BIRTHPLACE

(State or Country)

Sweden

10. NAME OF FATHER

Johannis Jonsson

11. BIRTHPLACE OF FATHER

(State or Country)

Sweden

12. MAIDEN NAME OF MOTHER

Anica Ericson

13. BIRTHPLACE OF MOTHER

(State or Country)

Sweden

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

Ellen C. Spaulding

(Address)

Burton - Ida

15.

Filed

July 10 1913 Ray H. Pike, M.D.
Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH

June 11 1913
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from

June 9 1913, to June 11 1913
that I last saw him alive on June 11 1913and that death occurred on the date stated above, at 6 A.M.

The CAUSE OF DEATH* was as follows:

Calitis

(Duration) yrs. mos. ds.

Contributory
(Secondary)

(Duration) yrs. mos. ds.

(Signed)

Jul 11 1913 (Address) Rebberg, Ida

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death yrs. mos. days. In the State yrs. mos. days.

Where was disease contracted if not at place of death?

Former or usual residence.

19. PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

Rebberg July 11 1913

20. UNDERTAKER

ADDRESS

John Phillips Rebberg, Ida

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Form V. S. No. 5 20M.1-16-12

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH.

Registration District No.

County of

Primary Registration District No.

City of

(No.

St.)

File No.

Registered No.

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX

4. COLOR OR RACE

5. SINGLE, MARRIED, WIDOWED OR DIVORCED.

6. DATE OF BIRTH

7. AGE

IF LESS than 1 day
how many hrs. or mins.?

8. OCCUPATION

- (a) Trade, profession or particular kind of work
(b) General nature of industry business, or establishment in which employed (or employer)

9. BIRTHPLACE

(State or Country)

10. NAME OF FATHER

11. BIRTHPLACE OF FATHER

(State or Country)

12. MAIDEN NAME OF MOTHER

13. BIRTHPLACE OF MOTHER

(State or Country)

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

(Address)

15.

Filed

1913

Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH

17. I HEREBY CERTIFY, That I attended deceased from

July 1 1913, to July 1 1913

that I last saw him alive on July 1 1913

and that death occurred on the date stated above, at 4 P. M.

The CAUSE OF DEATH* was as follows:

Contributory
(Secondary)

(Duration) yrs. mos. ds.

(Signed) H. A. Crismon M. D.

July 2 1913 (Address) Rexburg, Ida.

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death. yrs. mos. days. In the State. yrs. mos. days.

Where was disease contracted if not at place of death?

Former or usual residence.

19. PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

20. UNDERTAKER

ADDRESS

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Form V. S. No. 5 20M.1-16-12

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics
File No. 5308

1. PLACE OF DEATH.

Registration District No. 9

County of Fremont
City of Meridian

Primary Registration District No. 2040
(No. _____ St.)

Registered No. 72

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Anna Johnson

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX F. 4. COLOR OR RACE W. 5. SINGLE, MARRIED, WIDOWED OR DIVORCED. Widowed
(Write the word.)

6. DATE OF BIRTH July 9th 1888
(Month) (Day) (Year)

7. AGE 75 yrs. 11 mos. ds.
IF LESS than 1 day how many hrs. or mins.

8. OCCUPATION

(a) Trade, profession or particular kind of work
(b) General nature of industry, business, or establishment in which employed (or employer)

Housewife

9. BIRTHPLACE

(State or Country)

Sweden

10. NAME OF FATHER

Lars Carlsson

11. BIRTHPLACE OF FATHER

(State or Country)

Sweden

12. MAIDEN NAME OF MOTHER

Helena Danielson

13. BIRTHPLACE OF MOTHER

(State or Country)

Sweden

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

Loring Johnson

(Address)

Meridian

15. Filed June 23 1913 G. G. Goff
Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH

June 21 1913
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from June 20 1913, to June 21 1913, that I last saw her alive on June 20 1913, and that death occurred on the date stated above, at 8 P. M.
The CAUSE OF DEATH* was as follows:

Apoplexy

(Duration) yrs. mos. ds.

Contributory (Secondary)

(Duration) yrs. mos. ds.

(Signed)

J. C. Milton M. D.
July 21 1913 (Address) Meridian

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death.....yrs.....mos.....days. In the State.....yrs.....mos.....days.

Where was disease contracted if not at place of death?

Former or usual residence.....

19. PLACE OF BURIAL OR REMOVAL DATE OF BURIAL

BurtonJune 23 1913

20. UNDERTAKER

ADDRESS

John Phillips Reburg

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Form V. S. No. 5 20M.1-16-12

CERTIFICATE OF DEATH

1. PLACE OF DEATH

County of

City of

Registration District No.

Primary Registration District No.

(No.)

St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

File No.

Registered No.

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX

4. COLOR OR RACE

5. SINGLE, MARRIED, WIDOWED OR DIVORCED.

6. DATE OF BIRTH

7. AGE

IF LESS than 1 day
how many hrs. or
mins?

8. OCCUPATION

- (a) Trade, profession or particular kind of work
(b) General nature of industry business, or establishment in which employed (or employer)

9. BIRTHPLACE

(State or Country)

10. NAME OF FATHER

11. BIRTHPLACE OF FATHER

(State or Country)

12. MAIDEN NAME OF MOTHER

13. BIRTHPLACE OF MOTHER

(State or Country)

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

(Address)

15.

Filed

David Lawder

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

17. I HEREBY CERTIFY, That I attended deceased from

that I last saw him alive on

and that death occurred on the date stated above, at

The CAUSE OF DEATH* was as follows:

(Duration) yrs. mos. ds.

Contributory

(Secondary)

(Duration) yrs. mos. ds.

(Signed)

(Address)

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death yrs. mos. days. In the State yrs. mos. days.

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL DATE OF BURIAL

20. UNDERTAKER ADDRESS

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Form V. S. No. 5. 12½ M. 7-24-11

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics
File No. **5311**
Registered No. **16**

1. PLACE OF DEATH. Registration District No. **92**
County of **Leure** Primary Registration District No. **2127**
City of **Forest** (No. _____, _____ St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME **Joshua G. Marquis.**

If death occurred in a hospital, institution or camp give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX **Male** 4. COLOR OR RACE **White** 5. SINGLE, MARRIED, WIDOWED OR DIVORCED. **Married**
(Write the word.)

6. DATE OF BIRTH **April 8 1837**
(Month) (Day) (Year)

7. AGE **about 76 yrs. 3 mos. 8 ds.** IF LESS than 1 day how many _____ hrs. or _____ min?

8. OCCUPATION
(a) Trade, profession or particular kind of work. **None**
(b) General nature of industry business or establishment in which employed (or employer)

9. BIRTHPLACE (State or Country) **Illinois**

10. NAME OF FATHER **William Marquis**

11. BIRTHPLACE OF FATHER (State or Country) **Don't know**

12. MAIDEN NAME OF MOTHER **Mary Ann Wells**

13. BIRTHPLACE OF MOTHER (State or Country) **Pennsylvania**

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) **Clyde E. Cloris**
(Address) **Nezperce, Ida.**

15. Filed **6-17-1913** **Elton P. Rogers**
Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH **June 16 1913**
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased **on Jan 26th** 1912, to _____ 191____ that I last saw him alive on **January 26** 1912, and that death occurred on the date stated above, at **4 A. M.**

The CAUSE OF DEATH* was as follows:

Senility

(Duration) _____ yrs. _____ mos. _____ ds.

Contributory (Secondary)

(Duration) _____ yrs. _____ mos. _____ ds.

(Signed) **Elton P. Rogers** M. D.

June 17 1913 (Address) **Washburn**

State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place _____ In the _____ of death _____ yrs. _____ mos. _____ ds. State _____ yrs. _____ mos. _____ ds.

Where was disease contracted, If not at place of death? _____

Former or usual residence **Forest**

19. PLACE OF BURIAL OR REMOVAL DATE OF BURIAL

I.O.O.F. Cemetery, Ilo. June 18 1913

20. UNDERTAKER ADDRESS

T. T. Maynard., Forest, Ida

1. PLACE OF DEATH. Registration District No. 32
County of Sanjoy Primary Registration District No. 2127
City of Wendover (No. _____, _____ St.)

File No. 5312
Registered No. 15

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

Infant Nichols

If death occurred in a hospital, institution or camp give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX Female 4. COLOR OR RACE White 5. SINGLE, MARRIED, WIDOWED OR DIVORCED. Single
(Write the word.)

6. DATE OF BIRTH June 6th 1913
(Month) (Day) (Year)

7. AGE _____ yrs. _____ mos. 4 ds. IF LESS than 1 day how many _____ hrs. or _____ min?

8. OCCUPATION

- (a) Trade, profession or particular kind of work. _____
(b) General nature of industry business or establishment in which employed (or employer) _____

9. BIRTHPLACE

(State or Country) Sanjoy Co. Idaho

10. NAME OF FATHER

Thomas Nichols

11. BIRTHPLACE OF FATHER

(State or Country) Michigan

12. MAIDEN NAME OF MOTHER

Delia Tribe

13. BIRTHPLACE OF MOTHER

(State or Country) Canada

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Thomas Nichols
(Address) Wendover, Idaho

15. Filed 6-9-1913 Elmer B. Rogers
Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH

June 9th 1913
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from June 6th 1913, to June 9 1913 that I last saw her alive on June 9 1913 and that death occurred on the date stated above, at 5:30 P.M.

The CAUSE OF DEATH* was as follows:

Infantile Convulsions

(Duration) _____ yrs. _____ mos. one ds.

Contributory (Secondary)

(Duration) _____ yrs. _____ mos. _____ ds.

(Signed) Elmer B. Rogers M. D.
6-9-1913 (Address) Wendover

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place _____ In the _____
of death _____ yrs. _____ mos. _____ ds. State _____ yrs. _____ mos. _____ ds.
Where was disease contracted, _____
If not at place of death? _____
Former or _____
usual residence _____

19. PLACE OF BURIAL OR REMOVAL DATE OF BURIAL

Woodlawn Cemetery 6-10-1913
20. UNDERTAKER none ADDRESS _____

RECEIVED

NOV 20 1913

SECRETARY'S OFFICE
STATE BOARD OF HEALTH

WINCHESTER, IDAHO, 11-17- 1913

Dr. Ralph Falk.

Bair, Idaho

Dear Doctor:

Your inquiry concerning
the cause of death: "infantile convulsion"
in Infant Nichols as given by me
at hand.

I disliked to send in such a
diagnosis but I was unable to
make a positive diagnosis and
no autopsy was allowed. The child
was apparently normal at birth
and up until a few hours before

death. The parents have lost
five infants in the same
manner without anyone being
able to ascertain a definite cause.

While syphilis is denied, I
believe that is the only thing
that cannot be ruled out under
the circumstances.

Yours very truly
Elton B. Rogers.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Form V. S. No. 5, 20M.1-16-12

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics
File No. 5312

1. PLACE OF DEATH. Registration District No. 208
County of Shoshone Primary Registration District No. 1011
City of Maltese (No. _____, St.)

Registered No. 43

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

Mary Redding

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX Female 4. COLOR OR RACE white 5. SINGLE, MARRIED, WIDOWED OR DIVORCED. married
(Write the word.)

6. DATE OF BIRTH _____
(Month) (Day) (Year)

7. AGE 46 yrs. _____ mos. _____ ds.
IF LESS than 1 day how many _____ hrs. or _____ min.

8. OCCUPATION

(a) Trade, profession or particular kind of work
(b) General nature of industry, business, or establishment in which employed (or employer)

housewife

9. BIRTHPLACE

(State or Country)

Indiana

10. NAME OF FATHER

Geo. Stickman

11. BIRTHPLACE OF FATHER

(State or Country)

unknown

12. MAIDEN NAME OF MOTHER

"

13. BIRTHPLACE OF MOTHER

(State or Country)

"

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) M. Redding(Address) Maltese 2nd

15. Filed 6/2 1913 H. Leo Dingley
Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

June 1 1913
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from June 1 1913 to June 1 1913
that I last saw her alive on June 1 1913

and that death occurred on the date stated above, at 6 P.M.

The CAUSE OF DEATH was as follows:

Rupture of open-
ing of fresh
apex
(Duration) 20 yrs. _____ mos. _____ ds.

Contributory
(Secondary)

(Duration) 20 yrs. _____ mos. _____ ds.

(Signed)

Dr. M. Redding M. D.
(Address) Maltese

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death _____ yrs. _____ mos. _____ days. In the State _____ yrs. _____ mos. _____ days.

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF REMOVAL DATE OF BURIAL

Maltese 6/2 1913

20. UNDERTAKER

ADDRESS

Ward Undertaking Co.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Form V. S. No. 5 20M.1-16-12

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics
File No. 5314

1. PLACE OF DEATH Registration District No. 28
County of Shoshone Primary Registration District No. 1011
City of Wallace (No. St.)

Registered No. 47
If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME John Frank Harris

PERSONAL AND STATISTICAL PARTICULARS

3. SEX male 4. COLOR OR RACE white 5. SINGLE, MARRIED, WIDOWED OR DIVORCED single
(Write the word.)

6. DATE OF BIRTH (Month) (Day) (Year)

7. AGE 28 yrs. — mos. — ds. IF LESS than 1 day how many hrs. or mins.

8. OCCUPATION

(a) Trade, profession or particular kind of work miner
(b) General nature of industry business, or establishment in which employed (or employer)

9. BIRTHPLACE

(State or Country) Nevada

10. NAME OF FATHER

John S Harris

11. BIRTHPLACE OF FATHER

England

12. MAIDEN NAME OF MOTHER

Elizabeth Johnson

13. BIRTHPLACE OF MOTHER

England

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) A. J. Harris

(Address) Butte Mont.

15. Filed 6/6/1913 H. Leo Dwyer Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH June 4 1913
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from June 4 1913, to June 4 1913, that I last saw him alive on June 4 1913, and that death occurred on the date stated above, at P. M.
The CAUSE OF DEATH* was as follows:

Self inflicted
Cut throat

(Duration) yrs. mos. ds.

Contributory (Secondary)

(Duration) yrs. mos. ds.

(Signed) J. W. Mowbray M. D.

(Address) Wallace Ida.

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death yrs. mos. days Wallace Ida In the State yrs. mos. days Wallace Mont

Where was disease contracted if not at place of death? Hookout, Mont.

Former or usual residence.

19. PLACE OF BURIAL OR REMOVAL DATE OF BURIAL

Butte Mont. 6/7 1913

20. UNDERTAKER ADDRESS

Ward Undertaking Co Wallace Ida

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Form V. S. No. 5 20M.1-16-12

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH. Registration District No. 28
County of Shoshone Primary Registration District No. 1011
City of Wallace (No. _____ St.)

File No. 5319
Registered No. 46

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME J. E. Johnson

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX male 4. COLOR OR RACE white 5. SINGLE, MARRIED, WIDOWED OR DIVORCED. single
(Write the word.)

6. DATE OF BIRTH _____
(Month) (Day) (Year)

7. AGE 60 yrs. _____ mos. _____ ds. IF LESS than 1 day how many _____ hrs. or _____ mins.?

8. OCCUPATION

(a) Trade, profession or particular kind of work miner
(b) General nature of industry business, or establishment in which employed (or employer) _____

9. BIRTHPLACE

(State or Country) Ireland

10. NAME OF FATHER unknown

11. BIRTHPLACE OF FATHER _____
(State or Country)

12. MAIDEN NAME OF MOTHER _____

13. BIRTHPLACE OF MOTHER _____
(State or Country)

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Hard. Underlaking Co
(Address) Wallace Ida

15. Filed 6/7/1913 H. L. Linder
Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH June 4 1913
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from Aug 1912, to June 1913
that I last saw him alive on June 4 1913
and that death occurred on the date stated above, at 8 P.M.

The CAUSE OF DEATH* was as follows:

Pulmonary Tuberculosis

(Duration) 1 yrs. _____ mos. _____ ds.

Contributory (Secondary) _____

(Duration) _____ yrs. _____ mos. _____ ds.

(Signed) Dr. Mowery M.D.

June 7 1913 (Address) Wallace Ida

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.) Wallace Ida Prop Hop

At place of death _____ yrs. _____ mos. _____ days. State _____ yrs. _____ mos. _____ days.

Where was disease contracted if not at place of death? _____

Former or usual residence. Mace

19. PLACE OF BURIAL OR REMOVAL Wallace DATE OF BURIAL June 7 1913

20. UNDERTAKER Wards Undertaking Co ADDRESS Wallace Ida

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Form V. S. No. 5 20M.1-16-12

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH.

Registration District No. 28

County of Shoshone

Primary Registration District No. 1011

File No. 5317

City of Wallace

(No. _____ St.)

Registered No. 47

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Albert Earl Ross

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX

4. COLOR OR RACE

5. SINGLE, MARRIED, WIDOWED OR DIVORCED.

male

white

single
(Write the word.)

6. DATE OF BIRTH

(Month)

(Day)

(Year)

7. AGE

3 yrs. 8 mos. 11 ds.

IF LESS than 1 day
how many _____ hrs. or
_____ mins.

8. OCCUPATION

(a) Trade, profession or particular kind of work

(b) General nature of industry, business, or establishment in which employed (or employer)

none

9. BIRTHPLACE

(State or Country)

Gen

10. NAME OF FATHER

C. C. Ross

11. BIRTHPLACE OF FATHER

(State or Country)

Missouri

12. MAIDEN NAME OF MOTHER

Grace Parker

13. BIRTHPLACE OF MOTHER

(State or Country)

Kansas

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

C. C. Ross

(Address)

Gen. Ida

15.

Filed

4/13

1913

H. Leo Dunsley

Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH

June

11

1913

(Month)

(Day)

(Year)

17. I HEREBY CERTIFY, That I attended deceased from

June 9th 1913, to June 11th 1913

that I last saw him alive on June 11th 1913

and that death occurred on the date stated above, at 11:30 P.M.

The CAUSE OF DEATH* was as follows:

Broncho Pneumonia

(Duration)

yrs.

mos.

4 ds.

Contributory (Secondary)

Pertussis

(Duration)

yrs.

mos.

ds.

(Signed)

May 1, 1913

M. D.

Wallace (Address)

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death

.....yrs.....mos.....days.

In the

State.....yrs.....mos.....days.

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

Wallace

4/13

1913

20. UNDERTAKER

ADDRESS

Wards Undertaking Co Wallace 2da

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics
File No. **5318**

1. PLACE OF DEATH. Registration District No. 28
County of Choshone Primary Registration District No. 1011
City of Wallace (No. _____, St.)

Registered No. 48

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Simon Frances Carroll

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX male 4. COLOR OR RACE white 5. SINGLE, MARRIED, WIDOWED OR DIVORCED. married
(Write the word.)

6. DATE OF BIRTH _____
(Month) (Day) (Year)

7. AGE 44 yrs. _____ mos. _____ ds.
IF LESS than 1 day how many _____ hrs. or _____ mins.?

8. OCCUPATION
(a) Trade, profession or particular kind of work Teacher
(b) General nature of industry, business, or establishment in which employed (or employer) _____

9. BIRTHPLACE
(State or Country) Missi

10. NAME OF FATHER Simon Carroll

11. BIRTHPLACE OF FATHER Ireland
(State or Country)

12. MAIDEN NAME OF MOTHER Julia Huggan

13. BIRTHPLACE OF MOTHER Ireland
(State or Country)

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Eva C. Carroll
(Address) Wallace Ida

15. Filed June 20, 1913 Dr. Leo Tingle
Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH June 23 1913
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from Sept 3 1912, to June 23 1913, that I last saw him alive on June 23 1913, and that death occurred on the date stated above, at 3 P. M.
The CAUSE OF DEATH* was as follows:

epithelioma of lip followed by gangrene of mouth
(Duration) 1 1/2 yrs. _____ mos. _____ ds.

Contributory (Secondary) None

(Duration) _____ yrs. _____ mos. _____ ds.

(Signed) Dr. Hoover M. D.

June 24, 1913 (Address) Wallace, Ida

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death _____ yrs. _____ mos. _____ days. In the State _____ yrs. _____ mos. _____ days.

Where was disease contracted if not at place of death? _____

Former or usual residence _____

19. PLACE OF BURIAL OR REMOVAL Wallace DATE OF BURIAL June 25 1913

20. UNDERTAKER Ward Undertaking ADDRESS Wallace Ida

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Form V. S. No. 5 20M.1-16-12

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH.

Registration District No. 28

County of Shoshone

Primary Registration District No. 1011

File No. 5310

City of Wallace

(No. _____, _____ St.)

Registered No. 49

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

John Norman Turnbull

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX

male

4. COLOR OR RACE

white

5. SINGLE, MARRIED, WIDOWED OR DIVORCED.

single
(Write the word.)

6. DATE OF BIRTH

(Month)

(Day)

(Year)

7. AGE

29 yrs. _____ mos. _____ ds.IF LESS than 1 day
how many _____ hrs. or
_____ mins.?

8. OCCUPATION

(a) Trade, profession or particular kind of work

mines

(b) General nature of industry business, or establishment in which employed (or employer)

9. BIRTHPLACE

(State or Country)

England

10. NAME OF FATHER

unknown

11. BIRTHPLACE OF FATHER

(State or Country)

U.

12. MAIDEN NAME OF MOTHER

"

13. BIRTHPLACE OF MOTHER

(State or Country)

"

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

Roy H. Kingsbury

(Address)

Wallace, Idaho.

15.

Filed

June 24, 1913

1913

H. L. Quigley

Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH

June

(Month)

21

(Day)

1913

(Year)

17. I HEREBY CERTIFY, That I attended deceased from

191____, to

191____,

that I last saw h_____ alive on

191____,

and that death occurred on the date stated above, at _____ M.

The CAUSE OF DEATH was as follows:

Struck by falling
timber - fractured
fractured skull.

(Duration)

yrs.

mos.

ds.

Contributory

(Secondary)

(Duration)

yrs.

mos.

ds.

(Signed)

June 23 1913

(Address)

Dr. Mowery, M.D.
Wallace, Ida.

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place

of death _____ yrs. _____ mos. _____ days.

In the

State _____ yrs. _____ mos. _____ days.

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

WallaceJune 24 1913

20. UNDERTAKER

ADDRESS

Ward, Undelak, Co. Wallace Ida

Form V. S. No. 5 20M.1-16-12

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH.

Registration District No. 28County of ShoshonePrimary Registration District No. 100City of Wallace

(No. _____, _____ St.)

File No. 5320Registered No. 50

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

Bert Stettin

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX

4. COLOR OR RACE

5. SINGLE, MARRIED, WID-
OWED OR DIVORCED.
married
(Write the word.)malewhite

6. DATE OF BIRTH

(Month)

(Day)

(Year)

7. AGE

31 yrs. — mos. — ds.IF LESS than 1 day
how many _____ hrs. or
_____ mins.?

8. OCCUPATION

(a) Trade, profession or
particular kind of workBar tender(b) General nature of industry
business, or establishment in
which employed (or employer)

9. BIRTHPLACE

(State or Country)

Idaho10. NAME OF
FATHERClark Stettin11. BIRTHPLACE
OF FATHER

(State or Country)

Dakota12. MAIDEN NAME
OF MOTHERRosa O'Connor13. BIRTHPLACE
OF MOTHER

(State or Country)

Ill

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Mrs. Bert Stettin(Address) Wallace, Idaho

15.

Filed June 25 1913 H. Leo Zundel

Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH

(Month)

(Day)

1913
(Year)

17. I HEREBY CERTIFY, That I attended deceased from

June 6 1913, to June 25 1913,that I last saw him alive on June 25 1913and that death occurred on the date stated above, at 12:45

The CAUSE OF DEATH* was as follows:

Chronic Paralytic Tetanus(Duration) — yrs. — mos. — ds.Contributory
(Secondary)(Duration) — yrs. — mos. 3 ds.(Signed) Harold E. Hansen M. D.19. (Address) Wallace, Idaho

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death _____ yrs. _____ mos. 17 days. In the State _____ yrs. _____ mos. _____ days.Where was disease contracted if not at place of death? From Home

Former or usual residence _____

19. PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

Spokane 6/25 1913

20. UNDERTAKER

ADDRESS

Ward's Undertaking Co. Wallace

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Form V. S. No. 5 20M.1-16-12

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics
File No. 5321
Registered No. 31-

1. PLACE OF DEATH. Registration District No. 7
County of Bonerville Primary Registration District No. 7027
City of Ammon (No. 5 St.)
If death occurs away from usual residence, give facts called for under special information. 2. FULL NAME Freeman J Mitchell

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX Male 4. COLOR OR RACE White 5. SINGLE, MARRIED, WIDOWED OR DIVORCED. Child (Write the word.)
6. DATE OF BIRTH May 20 1913 (Month) (Day) (Year)
7. AGE X yrs. X mos. 11 ds. IF LESS than 1 day how many hrs. or mins.?

8. OCCUPATION (a) Trade, profession or particular kind of work (b) General nature of industry business, or establishment in which employed (or employer) Child

9. BIRTHPLACE (State or Country) Ammon, Ida

10. NAME OF FATHER J. E. Mitchell

11. BIRTHPLACE OF FATHER (State or Country) Utah

12. MAIDEN NAME OF MOTHER Annie L. Hiatt

13. BIRTHPLACE OF MOTHER (State or Country) Utah

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE (Informant) J. E. Mitchell (Address) R D 3 - City

15. Filed June 5- 1913 Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH May 31 1913 (Month) (Day) (Year)
17. I HEREBY CERTIFY, That I attended deceased from 191. to 191., that I last saw h. alive on 191., and that death occurred on the date stated above, at 10 P. M.
The CAUSE OF DEATH* was as follows:

Broncho pneumonia
As physician in attendance
(Duration) yrs. mos. ds.
Contributory (Secondary)
(Duration) yrs. mos. ds.
(signed) J. E. Mitchell M. D.
4-19-13 (Address) Idaho Falls, Ida

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death yrs. mos. days. In the State yrs. mos. days.

Where was disease contracted if not at place of death?
Former or usual residence.

19. PLACE OF BURIAL OR REMOVAL Ammon DATE OF BURIAL 6/1 1913

20. UNDERTAKER E. E. Hinwood ADDRESS Idaho Falls

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Form V. S. No. 5 20M.1-16-12

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH.

Registration District No.

County of Bonnerille

Primary Registration District No. 72027

City of Idaho Falls

(No. , St.)

File No. 323

Registered No. 37

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

Charles Beck

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX

4. COLOR OR RACE

5. SINGLE, MARRIED, WIDOWED OR DIVORCED.

Male

White

Single
(Write the word.)

6. DATE OF BIRTH

July
(Month)

18
(Day)

1901
(Year)

7. AGE

11 yrs. 10 mos. 19 ds.

IF LESS than 1 day
how many hrs. or
..... mins.?

8. OCCUPATION

(a) Trade, profession or particular kind of work
(b) General nature of industry business, or establishment in which employed (or employer)

School boy

9. BIRTHPLACE

(State or Country)

Germany

10. NAME OF FATHER

Francis Beck

11. BIRTHPLACE OF FATHER

(State or Country)

Germany

12. MAIDEN NAME OF MOTHER

Carlstone E. Fretzner

13. BIRTHPLACE OF MOTHER

(State or Country)

Germany

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

Chas. Mueich

(Address)

Idaho Falls

15.

Filed

June 10 1913

C. E. Quinn
Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH

June
(Month)

4
(Day)

1913
(Year)

17. I HEREBY CERTIFY, That I attended deceased from June, 2, 1913 to June, 7, 1913, and that death occurred on the date stated above, at 11:45 A.M.

that I last saw him alive on 6/7/13, 1913, and that death occurred on the date stated above, at 11:45 A.M.

The CAUSE OF DEATH* was as follows:

Fracture base of skull,

five days,

(Duration) yrs. mos. ds.

Contributory Struck by lightning.

(Secondary)

5 days.

(Duration) yrs. mos. ds.

(Signed) J. M. Bridges M. D.

19 (Address) Idaho Falls, Ida.

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death yrs. mos. days. In the State yrs. mos. days.

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

Bolton Idaho

June 10 1913

20. UNDERTAKER

ADDRESS

J. H. Hunt

Idaho Falls

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Form V. S. No. 5 20M.1-16-12

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics
File No. 5321

1. PLACE OF DEATH.
County of Bonerville
City of Ida Falls
(No. _____ St.)
Registration District No. 7
Primary Registration District No. 2027

Registered No. 37
If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Jno. Wade Lundberg

PERSONAL AND STATISTICAL PARTICULARS

3. SEX Male 4. COLOR OR RACE White 5. SINGLE, MARRIED, WID-
OWED OR DIVORCED. Child
(Write the word.)

6. DATE OF BIRTH May 26 1913
(Month) (Day) (Year)

7. AGE 24 yrs. 1 mo. 4 da.
IF LESS than 1 day how many hrs. or min.?

8. OCCUPATION Child
(a) Trade, profession or particular kind of work
(b) General nature of industry, business, or establishment in which employed (or employer)

9. BIRTHPLACE Ida Falls, Ida
(State or Country)

10. NAME OF FATHER N.O. Lundberg

11. BIRTHPLACE OF FATHER Nebraska
(State or Country)

12. MAIDEN NAME OF MOTHER Hannah Lunderson

13. BIRTHPLACE OF MOTHER Minnesota
(State or Country)

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) N.O. Lundberg
(Address) Idaho Falls

15. Filed June 10 1913
Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH June 9 1913
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from June 9 1913, to June 9 1913, that I last saw him alive on June 9 1913, and that death occurred on the date stated above, at 8:30 P.M.

The CAUSE OF DEATH* was as follows:
Mulberry throat
(Duration) ✓ yrs. ✓ mos. ✓ ds.

Contributory (Secondary)
(Duration) ✓ yrs. ✓ mos. ✓ ds.
(Signed) A.R. Soderquist M.D.
6/10 1913 (Address) Idaho Falls, Ida.

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death ✓ yrs. ✓ mos. ✓ days. In the State ✓ yrs. ✓ mos. ✓ days.
Where was disease contracted if not at place of death?
Former or usual residence.

19. PLACE OF BURIAL OR REMOVAL Idaho Falls DATE OF BURIAL June 10 1913

20. UNDERTAKER E.E. Dimwoody ADDRESS Idaho Falls

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Form V. S. No. 5 20M.1-16-12

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH

Registration District No. _____

County of Bainville

Primary Registration District No. 229

City of Idaho Falls

(No. _____, _____ St.)

File No. 532

Registered No. 40

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

Ivan Lee Storer

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX

Male

4. COLOR OR RACE

White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED.

Child
(Write the word.)

6. DATE OF BIRTH

Aug. 13 1909
(Month) (Day) (Year)

7. AGE

3 yrs. 9 mos. 28 ds.

IF LESS than 1 day
how many _____ hrs. or
_____ mins.?

8. OCCUPATION

(a) Trade, profession or particular kind of work
(b) General nature of industry, business, or establishment in which employed (or employer)

Child

9. BIRTHPLACE

(State or Country)

Idaho

10. NAME OF FATHER

Ivan Storer

11. BIRTHPLACE OF FATHER

(State or Country)

Idaho

12. MAIDEN NAME OF MOTHER

Martha A. Simmons

13. BIRTHPLACE OF MOTHER

(State or Country)

Idaho

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

Eli Simmons

(Address)

R.D. - Idaho Falls

15.

Filed

June 13 1913

E. G. L...

Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

June 11 1913
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from

_____ 191____, to _____ 191____,
that I last saw h_____ alive on _____ 191____,

and that death occurred on the date stated above, at 3 P. M.

The CAUSE OF DEATH* was as follows:

Accidental Drowning
no medical attendance
(Duration) _____ yrs. _____ mos. _____ ds.

Contributory
(Secondary)

(Duration) _____ yrs. _____ mos. _____ ds.

(Signed) E. G. L... M. D.

6/13 1913 (Address) Idaho Falls, Id.

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death _____ yrs. _____ mos. _____ days. In the State _____ yrs. _____ mos. _____ days.

Where was disease contracted if not at place of death?

Former or usual residence.

19. PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

Milo Cemetery

June 13 1913

20. UNDERTAKER

ADDRESS

B. E. Hinwood

Idaho Falls

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Form V. S. No. 5 20M.1-16-12

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH

Registration District No. 7

County of Bonnell

Primary Registration District No. 2027

City of Idaho Falls

(No.)

(St.)

File No. 5327

Registered No. 4

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

Johana Winter

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX

4. COLOR OR RACE

5. SINGLE, MARRIED, WIDOWED OR DIVORCED.

Female

White

Married

(Write the word.)

6. DATE OF BIRTH

Jan

10

1863

(Month)

(Day)

(Year)

7. AGE

49 yrs. 6 mos. 9 ds.

IF LESS than 1 day
how many hrs. or
..... mins.?

8. OCCUPATION

(a) Trade, profession or particular kind of work

(b) General nature of industry business, or establishment in which employed (or employer)

Housewife

9. BIRTHPLACE

(State or Country)

Norway

10. NAME OF FATHER

Torga Anderson

11. BIRTHPLACE OF FATHER

(State or Country)

Norway

12. MAIDEN NAME OF MOTHER

Martha Johnson

13. BIRTHPLACE OF MOTHER

(State or Country)

Norway

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

Hans A. Winter

(Address)

Jona Falls

15.

Filed

June 17

1913

J. C. Cunningham

Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH

June

12

1913

(Month)

(Day)

(Year)

17. I HEREBY CERTIFY, That I attended deceased from

191.., to

191..,

that I last saw h..... alive on

191..,

and that death occurred on the date stated above, at..... M.

The CAUSE OF DEATH* was as follows:

Small Pox

Died without Medical Attendance,

(Duration) yrs. mos. ds.

Contributory.....

(Secondary)

(Duration) yrs. mos. ds.

(Signed)

J. C. Cunningham

19..... (Address) Jona Falls

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death.....

yrs.

mos.

days.

In the State.....

yrs.

mos.

days.

Where was disease contracted if not at place of death?

Former or usual residence.....

19. PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

Jona Falls

June 17 1913

20. UNDERTAKER

ADDRESS

J. C. Cunningham

Jona Falls

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Form V. S. No. 5 20M.1-16-12

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH

Registration District No. 7

County of Bonneville

Primary Registration District No. 2027

City of Idaho Falls

(No.)

(St.)

File No. 532

Registered No. 47

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

Stephen Gilbert

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX

Male

4. COLOR OR RACE

White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED

Single
(Write the word.)

6. DATE OF BIRTH

Feb

25

1886

(Month)

(Day)

(Year)

7. AGE

27

yrs.

3

mos. 19

ds.

IF LESS than 1 day
how many hrs. or
mins.?

8. OCCUPATION

(a) Trade, profession or particular kind of work

Electrician

(b) General nature of industry business, or establishment in which employed (or employer)

9. BIRTHPLACE

(State or Country)

Iowa

10. NAME OF FATHER

Arvis Gilbert

11. BIRTHPLACE OF FATHER

(State or Country)

Iowa

12. MAIDEN NAME OF MOTHER

Edna Locking

13. BIRTHPLACE OF MOTHER

(State or Country)

Iowa

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

Arvis B. Gilbert

(Address)

Idaho Falls

15.

Filed

June 17, 1913

J. E. Bennett
Dep. Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

June

(Month)

14

(Day)

1913

(Year)

17. I HEREBY CERTIFY, That I attended deceased from

191., to

191.,

that I last saw h. alive on

191.,

and that death occurred on the date stated above, at 7:40 P.M.

The CAUSE OF DEATH* was as follows:

Accidental electrocution
came in contact with a live
wire carrying 40,000 Volts of Electricity.

(Duration) yrs. mos. ds.

Contributory

(Secondary)

(Duration) yrs. mos. ds.

(Signed)

Geo. Morley M. D.

16/17 1913 (Address) Bonneville County

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place

of death

yrs.

mos.

days.

In the

State

yrs.

mos.

days.

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL

Idaho Falls

DATE OF BURIAL

June 17, 1913

20. UNDERTAKER

St. Hunt

ADDRESS

Idaho Falls

Form V. S. No. 5 20M.1-16-12

CERTIFICATE OF DEATH

 State of Idaho
 BOARD OF HEALTH
 Bureau of Vital Statistics

1. PLACE OF DEATH.

Registration District No. 7County of BannockPrimary Registration District No. 2027File No. 5329City of Ammon

(No. _____, St.)

Registered No. 77

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Maggie Jane Hayes

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX

Female

4. COLOR OR RACE

White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED.

Child
(Write the word.)

6. DATE OF BIRTH

 _____ 1 20
 (Month) (Day) (Year)

7. AGE

13 yrs. _____ mos. _____ ds.
 IF LESS than 1 day
 how many _____ hrs. or
 _____ mins.

8. OCCUPATION

(a) Trade, profession or particular kind of work

at Home

(b) General nature of industry business, or establishment in which employed (or employer)

9. BIRTHPLACE

(State or Country)

Idaho

10. NAME OF FATHER

Charles Hayes

11. BIRTHPLACE OF FATHER

(State or Country)

England

12. MAIDEN NAME OF MOTHER

Eli. Carnell

13. BIRTHPLACE OF MOTHER

(State or Country)

England

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

Charles Hayes

(Address)

P.O. 3 - Idaho Falls

15.

Filed

June 10 - 1913

Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH

June 15 1913
 (Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from

June 15 1913 to June 17 1913that I last saw him alive on June 17 1913and that death occurred on the date stated above, at 5 A.M.

The CAUSE OF DEATH* was as follows:

Myocardial Infarction

(Duration) _____ yrs. _____ mos. _____ ds.

Contributory Death Antecedes Rheumatism
(Secondary) - 3 weeks before

(Duration) _____ yrs. _____ mos. _____ ds.

(Signed) E. J. Hammond M. D.6/15-1913 (Address) Idaho Falls

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death _____ yrs. _____ mos. _____ days. In the State _____ yrs. _____ mos. _____ days.

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

Ammon June 16 1913

20. UNDERTAKER

ADDRESS

C. H. Woodward Idaho Falls

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Form V. S. No. 5 20M.1-16-12

CERTIFICATE OF DEATH

 State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH.

Registration District No.

County of BlainePrimary Registration District No. 12027City of Shoshone Falls

(No., St.)

File No. 5330Registered No. 11

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

Levi Norton Harmon

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX

4. COLOR OR RACE

5. SINGLE, MARRIED, WIDOWED OR DIVORCED.

MaleWhiteWidowed
(Write the word.)

6. DATE OF BIRTH

August 3 1883
(Month) (Day) (Year)

7. AGE

59 yrs. 10 mos. 18 ds.
 IF LESS than 1 day
how many hrs. or
..... mins.

8. OCCUPATION

- (a) Trade, profession or particular kind of work
(b) General nature of industry business, or establishment in which employed (or employer)

Farming

9. BIRTHPLACE

(State or Country)

Illinois

10. NAME OF FATHER

Jesse N. Harmon

11. BIRTHPLACE OF FATHER

(State or Country)

U. S.

12. MAIDEN NAME OF MOTHER

Emily Harmon

13. BIRTHPLACE OF MOTHER

(State or Country)

U. S.

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

J. L. Harmon

(Address)

15.

Filed

June 23 1913
C. L. Harmon
Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH

June 21 1913
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from

June 17, 1913, to June 20, 1913
that I last saw him alive on June 20, 1913

 and that death occurred on the date stated above, at 3 a.m.

The CAUSE OF DEATH* was as follows:

Strangulated hernia.(Duration) 7 yrs. 7 mos. 7 ds.Contributory
(Secondary)(Duration) 7 yrs. 7 mos. 7 ds.

(Signed)

John C. Miller M. D.

19

(Address) Idaho Falls

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death yrs. mos. days. In the State yrs. mos. days.

Where was disease contracted if not at place of death?

Former or usual residence.

19. PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

Idaho Falls 6/22 1913

20. UNDERTAKER

ADDRESS

B. E. Dimwoody Idaho Falls

Form V. S. No. 5 20M.1-16-12

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH.

Registration District No. 7

County of Banner

Primary Registration District No. 27

City of Idaho Falls

(No. 7 St.)

File No. 5331

Registered No. 46

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Chas. Akin

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX Male 4. COLOR OR RACE Wt. 5. SINGLE, MARRIED, WIDOWED OR DIVORCED. Single

6. DATE OF BIRTH

Oct, 1837
(Month) (Day) (Year)

7. AGE

76 yrs. 0 mos. 0 ds.

IF LESS than 1 day
how many hrs. or mins.

8. OCCUPATION

(a) Trade, profession or particular kind of work Farmer
(b) General nature of industry, business, or establishment in which employed (or employer)

9. BIRTHPLACE

(State or Country) N.Y.

10. NAME OF FATHER

J. Akin.

11. BIRTHPLACE OF FATHER

(State or Country) N.Y.

12. MAIDEN NAME OF MOTHER

Mary Bentley.

13. BIRTHPLACE OF MOTHER

(State or Country) N.Y.

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) W. Akin
(Address) Farmington Neb.

15. Filed June 24 1913 W. Akin
Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH

June 22 1913
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from

June 19 1913, to June 22 1913

that I last saw him alive on June 22 1913

and that death occurred on the date stated above, at 4 A.M.

The CAUSE OF DEATH* was as follows:

Pneumonia. Later

(Duration) 3 yrs. 0 mos. 0 ds.

Contributory
(Secondary)

(Duration) 0 yrs. 0 mos. 0 ds.

(Signed) W. Akin M. D.

June 24 1913 (Address) Idaho Falls

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL OR HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death 3 days at Fuller Hospital

Where was disease contracted if not at place of death? Idaho

Former or usual residence Idaho

19. PLACE OF BURIAL OR REMOVAL DATE OF BURIAL

Blackfoot Id. June 1913

20. UNDERTAKER

ADDRESS

C. J. Sweeney Idaho Falls, Id.

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics
File No. 5332
Registered No. 47
If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

1. PLACE OF DEATH. Registration District No. 7
County of Bernier Primary Registration District No. 7027
City of Idaho Falls (No. , St.)
If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Eustof Schuitz

PERSONAL AND STATISTICAL PARTICULARS

3. SEX Male 4. COLOR OR RACE White 5. SINGLE, MARRIED, WIDOWED OR DIVORCED. Single
(Write the word.)

6. DATE OF BIRTH ?
(Month) (Day) (Year)

7. AGE about 30 years
yrs. mos. ds. IF LESS than 1 day how many hrs. or mins.?

8. OCCUPATION Farm Land
(a) Trade, profession or particular kind of work
(b) General nature of industry business, or establishment in which employed (or employer)

9. BIRTHPLACE (State or Country) Idaho

10. NAME OF FATHER

11. BIRTHPLACE OF FATHER (State or Country) Idaho

12. MAIDEN NAME OF MOTHER

13. BIRTHPLACE OF MOTHER (State or Country) Idaho

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) B. E. Diuwoodey
(Address) Idaho Falls

15. Filed June 27 1913 W. J. [unclear]
Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH June 23 1913
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from June 22 1913, to June 23 1913, that I last saw him alive on June 22 1913, and that death occurred on the date stated above, at 6 a.m.

The CAUSE OF DEATH* was as follows:
Pneumonia from following gastric intestinal obstruction

(Duration) yrs. mos. 4 ds.

Contributory (Secondary)

(Duration) yrs. mos. ds.

(Signed) W. J. [unclear] M. D.

4/27 1913 (Address) Idaho Falls, Idaho

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death.....yrs.....mos.....days. In the State.....yrs.....mos.....days.

Where was disease contracted if not at place of death?.....

Former or usual residence.....

19. PLACE OF BURIAL OR REMOVAL Idaho Falls DATE OF BURIAL 6/27 1913

20. UNDERTAKER B. E. Diuwoodey ADDRESS Idaho Falls

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Form V. S. No. 5 20M.1-16-12

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics
File No. 5333
Registered No. 41
If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

1. PLACE OF DEATH. Registration District No. 7
County of Bonneville Primary Registration District No. 2027
City of Eagle Lake (No. St.)
If death occurs away from usual residence, give facts called for under special information. 2. FULL NAME John F White

PERSONAL AND STATISTICAL PARTICULARS

3. SEX Male 4. COLOR OR RACE White 5. SINGLE, MARRIED, WIDOWED OR DIVORCED Married (Write the word.)
6. DATE OF BIRTH March 31 1866 (Month) (Day) (Year)
7. AGE 47 yrs. 2 mos. 25 ds. IF LESS than 1 day how many hrs. or mins?

8. OCCUPATION (a) Trade, profession or particular kind of work Farming (b) General nature of industry, business, or establishment in which employed (or employer)

9. BIRTHPLACE Utah (State or Country)

10. NAME OF FATHER Wm M White

11. BIRTHPLACE OF FATHER Ill (State or Country)

12. MAIDEN NAME OF MOTHER Martha Ann Gray

13. BIRTHPLACE OF MOTHER Ga (State or Country)

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE (Informant) Mrs Orrin Lee (sister) (Address) Leonida Ida

15. Filed June 24 1913 Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH June 25 1913 (Month) (Day) (Year)
17. I HEREBY CERTIFY, That I attended deceased from June 22 1913, to June 25 1913, that I last saw him alive on June 25 1913, and that death occurred on the date stated above, at 10 P. M. The CAUSE OF DEATH* was as follows:

Heus (Duration) yrs. mos. 3 ds.
Contributory (Secondary)
(Duration) yrs. mos. ds.
(Signed) M. D. (Address) Eagle Lake, Idaho

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death yrs. mos. days. In the State yrs. mos. days.
Where was disease contracted if not at place of death?
Former or usual residence

19. PLACE OF BURIAL OR REMOVAL Idaho Falls DATE OF BURIAL 6/29 1913

20. UNDERTAKER B E Dimmwoody ADDRESS Idaho Falls

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Form V. S. No. 5 20M.1-16-12

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH. Registration District No. 7
County of Banner Primary Registration District No. 2027
City of Idaho Falls (No. St.)

File No. 5331Registered No. 49

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Fred Butcher

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX Male 4. COLOR OR RACE White 5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.)

6. DATE OF BIRTH

(Month) (Day) (Year)

7. AGE

... yrs. ... mos. ... ds.

IF LESS than 1 day
how many ... hrs. or
... mins.?

8. OCCUPATION

- (a) Trade, profession or particular kind of work
(b) General nature of industry business, or establishment in which employed (or employer)

9. BIRTHPLACE

(State or Country)

10. NAME OF FATHER

11. BIRTHPLACE OF FATHER

(State or Country)

12. MAIDEN NAME OF MOTHER

13. BIRTHPLACE OF MOTHER

(State or Country)

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

(Address)

15.

Filed June 30 1913 George Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH

(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from June 21, 1913, to June 30, 1913,
that I last saw him alive on June 29, 1913,
and that death occurred on the date stated above, at 5 A. M.

The CAUSE OF DEATH* was as follows:

(Duration) unknown yrs. ... mos. ... ds.
Contributory and Myocarditis
(Secondary)

(Duration) unknown yrs. ... mos. ... ds.
(Signed) John Miller M. D.

6/30 1913 (Address) Idaho Falls

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death ... yrs. ... mos. 7 days. In the State ... yrs. ... mos. ... days.

Where was disease contracted if not at place of death? unknown

Former or usual residence Ohio

19. PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

Idaho Falls 6/30 1913

20. UNDERTAKER

ADDRESS

Idaho Falls Idaho Falls

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Form V. S. No. 5 20M.1-16-12

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH.

Registration District No. 7

County of Bonneville

Primary Registration District No. 2027

City of Idaho Falls

(No. , St.)

File No. 5335

Registered No. 50

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Lucille Empey

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX

Female

4. COLOR OR RACE

White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED.

Child
(Write the word.)

6. DATE OF BIRTH

July 10 1907
(Month) (Day) (Year)

7. AGE

5 yrs. 11 mos. 18 ds.

IF LESS than 1 day
how many hrs. or
mins.?

8. OCCUPATION

(a) Trade, profession or particular kind of work
(b) General nature of industry, business, or establishment in which employed (or employer)

Child

9. BIRTHPLACE

(State or Country)

Idaho

10. NAME OF FATHER

Jos Empey

11. BIRTHPLACE OF FATHER

(State or Country)

Utah

12. MAIDEN NAME OF MOTHER

Christy A Lewis

13. BIRTHPLACE OF MOTHER

(State or Country)

Wales

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

Jos Empey

(Address)

Idaho Falls

15.

Filed

July 1 1913

C. J. Empey

Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

June 29 1913
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from

June 1913, to June 29 1913,
that I last saw him alive on June 29 1913,

and that death occurred on the date stated above, at 3 P.M.

The CAUSE OF DEATH* was as follows:

Acute spinal meningitis

(Duration) yrs. mos. ds.

Contributory
(Secondary)

(Duration) yrs. mos. ds.

(Signed) G. H. Gaultthard M. D.

7/1/1913 (Address) Idaho Falls

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death yrs. mos. days. In the State yrs. mos. days.

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL DATE OF BURIAL

Amman, Ida July 1 1913

20. UNDERTAKER ADDRESS

B. J. Empey Idaho Falls

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Form V. S. No. 5 20M.1-16-12

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH.

Registration District No. 7County of SonnevillePrimary Registration District No. 2027City of Idaho Falls(No. 392, N. Water Ave St.)File No. 5336Registered No. 51

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

William H. Hyde

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX

Male

4. COLOR OR RACE

White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED.

Married

6. DATE OF BIRTH

January 9th 1842
(Month) (Day) (Year)

7. AGE

71 yrs. 5 mos. 20 ds.

IF LESS than 1 day
how many hrs. or
..... mins.

8. OCCUPATION

(a) Trade, profession or particular kind of work

Foreman Lumber Yard

(b) General nature of industry business, or establishment in which employed (or employer)

9. BIRTHPLACE

(State or Country)

Montreal, Canada

10. NAME OF FATHER

William Hyde

11. BIRTHPLACE OF FATHER

(State or Country)

Canada

12. MAIDEN NAME OF MOTHER

Mary Bowman

13. BIRTHPLACE OF MOTHER

(State or Country)

England

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

M. Bowman

(Address)

Idaho Falls, Idaho

15.

Filed

July 2 1913

J. H. Bennett
Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH

June 29th 1913
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from June 28 1913, to June 29 1913, that I last saw him alive on June 29 1913

and that death occurred on the date stated above, at 4:35 M.

The CAUSE OF DEATH* was as follows:

Cardiac arrhythmia

(Duration) yrs. 6 mos. ds.

Contributory
(Secondary)

(Duration) yrs. mos. ds.

(Signed)

H. D. Spencer M. D.6/30/1913(Address) Idaho Falls

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death yrs. mos. days. In the State yrs. mos. days.

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

Idaho FallsJuly 2 1913

20. UNDERTAKER

ADDRESS

J. H. BennettIdaho Falls

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Form V. S. No. 5. 10M. 6-20-11.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH.

Registration District No. 21County of BearPrimary Registration District No. 7022City of Hailey

(No. _____, St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

Wong SueFile No. 5337Registered No. 18

If death occurred in a hospital, institution or camp give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX

Male

4. COLOR OR RACE

yellow

5. SINGLE, MARRIED, WIDOWED OR DIVORCED.

married
(Write the word.)

6. DATE OF BIRTH

1858
(Month) (Day) (Year)

7. AGE

55 yrs.

mos.

ds.

IF LESS than 1 day
how many hrs. or
min.?

8. OCCUPATION

- (a) Trade, profession or particular kind of work
(b) General nature of industry business or establishment in which employed (or employer)

Gardener

9. BIRTHPLACE

(State or Country)

China

10. NAME OF FATHER

11. BIRTHPLACE OF FATHER

(State or Country)

12. MAIDEN NAME OF MOTHER

13. BIRTHPLACE OF MOTHER

(State or Country)

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

Jim Sue

(Address)

Hailey

15.

Filed

June 20 1913

Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

June 19 1913
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from

June 19 1913
that I last saw h. alive on June 19 1913
and that death occurred on the date stated above, at 7 P.M.

The CAUSE OF DEATH* was as follows:

Tuberculosis
No Physician

(Duration) _____ yrs. _____ mos. _____ ds.

Contributory
(Secondary)

(Duration) _____ yrs. _____ mos. _____ ds.

(Signed) J. Shroyer M. D.
June 19 1913 (Address) Hailey, Ida

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place _____ In the _____
of death _____ yrs. _____ mos. _____ ds. State _____ yrs. _____ mos. _____ ds.

Where was disease contracted,

If not at place of death?

Former or

usual residence.

19. PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

Hailey, IdaJune 20 1913

20. UNDERTAKER

ADDRESS

W. D. HarrisHailey, Ida

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Form V. S. No. 5. 10M. 6-20-11.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH.

Registration District No. 21

County of Blaine

Primary Registration District No. 2022

City of Hailey

(No. _____ St.)

Registered No. 27

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

Barney R. Cook

If death occurred in a hospital, institution or camp give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX

male

4. COLOR OR RACE

white

5. SINGLE, MARRIED, WIDOWED OR DIVORCED.

Single
(Write the word.)

6. DATE OF BIRTH

Sep

16

1885

(Month)

(Day)

(Year)

7. AGE

27 yrs. 9 mos. 10 ds.

IF LESS than 1 day
how many hrs. or
..... min.?

8. OCCUPATION

- (a) Trade, profession or particular kind of work
(b) General nature of industrial business or establishment in which employed (or employer)

farmer

9. BIRTHPLACE

(State or Country)

Idaho

10. NAME OF FATHER

S. C. Cook

11. BIRTHPLACE OF FATHER

(State or Country)

Idaho

12. MAIDEN NAME OF MOTHER

Alfreda Lowe

13. BIRTHPLACE OF MOTHER

(State or Country)

Idaho

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

S. C. Cook

(Address)

Richfield Idaho

15.

Filed

June 30 1913

Robert H. Wright

Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

June

26

1913

(Month)

(Day)

(Year)

17. I HEREBY CERTIFY, That I attended deceased from June 12 1913, to June 26 1913 that I last saw him alive on June 26 1913, and that death occurred on the date stated above, at 11-0 M.

The CAUSE OF DEATH* was as follows:

Typhoid fever

(Duration) yrs. mos. ds.

Contributory
(Secondary)

(Duration) yrs. mos. ds.

(Signed) John J. Raaf M. D.

June 27 1913 (Address) Hailey

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death yrs. mos. ds. State yrs. mos. ds.

Where was disease contracted,

If not at place of death?

Former or

usual residence.

19. PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

Hailey Ida

June 28 1913

20. UNDERTAKER

ADDRESS

R. D. Harris

Hailey Ida

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. PHYSI-
 CANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact state-
 ment of OCCUPATION is very important. See instructions on back of certificate.

Form V. S. No. 5. 10M. 6-20-11.

CERTIFICATE OF DEATH

 State of Idaho
 BOARD OF HEALTH
 Bureau of Vital Statistics

1. PLACE OF DEATH.

Registration District No. 21County of BlainePrimary Registration District No. 2022City of Hailey

(No. _____, _____ St.)

File No. 5339Registered No. 26

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

Jacob Kauffman

If death occurred in a hospital, institution or camp give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX

Male4. COLOR OR RACE 5. SINGLE, MARRIED, WID-
OWED OR DIVORCED.WhiteSingle
(Write the word.)

6. DATE OF BIRTH

(Month)

(Day)

1
(Year)

7. AGE

63

yrs.

mos.

ds.

 IF LESS than 1 day
 how many hrs. or
 min. ?

8. OCCUPATION

(a) Trade, profession or particular kind of work

(b) General nature of industry business or establishment in which employed (or employer)

Miner

9. BIRTHPLACE

(State or Country)

Germany

10. NAME OF FATHER

11. BIRTHPLACE OF FATHER

(State or Country)

12. MAIDEN NAME OF MOTHER

13. BIRTHPLACE OF MOTHER

(State or Country)

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

Jos Anderson

(Address)

Kelchum

15.

Filed

June 12 1913

Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

(Month)

10
(Day)1913
(Year)

17. I HEREBY CERTIFY, That I attended deceased from

191

to

191

that I last saw h _____ alive on _____ 191

and that death occurred on the date stated above, at _____ M.

The CAUSE OF DEATH* was as follows:

Shock from fall
head in rock

(Duration) yrs. mos. ds.

Contributory
(Secondary)

(Duration) yrs. mos. ds.

(Signed)

June 12, 1913

(Address)

Hailey, Idaho

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place

In the

of death yrs. mos. ds. State yrs. mos. ds.

Where was disease contracted,

If not at place of death?

Former or

usual residence

19. PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

Kelchum, IdahoJune 12, 1913

20. UNDERTAKER

ADDRESS

R. D. HarrisHailey

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Form V. S. No. 5 20M.1-16-12

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH.

Registration District No. 16County of LatahPrimary Registration District No. 1009City of Leidy(No. Hopital St.)File No. 531Registered No. 64

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

Lella Woodworth

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX

F

4. COLOR OR RACE

W

5. SINGLE, MARRIED, WIDOWED OR DIVORCED.

Single
(Write the word.)

6. DATE OF BIRTH

1
(Month) (Day) (Year)

7. AGE

9 yrs. 6 mos. 8 ds.IF LESS than 1 day
how many hrs. or
..... mins.?

8. OCCUPATION

(a) Trade, profession or particular kind of work

school girl

(b) General nature of industry business, or establishment in which employed (or employer)

9. BIRTHPLACE

(State or Country)

Ferdinand Id.

10. NAME OF FATHER

A. D. Woodworth

11. BIRTHPLACE OF FATHER

(State or Country)

N. Y.

12. MAIDEN NAME OF MOTHER

Kora. Klutso

13. BIRTHPLACE OF MOTHER

(State or Country)

N. D.

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

A. D. Woodworth

(Address)

Ferdinand Idaho

15.

Filed

July 101913L. J. Perkins

Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH

June 2 1913
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from

May 25 1913 to June 2 1913,that I last saw h. m. alive on June 2 1913,and that death occurred on the date stated above, at 1046 M.

The CAUSE OF DEATH* was as follows:

Mitral insufficiency(Duration) yrs. 6 mos. ds.Contributory
(Secondary)(Duration) yrs. ds.

(Signed)

G. P. Brown M. D.

19

(Address)

Leidy Idaho

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death.....yrs.....mos.....days. In the State.....yrs.....mos.....days.

Where was disease contracted if not at place of death?

Former or usual residence.....

19. PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

FerdinandJune 1913

20. UNDERTAKER

ADDRESS

L. J. PerkinsLeidy

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Form V. S. No. 5 20M.1-16-12

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics
File No. 3311

1. PLACE OF DEATH. Registration District No. 16
County of Nez Perce Primary Registration District No. 1009
City of L. E. Smith (No. St.)

Registered No. 63

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

Marquet C. Smith

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX F 4. COLOR OR RACE W. 5. SINGLE, MARRIED, WIDOWED OR DIVORCED. Divorced (Write the word.)

6. DATE OF BIRTH March 20 1913 (Month) (Day) (Year)

7. AGE 62 yrs. 2 mos. 10 ds. IF LESS than 1 day how many hrs. or mins.?

8. OCCUPATION

(a) Trade, profession or particular kind of work Housewife
(b) General nature of industry business, or establishment in which employed (or employer)

9. BIRTHPLACE

(State or Country) Ind.

10. NAME OF FATHER

Hargue

11. BIRTHPLACE OF FATHER

(State or Country) Not known

12. MAIDEN NAME OF MOTHER

13. BIRTHPLACE OF MOTHER

(State or Country)

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) H. L. Smith
(Address) Orofino

15. Filed July 10 1913 L. J. Perkins Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

June 10 1913 (Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from June 7 1913, to June 10 1913, that I last saw her alive on June 10 1913, and that death occurred on the date stated above, at 2:00 P.M.

The CAUSE OF DEATH* was as follows:

Myocardial degeneration of supracardiac type

(Duration) yrs. mos. ds. Contributory cause of death (Secondary)

(Signed) J. H. Hurling M. D. (Address) Orofino

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death... yrs. mos. 4 days. In the State... yrs. mos. days.

Where was disease contracted if not at place of death?

Former or usual residence. Orofino, Ida.

19. PLACE OF BURIAL OR REMOVAL DATE OF BURIAL

To Orofino June 11 1913

20. UNDERTAKER ADDRESS

C. J. Vassar Lewiston

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Form V. S. No. 5. 12½ M. 7-24-11

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH. Registration District No. 16
County of Nagle Primary Registration District No. 1009
City of Leicester (No. _____, _____ St.)

File No. 5342
Registered No. 66

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

Gwendolyn Beasley

If death occurred in a hospital, institution or camp give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX Female 4. COLOR OR RACE white 5. SINGLE, MARRIED, WIDOWED OR DIVORCED.

(Write the word.)

6. DATE OF BIRTH October twenty-eight 1908
(Month) (Day) (Year)

7. AGE 4 yrs. 7 mos. 18 ds. IF LESS than 1 day
how many _____ hrs. or _____ min?

8. OCCUPATION

- (a) Trade, profession or particular kind of work
(b) General nature of industry business or establishment in which employed (or employer)

9. BIRTHPLACE

(State or Country) Washington

10. NAME OF FATHER

R. L. Beasley

11. BIRTHPLACE OF FATHER

(State or Country) Idaho

12. MAIDEN NAME OF MOTHER

Zoe Beasley

13. BIRTHPLACE OF MOTHER

(State or Country) Colorado

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Lizzie Harris

(Address) Clarkston Wash.

15.

Filed July 10 1918

R. L. Harris
Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH

June 13 1918
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from

June 11 1918, to June 13 1918

that I last saw her alive on June 13 1918

and that death occurred on the date stated above, at 10 A. M.

The CAUSE OF DEATH* was as follows:

Appendicitis

(Duration) _____ yrs. _____ mos. 9 ds.

Contributory Operation
(Secondary)

(Duration) _____ yrs. _____ mos. _____ ds.

(Signed) Paul W. Johnson M. D.

June 14 1918 (Address) Clarkston Wash.

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place _____ In the _____
of death _____ yrs. _____ mos. 2 ds. State _____ yrs. _____ mos. 2 ds.

Where was disease contracted, Clarkston Wash.
If not at place of death?
Former or Clarkston Wash.
usual residence.

19. PLACE OF BURIAL OR REMOVAL DATE OF BURIAL

Clarkston Wash. June 15 1918

20. UNDERTAKER

ADDRESS

R. J. Vassar

Clarkston

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Form V. S. No. 5 20M.1-16-12

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH.

Registration District No. 16County of Noz PricePrimary Registration District No. 1009City of Lewiston(No. 1st Ave - 5th St.)File No. 5342Registered No. 67

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

Martin Alexander Barber

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX

M

4. COLOR OR RACE

W

5. SINGLE, MARRIED, WIDOWED OR DIVORCED.

Widow
(Write the word.)

6. DATE OF BIRTH

March 11 1912
(Month) (Day) (Year)

7. AGE

91 yrs. 3 mos. 14 ds.

IF LESS than 1 day
how many hrs. or
mins.?

8. OCCUPATION

(a) Trade, profession or particular kind of work

retired

(b) General nature of industry business, or establishment in which employed (or employer)

9. BIRTHPLACE

(State or Country)

North Carolina

10. NAME OF FATHER

Levi Barber

11. BIRTHPLACE OF FATHER

(State or Country)

North Carolina

12. MAIDEN NAME OF MOTHER

Martha Lagason

13. BIRTHPLACE OF MOTHER

(State or Country)

not known

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

Norman P. Fuller

(Address)

15.

Filed July 10 1913L. J. Perkins

Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH

June 23 1913
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from

June 21 1913, to June 23 1913,
that I last saw him alive on June 23 1913,
and that death occurred on the date stated above, at 80 M.

The CAUSE OF DEATH* was as follows:

Exhaustion following
bronchitis

(Duration) yrs. mos. 5 ds.Contributory
(Secondary)Bronchitis(Duration) yrs. mos. 1 ds.

(Signed)

C. W. Shaff M. D.19. (Address) Lewiston

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death yrs. mos. days. In the State yrs. mos. days.

Where was disease contracted
if not at place of death?

Former or
usual residence

19. PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

Lewiston IdaJune 27 1913

20. UNDERTAKER

ADDRESS

C. G. VassarLewiston

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Form V. S. No. 5 20M.1-16-12

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH.

Registration District No. 16County of Nez PercePrimary Registration District No. 1009City of Lewiston(No. 1811, Snake River Ave St.)File No. 5341Registered No. 68

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

H. E. Ahlman

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX

M.

4. COLOR OR RACE

W.

5. SINGLE, MARRIED, WIDOWED OR DIVORCED.

Widow
(Write the word.)

6. DATE OF BIRTH

Jan - 28 - 1852
(Month) (Day) (Year)

7. AGE

31 yrs. 5 mos. 9 ds.

IF LESS than 1 day
how many hrs. or
..... mins.?

8. OCCUPATION

(a) Trade, profession or
particular kind of work

Contractor

(b) General nature of industry
business, or establishment in
which employed (or employer)

9. BIRTHPLACE

(State or Country)

N. Y.

10. NAME OF FATHER

A. Ahlman

11. BIRTHPLACE OF FATHER

(State or Country)

N. Y.

12. MAIDEN NAME OF MOTHER

S. Piney

13. BIRTHPLACE OF MOTHER

(State or Country)

N. Y.

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

A. R. Ahlman

(Address)

2202 7 av city

15.

Filed July 10 1913L. J. Perkins

Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH

June 28 1913
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from

May 6 1913, to June 28 1913,

that I last saw him alive on June 28 1913,

and that death occurred on the date stated above, at 10 AM.

The CAUSE OF DEATH* was as follows:

Endocarditis

(Duration) 18 yrs. mos. ds.

Contributory
(Secondary)

Rheumatism

(Duration) yrs. mos. ds.

(Signed)

C. Saussey

M. D.

6/28/13 (Address) Lewiston

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death yrs. mos. days. In the State yrs. mos. days.

Where was disease contracted
if not at place of death?

Former or
usual residence

19. PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

Lewiston29th 1913

20. UNDERTAKER

ADDRESS

C. J. VassarLewiston

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Form V. S. No. 5. 12½ M. 7-24-11

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH
County of Clearwater
City of Orfino

Registration District No. 17
Primary Registration District No. 2074
(No. _____, _____ St.)

File No. 5345
Registered No. 26

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

Sora Olney

If death occurred in a hospital, institution or camp give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX 4. COLOR OR RACE 5. SINGLE, MARRIED, WIDOWED OR DIVORCED.

Female White

Married
(Write the word.)

6. DATE OF BIRTH

June 11 1913
(Month) (Day) (Year)

7. AGE

31 yrs. _____ mos. _____ ds.

IF LESS than 1 day
how many _____ hrs. or
_____ min?

8. OCCUPATION

- (a) Trade, profession or particular kind of work
(b) General nature of industry business or establishment in which employed (or employer)

House wife

9. BIRTHPLACE

(State or Country)

9

10. NAME OF FATHER

9

11. BIRTHPLACE OF FATHER

(State or Country)

9

12. MAIDEN NAME OF MOTHER

9

13. BIRTHPLACE OF MOTHER

(State or Country)

9

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

(Address)

Geo. H. H. H.
Orfino, Ida

15.

Filed

July 1 1913

J. M. Fairly
Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH

June 11 1913
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from July 15 1908, to June 11 1913

that I last saw h.e. alive on June 11 1913

and that death occurred on the date stated above, at 50 M.

The CAUSE OF DEATH* was as follows:

Organic heart disease
Insanity

(Duration) 5 yrs. _____ mos. _____ ds.

Contributory

(Secondary)

(Duration) 5 yrs. _____ mos. _____ ds.

(Signed)

June 11 1913 (Address) Orfino, Idaho

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place

In the

of death _____ yrs. _____ mos. _____ ds. State _____ yrs. _____ mos. _____ ds.

Where was disease contracted?

If not at place of death?

Former or

usual residence.

19. PLACE OF BURIAL OR REMOVAL DATE OF BURIAL

Julia H. H. H. June 13 1913

20. UNDERTAKER

ADDRESS

W. H. H. H. Orfino

Form V. S. No. 5. 12½ M. 7-24-11

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics
File No. 531
Registered No. 28

1. PLACE OF DEATH.
County of Clearwater
City of Orford

Registration District No. 17
Primary Registration District No. 2078
(No. _____ St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

Phoebe K. Beck

If death occurred in a hospital, institution or camp give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX Female 4. COLOR OR RACE White 5. SINGLE, MARRIED, WIDOWED OR DIVORCED. Single
(Write the word.)

6. DATE OF BIRTH Dec 26 1892
(Month) (Day) (Year)

7. AGE 20 yrs. 5 mos. 28 ds. IF LESS than 1 day how many.....hrs. or.....min?

8. OCCUPATION

(a) Trade, profession or particular kind of work.....
(b) General nature of industry business or establishment in which employed (or employer).....

None

9. BIRTHPLACE

(State or Country)

Wisconsin

10. NAME OF FATHER

Peter G. Beck

11. BIRTHPLACE OF FATHER

(State or Country)

Norway

12. MAIDEN NAME OF MOTHER

Maria Johnston

13. BIRTHPLACE OF MOTHER

(State or Country)

Norway

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

Peter G. Beck

(Address)

Moscow

15.

Filed July 1 1913 J. J. Fairley
Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH

June 23rd 1913
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from Sept-27 1910, to June 23 1913 that I last saw her alive on June 23 1913 and that death occurred on the date stated above, at 6:30 P.

The CAUSE OF DEATH* was as follows:

Inanition

(Duration) _____ yrs. _____ mos. 23 ds.
Contributory Insanity
(Secondary)

(Duration) 2 yrs. 8 mos. 26 ds.
(Signed) John W. Sirens M. D.
June 24 1913 (Address) Orford, Idaho

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; (2) whether ACCIDENTAL, SUICIDAL OR HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death 2 yrs. 6 mos. 26 ds. In the 13 yrs. _____ mos. _____ ds.
Where was disease contracted,
If not at place of death?
Former or usual residence Latah County, Ida.

19. PLACE OF BURIAL OR REMOVAL DATE OF BURIAL

Moscow Idaho June 25 1913

20. UNDERTAKER ADDRESS

H. C. Suddard Orford Idaho

Form V. S. No. 5. 12½ M. 7-24-11

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics
File No. **5348**
Registered No. **89**

1. **PLACE OF DEATH**
County of Latah
City of Moscow
Registration District No. 15
Primary Registration District No. 1008
(No. _____, _____ St.)

If death occurs away from usual residence, give facts called for under special information.

2. **FULL NAME** Armintha A. Hawks

If death occurred in a hospital, institution or camp give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. **SEX** Female 4. **COLOR OR RACE** White 5. **SINGLE, MARRIED, WIDOWED OR DIVORCED.** Married
(Write the word.)

6. **DATE OF BIRTH** June 18 1888
(Month) (Day) (Year)

7. **AGE** 25 yrs. 2 mos. 2 ds.
IF LESS than 1 day
how many _____ hrs. or
_____ min?

8. **OCCUPATION**

(a) Trade, profession or particular kind of work. House wife
(b) General nature of industry business or establishment in which employed (or employer)

9. **BIRTHPLACE**

(State or Country) Nebr.

10. **NAME OF FATHER**

Wm F. Dennis

11. **BIRTHPLACE OF FATHER**

(State or Country)

12. **MAIDEN NAME OF MOTHER**

Laura Mullins

13. **BIRTHPLACE OF MOTHER**

(State or Country) Iowa

14. **THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE**

(Informant) Frank Hawks

(Address) Moscow

15.

Filed June 21 1913

J. F. Rao
Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. **DATE OF DEATH**

June 20 1913
(Month) (Day) (Year)

17. **I HEREBY CERTIFY, That I attended deceased from**

June 5 1913 to June 20 1913
that I last saw her alive on June 17 1913

and that death occurred on the date stated above, at _____ M.

The CAUSE OF DEATH* was as follows:

Poisoned by Corrasive
Sublimated Soda

(Duration) _____ yrs. _____ mos. 17 ds.

Contributory
(Secondary)

(Duration) _____ yrs. _____ mos. _____ ds.

(Signed) J. M. Clarke, J. C. Lewis, M. D.

June 20 1913 (Address) Moscow, Idaho

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. **LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)**

At place _____ In the _____
of death _____ yrs. _____ mos. _____ ds. State _____ yrs. _____ mos. _____ ds.

Where was disease contracted,

If not at place of death?

Former or

usual residence.

19. **PLACE OF BURIAL OR REMOVAL**

Moscow

DATE OF BURIAL

June 24 1913

20. **UNDERTAKER**

E. J. Stutz

ADDRESS

Moscow

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Form V. S. No. 5 20M.1-16-12

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH.

Registration District No. 15County of LatahPrimary Registration District No. 1008City of Moscow

(No. _____, St.)

File No. 534Registered No. 88

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

Carl Oscar Gabrielsen

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX

M

4. COLOR OR RACE

White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED.

Single
(Write the word.)

6. DATE OF BIRTH

August 24 1912
(Month) (Day) (Year)

7. AGE

9 yrs. 9 mos. 28 ds.IF LESS than 1 day
how many hrs. or
..... mins.?

8. OCCUPATION

- (a) Trade, profession or particular kind of work
(b) General nature of industry business, or establishment in which employed (or employer)

9. BIRTHPLACE

(State or Country)

Winchester, Ida.

10. NAME OF FATHER

Andrew Gabrielsen

11. BIRTHPLACE OF FATHER

(State or Country)

Sweden

12. MAIDEN NAME OF MOTHER

Ida Kungzli

13. BIRTHPLACE OF MOTHER

(State or Country)

Wisconsin

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Andrew Gabrielsen(Address) Winchester Idaho

15.

Filed June 22 1913S. F. Ror
Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH

June 22 1913
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from

June 17 1913, to June 22 1913
that I last saw him alive on June 22 1913and that death occurred on the date stated above, at 8 A.M.

The CAUSE OF DEATH* was as follows:

Intussusception(Duration) yrs. mos. 8 ds.Contributory
(Secondary)

(Duration) yrs. mos. ds.

(Signed) Chas. L. Gittinger M. D.1913 (Address) Moscow, Ida.

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death yrs. mos. days. In the State yrs. mos. days.

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL

Palouse Wash

DATE OF BURIAL

June 23 1913

20. UNDERTAKER

E. Anderson

ADDRESS

Palouse

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Form V. S. No. 5. 12½ M. 7-24-11

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics
File No. 535
Registered No. 87

1. PLACE OF DEATH. Registration District No. 15
County of Latah Primary Registration District No. 1006
City of Moscow (No. _____, St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

Judith C. Sturdevant

If death occurred in a hospital, institution or camp give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX Female 4. COLOR OR RACE White 5. SINGLE, MARRIED, WIDOWED OR DIVORCED. Widowed (Write the word.)

6. DATE OF BIRTH May 3 1854
(Month) (Day) (Year)

7. AGE 59 yrs. 1 mos. 1 ds. IF LESS than 1 day how many _____ hrs. or _____ min?

8. OCCUPATION

(a) Trade, profession or particular kind of work.
(b) General nature of industry business or establishment in which employed (or employer)

Retired

9. BIRTHPLACE

(State or Country)

Arkansas

10. NAME OF FATHER

Thomas Selby

11. BIRTHPLACE OF FATHER

(State or Country)

Kentucky

12. MAIDEN NAME OF MOTHER

Mary C. Moody

13. BIRTHPLACE OF MOTHER

(State or Country)

N. C. Carolina

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

(Address)

J. C. Sturdevant
Moscow Ida.

15.

Filed June 6 1913

F. R. R.

Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

June 4 1913
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from May 24 1913, to June 4 1913, that I last saw her alive on June 4 1913, and that death occurred on the date stated above, at 12 M.

THE CAUSE OF DEATH* was as follows:

Pneumonia

(Duration) _____ yrs. _____ mos. 10 ds.

Contributory (Secondary)

(Duration) _____ yrs. _____ mos. _____ ds.

(Signed) J. H. Clarke M. D.

June 5 1913 (Address)

State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place _____ In the _____
of death _____ yrs. _____ mos. _____ ds. State _____ yrs. _____ mos. _____ ds.

Where was disease contracted,

If not at place of death?

Former or

usual residence.

19. PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

Moscow

June 6 1913

20. UNDERTAKER

ADDRESS

Geo. Slitz

Moscow

-SUPPLEMENTARY DEATH CERTIFICATE-

(Please reply on this sheet to
the registrar of Vital Statistics)

Death Certificate No.

Name..... Juletta Sturdevant

Date of Death..... June 4, 1913.

Cause of Death..... *Tubercular Pneumonia*

Contributory Cause of death.....

(Sign here) *J. N. Clarke* M.D.

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Form V. S. No. 5. 12½ M. 7-24-11

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics
File No. 5351
Registered No. 90

1. PLACE OF DEATH. Registration District No. 15
County of Latah Primary Registration District No. 1008
City of Idaho Moscow (No. , St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Franklin Marion Johnson

If death occurred in a hospital, institution or camp give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX 4. COLOR OR RACE 5. SINGLE, MARRIED, WIDOWED OR DIVORCED.

Male White Married (Write the word.)

6. DATE OF BIRTH Dec 16 1855
(Month) (Day) (Year)

7. AGE 57 yrs. 5 mos. 2 ds. IF LESS than 1 day how many hrs. or min?

8. OCCUPATION (a) Trade, profession or particular kind of work Retired Farmer
(b) General nature of industry business or establishment in which employed (or employer)

9. BIRTHPLACE (State or Country) Marion Co. Oregon

10. NAME OF FATHER Hiram A Johnson

11. BIRTHPLACE OF FATHER New York
(State or Country)

12. MAIDEN NAME OF MOTHER Elizabeth Whitley

13. BIRTHPLACE OF MOTHER Illinois
(State or Country)

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE (Informant) Herbert D Johnson
(Address) Troy Ida.

15. June 19 1913 T. F. Roe
Filed Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH June 18 1913
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from May 5 1913, to June 18 1913
that I last saw him alive on June 18 1913
and that death occurred on the date stated above, at 8:30 P.M.

The CAUSE OF DEATH* was as follows:

central hemorrhage

(Duration) yrs. mos. ds.

Contributory arteriosclerosis
(Secondary)

(Duration) yrs. mos. ds.

(Signed) Chas. S. Gutfinger, M. D.
June 21 1913 (Address) Moscow, Ida.

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place In the
of death yrs. mos. ds. State yrs. mos. ds.

Where was disease contracted,
If not at place of death?

Former or
usual residence.

19. PLACE OF BURIAL OR REMOVAL DATE OF BURIAL

Moscow June 21 1913

20. UNDERTAKER ADDRESS

Geo. Seely Moscow

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Form V. S. No. 5. 12½M.7-24-11

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics
File No. 5359
Registered No. 92

1. PLACE OF DEATH
County of Salt Lake
City of Moscow

Registration District No. 15
Primary Registration District No. 1008
(No. _____ St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

Moley, C. Foster

If death occurred in a hospital, institution or camp give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX

4. COLOR OR RACE

5. SINGLE, MARRIED, WIDOWED OR DIVORCED.

White

Married
(Write the word.)

6. DATE OF BIRTH

June 16 1894
(Month) (Day) (Year)

7. AGE

69 yrs. 4 mos. 4 ds.

IF LESS than 1 day
how many.....hrs. or
.....min?

8. OCCUPATION

(a) Trade, profession or particular kind of work.
(b) General nature of industry business or establishment in which employed (or employer)

House Wife

9. BIRTHPLACE

(State or Country)

Kentucky

10. NAME OF FATHER

William Cary

11. BIRTHPLACE OF FATHER

(State or Country)

Moscow Idaho

12. MAIDEN NAME OF MOTHER

13. BIRTHPLACE OF MOTHER

(State or Country)

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

J. H. Lumpkin
(Address) Moscow Idaho

15.

Filed June 20 1913

S. F. Bar
Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH

June 20 1913
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from June 1 1913, to June 20 1913
that I last saw h.e.x. alive on June 10 1913
and that death occurred on the date stated above, at 2 P.M.

The CAUSE OF DEATH* was as follows:

Nephritis & Endocarditis

(Duration) 1 yrs. _____ mos. _____ ds.

Contributory
(Secondary)

(Duration) _____ yrs. _____ mos. _____ ds.

(Signed) Joseph Aspray M. D.
June 20 1913 (Address) Moscow Idaho

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place In the
of death.....yrs.....mos.....ds. State.....yrs.....mos.....ds.
Where was disease contracted,
If not at place of death?
Former or
usual residence.

19. PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

Moscow

June 21 1913

20. UNDERTAKER

ADDRESS

Geo. Smith

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Form V. S. No. 5. 12½ M. 7-24-11

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH

Registration District No. 15

County of Las Alamos

Primary Registration District No. 1008

City of Moscow

(No. _____ St.)

File No. 5353

Registered No. 94

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

Charles Howard Callman

If death occurred in a hospital, institution or camp give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

MEDICAL CERTIFICATE OF DEATH

3. SEX

4. COLOR OR RACE

5. SINGLE, MARRIED, WIDOWED OR DIVORCED.

MaleWhite

(Write the word.)

6. DATE OF BIRTH

Jan. 301913

(Month)

(Day)

(Year)

7. AGE

4 yrs. 22 mos. 22 ds.

IF LESS than 1 day
how many hrs. or
..... min?

8. OCCUPATION

- (a) Trade, profession or particular kind of work.....
(b) General nature of industry business or establishment in which employed (or employer)

9. BIRTHPLACE

(State or Country)

Idaho

10. NAME OF FATHER

C. F. Callman

11. BIRTHPLACE OF FATHER

(State or Country)

Idaho

12. MAIDEN NAME OF MOTHER

Agnes Delisha

13. BIRTHPLACE OF MOTHER

(State or Country)

Minnesota

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

S. F. Bar

(Address)

Oshtemo

15.

Filed June 24 1913S. F. Bar

Local Registrar

16. DATE OF DEATH

June 22

(Month)

(Day)

1913 (Year)

17. I HEREBY CERTIFY, That I attended deceased from

June 20 1913, to June 22 1913that I last saw him alive on June 21 1913and that death occurred on the date stated above, at 10 P. M.

The CAUSE OF DEATH* was as follows:

Pneumonia

(Duration) yrs. mos. ds.

Contributory Catarrhal Enteritis

(Secondary)

(Duration) yrs. mos. ds.

(Signed) J. B. Wick M. D.June 19 1913 (Address) Moscow, Idaho

State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place In the

of death yrs. mos. ds. State yrs. mos. ds.

Where was disease contracted,

If not at place of death?

Former or

usual residence.

19. PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

MoscowJune 24 1913

20. UNDERTAKER

ADDRESS

Geo. SteigMoscow

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
N. B.—Every item of information should be carefully supplied. AGE should be stated. EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Form V. S. No. 5. 12½ M. 7-24-11

CERTIFICATE OF DEATH

1. PLACE OF DEATH
County of Latah
City of Moscow
Registration District No. 15
Primary Registration District No. 2062
(No., St.)

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics
File No. 5351
Registered No. 93

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

See Weber

If death occurred in a hospital, institution or camp give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX Male 4. COLOR OR RACE White 5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.)

6. DATE OF BIRTH Dec (Month) 1 (Day) 1913 (Year)

7. AGE 18 yrs. 8 mos. ds. IF LESS than 1 day how many hrs. or min?

8. OCCUPATION

- (a) Trade, profession or particular kind of work
(b) General nature of industry business or establishment in which employed (or employer)

9. BIRTHPLACE (State or Country) Clarksston Wash

10. NAME OF FATHER H. J. Weber

11. BIRTHPLACE OF FATHER (State or Country) Wis.

12. MAIDEN NAME OF MOTHER Nellie Painter

13. BIRTHPLACE OF MOTHER (State or Country) Wis.

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Joseph Asprey
(Address) Moscow

15. Filed May 14 1913 S. F. Roe Local Registrar
Per J. H. Clarke County Physician

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH May (Month) 14 (Day) 1913 (Year)

17. I HEREBY CERTIFY, That I attended deceased from May 13 1913, to May 14 1913 that I last saw him alive on May 13 1913 and that death occurred on the date stated above, at 8 A.M.

The CAUSE OF DEATH* was as follows:

Bronchitis & Scarlet fever

..... (Duration) yrs. mos. 6 ds.

Contributory (Secondary)

..... (Duration) yrs. mos. ds.

(Signed) Joseph Asprey M. D.
May 14 1913 (Address) Moscow Ida

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place In the
of death yrs. mos. ds. State yrs. mos. ds.
Where was disease contracted,
If not at place of death?
Former or
usual residence

19. PLACE OF BURIAL OR CREMATION DATE OF BURIAL

Moscow May 14 1913
20. UNDERTAKER Leo J. Stitz ADDRESS Moscow

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Form V. S. No. 5. 12½ M. 7-24-11

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH. Registration District No. 15
County of Idaho Primary Registration District No. 2062
City of Country (No. _____ St.)

File No. 535
Registered No. 91

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Jas Edward Robinson

If death occurred in a hospital, institution or camp give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX Male 4. COLOR OR RACE White 5. SINGLE, MARRIED, WIDOWED OR DIVORCED. single
(Write the word.)

6. DATE OF BIRTH May 30 1913
(Month) (Day) (Year)

7. AGE _____ yrs. _____ mos. 13 ds. IF LESS than 1 day how many _____ hrs. or _____ min?

8. OCCUPATION

- (a) Trade, profession or particular kind of work _____
(b) General nature of industry business or establishment in which employed (or employer) _____

9. BIRTHPLACE Idaho
(State or Country)

10. NAME OF FATHER A W Robinson

11. BIRTHPLACE OF FATHER Illinois
(State or Country)

12. MAIDEN NAME OF MOTHER Cynthia Zimmerman

13. BIRTHPLACE OF MOTHER Illinois
(State or Country)

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) A W Robinson
(Address) Garfield Wash.

15. Filed June 13 1913 R. F. D. 1
S. F. Rar
Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH June 12 1913
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from June 11 1913, to June 11 1913, that I last saw him alive on June 11 1913 and that death occurred on the date stated above, at 130 A.M.

The CAUSE OF DEATH* was as follows:

Patent Foramen Ovale
(Blue Baby)

_____ (Duration) _____ yrs. _____ mos. 12 ds.

Contributory
(Secondary)

_____ (Duration) _____ yrs. _____ mos. _____ ds.

(Signed) Geo T Boyd M. D.
June 12 1913, (Address) Palouse, Ida

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place _____ In the _____
of death _____ yrs. _____ mos. _____ ds. State _____ yrs. _____ mos. _____ ds.
Where was disease contracted,
If not at place of death? _____
Former or
usual residence _____

19. PLACE OF BURIAL OR REMOVAL DATE OF BURIAL

Garfield Wash. June 13 1913

20. UNDERTAKER ADDRESS

F. L. Gwynn Garfield, Wash.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Form V. S. No. 5 20M.1-16-12

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH.

Registration District No. 15

County of IdahoPrimary Registration District No. 2063City of Genesee

(No. _____)

(St. _____)

File No. 535Registered No. 97

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

Rubie Marie Stewart

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX

Female

4. COLOR OR RACE

white

5. SINGLE, MARRIED, WIDOWED OR DIVORCED.

single
(Write the word.)

6. DATE OF BIRTH

Dec11903

(Month)

(Day)

(Year)

7. AGE

9 yrs. 6 mos. 12 ds.IF LESS than 1 day
how many hrs. or
..... mins.?

8. OCCUPATION

(a) Trade, profession or particular kind of work

school girl

(b) General nature of industry, business, or establishment in which employed (or employer)

9. BIRTHPLACE

(State or Country)

Arkansas (Ottawa)

10. NAME OF FATHER

J. F. Stewart

11. BIRTHPLACE OF FATHER

(State or Country)

Ill.

12. MAIDEN NAME OF MOTHER

Minnie E. Foster

13. BIRTHPLACE OF MOTHER

(State or Country)

Ill.

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

J. F. Stewart

(Address)

Genesee Idaho

15.

Filed

June 171913W. Green

Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH

June111913

(Month)

(Day)

(Year)

17. I HEREBY CERTIFY, That I attended deceased from

June 3 1913 to 11 1913that I last saw him alive on June 11 1913and that death occurred on the date stated above, at 2 P.M.

The CAUSE OF DEATH* was as follows:

Surgical Shock

(Duration)

23 hrs

Contributory (Secondary)

Perityphilitis

(Duration)

8 yrs.8 mos.8 ds.

(Signed)

E. J. Green M. D.June 12, 1913 (Address) Genesee Idaho

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death

..... yrs. mos. days.

In the

State..... yrs. mos. days.

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL DATE OF BURIAL

F. E. 100 E. Genesee6/12 1913

20. UNDERTAKER

E. E. Kaubert

ADDRESS

Genesee Idaho

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics
File No. 335
Registered No. 95

1. PLACE OF DEATH. Registration District No. 15
County of Latah Primary Registration District No. 2063
City of Genesee (No. , St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Alice Danouck

If death occurred in a hospital, institution or camp give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX Female 4. COLOR OR RACE White 5. SINGLE, MARRIED, WIDOWED OR DIVORCED.
(Write the word.)

6. DATE OF BIRTH June 26 1913
(Month) (Day) (Year)

7. AGE IF LESS than 1 day how many min? 12 hrs. or
— yrs. — mos. — ds.

8. OCCUPATION (a) Trade, profession or particular kind of work. Infant-
(b) General nature of industry business or establishment in which employed (or employer)

9. BIRTHPLACE Genesee Idaho
(State or Country)

10. NAME OF FATHER Elmer Danouck

11. BIRTHPLACE OF FATHER Michigan
(State or Country)

12. MAIDEN NAME OF MOTHER Rena Wood

13. BIRTHPLACE OF MOTHER Ohio
(State or Country)

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE (Informant) Elmer Danouck
(Address) Genesee Idaho

15. File June 26 1913 1011 Elmer
Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH June 26 1913
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from June 26 1913, to June 26 1913
that I last saw her alive on June 26 1913
and that death occurred on the date stated above, at 11:00 AM

The CAUSE OF DEATH* was as follows:
Premature Birth
(Duration) — yrs. — mos. — ds.

Contributory (Secondary)
(Duration) — yrs. — mos. — ds.

(Signed) J. M. D. June 26 1913 (Address) Genesee Idaho

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place In the
of death — yrs. — mos. — ds. State — yrs. — mos. — ds.

Where was disease contracted,
If not at place of death?
Former or usual residence

19. PLACE OF BURIAL OR REMOVAL DATE OF BURIAL
I.O.O.F. Genesee 6-26 1913

20. UNDERTAKER ADDRESS
E. H. Danouck Genesee

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Form V. S. No. 5. 12½ M. 7-24-11

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH.

Registration District No. 15

County of LatahPrimary Registration District No. 2062City of Genesee

(No. _____ St.)

File No. 335Registered No. 96

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

Helen Farnouck

If death occurred in a hospital, institution or camp give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX

Female

4. COLOR OR RACE

white

5. SINGLE, MARRIED, WIDOWED OR DIVORCED.

(Write the word.)

6. DATE OF BIRTH

June 26 1913
(Month) (Day) (Year)

7. AGE

— yrs. — mos. — ds.

IF LESS than 1 day
how many 1/2 hrs. or
min?

8. OCCUPATION

- (a) Trade, profession or particular kind of work.
(b) General nature of industry business or establishment in which employed (or employer)

Infant -

9. BIRTHPLACE

(State or Country)

Genesee Idaho

10. NAME OF FATHER

Elmer Farnouck

11. BIRTHPLACE OF FATHER

(State or Country)

Michigan

12. MAIDEN NAME OF MOTHER

Ilena Wood

13. BIRTHPLACE OF MOTHER

(State or Country)

Ohio

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

Elmer Farnouck

(Address)

Genesee Idaho

15.

Filed June 26 1913W. E. Farnouck

Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH

June 26 1913
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from

June 26 1913, to June 26 1913that I last saw h. er alive on June 26 1913and that death occurred on the date stated above, at 11 A. M.

The CAUSE OF DEATH* was as follows:

Premature Birth

(Duration) — yrs. — mos. — ds.

Contributory
(Secondary)

(Duration) — yrs. — mos. — ds.

(Signed)

June 26 1913 (Address) Genesee Idaho

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place In the
of death. — yrs. — mos. — ds. State. — yrs. — mos. — ds.

Where was disease contracted,

If not at place of death?

Former or

usual residence.

19. PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

J. O. F. Cemetery - Genesee 6-26 1913

20. UNDERTAKER

ADDRESS

E. A. Farnouck Genesee

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Form V. S. No. 5. 10M. 6-20-11.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics
File No. 5359
Registered No. 72

1. PLACE OF DEATH.

Registration District No. 3County of LanyonPrimary Registration District No. 2005City of Caldwell

(No. _____, _____ St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

James Patton

If death occurred in a hospital, institution or camp give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX

Male

4. COLOR OR RACE 5. SINGLE, MARRIED, WIDOWED OR DIVORCED.

WhiteCaucasianSingle

(Write the word.)

6. DATE OF BIRTH

Don't know

(Month)

(Day)

1 (Year)

7. AGE about21 yrs.

mos.

ds.

IF LESS than 1 day
how many hrs. or
..... min.?

8. OCCUPATION

(a) Trade, profession or
particular kind of work

Cooper

(b) General nature of industry
business or establishment in
which employed (or employer)

9. BIRTHPLACE

(State or Country)

Texas

10. NAME OF FATHER

L. A. Patton

11. BIRTHPLACE OF FATHER

(State or Country)

Texas

12. MAIDEN NAME OF MOTHER

Don't know

13. BIRTHPLACE OF MOTHER

(State or Country)

Don't know

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) W. E. Platt(Address) Caldwell

15.

Filed June 16 1913John S. Meyer

Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

June7

(Month)

(Day)

1913

(Year)

17. I HEREBY CERTIFY, That I attended deceased from

June 31913to June 71913that I last saw him alive on June 7 1913and that death occurred on the date stated above, at 2 P. M.

The CAUSE OF DEATH* was as follows:

Pneumonia(Duration) 3 yrs. 3 mos. 3 ds.

Contributory (Secondary)

Appendicitis(Duration) unknown yrs. unknown mos. unknown ds.

(Signed)

W. E. Johnson M. D.6/16/13

(Address)

Caldwell

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place

In the

of death yrs. mos. ds. State yrs. mos. ds.

Where was disease contracted.

If not at place of death?

Former or

usual residence.

19. PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

Lanyon Hill6/16 1913

20. UNDERTAKER

ADDRESS

Platt RecklessCaldwell

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Form V. S. No. 5 20M.1-16-12

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH.

Registration District No. 3

County of Canyon

Primary Registration District No. 2005

City of Caldwell.

(No.

St.)

File No. 536

Registered No. 73

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

A. E. Lewis

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX

M

4. COLOR OR RACE

W.

5. SINGLE, MARRIED, WIDOWED OR DIVORCED.

married
(Write the word.)

6. DATE OF BIRTH

Aug

4

1858

(Month)

(Day)

(Year)

7. AGE

24 yrs. 10 mos. 4 ds.

IF LESS than 1 day
how many hrs. or
mins.?

8. OCCUPATION

(a) Trade, profession or particular kind of work

Farmer

(b) General nature of industry business, or establishment in which employed (or employer)

9. BIRTHPLACE

(State or Country)

Wisconsin

10. NAME OF FATHER

Leroy Lewis

11. BIRTHPLACE OF FATHER.

(State or Country)

N. Y.

12. MAIDEN NAME OF MOTHER

Rosna Curtis

13. BIRTHPLACE OF MOTHER

(State or Country)

N. Y.

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

Mrs. A. E. Lewis

(Address)

Caldwell.

15.

Filed

June 10 -

1913

Johd. Meyer

Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH

June

8

1913

(Month)

(Day)

(Year)

17. I HEREBY CERTIFY, That I attended deceased from

June, 7th 1913, to June 8th 1913,

that I last saw him alive on June 8th 1913,

and that death occurred on the date stated above, at 9 P. M.

The CAUSE OF DEATH* was as follows:

Accidental Gun shot wound.

(Duration)

yrs.

mos.

1

ds.

Contributory (Secondary)

Negative

(Duration)

yrs.

mos.

0

ds.

(Signed)

W. B. Dyer

(Address) Caldwell, Ida.

State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death

yrs.

mos.

days.

In the State

yrs.

mos.

days.

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

Dayton Iowa

191

20. UNDERTAKER

ADDRESS

W. B. Dyer

Caldwell

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Form V. S. No. 5 20M.1-16-12

CERTIFICATE OF DEATH

7 30 am
State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH. Registration District No. 3
County of Canyon Primary Registration District No. 2005
City of Calhoun (No. _____ St.)

File No. 5361
Registered No. 74

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Charles B. Byers.

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX M. 4. COLOR OR RACE W. 5. SINGLE, MARRIED, WIDOWED OR DIVORCED. Married
(Write the word.)

6. DATE OF BIRTH Jan 5 1866
(Month) (Day) (Year)

7. AGE 47 yrs. 5 mos. 16 ds. IF LESS than 1 day how many hrs. or mins.?

8. OCCUPATION
(a) Trade, profession or particular kind of work Farming
(b) General nature of industry business, or establishment in which employed (or employer)

9. BIRTHPLACE (State or Country) Virginia

10. NAME OF FATHER Chalmers Byers

11. BIRTHPLACE OF FATHER (State or Country) Maryland

12. MAIDEN NAME OF MOTHER Mary Blecker

13. BIRTHPLACE OF MOTHER (State or Country) Don't know

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Elizabeth Byers.
(Address) Calhoun, Idaho.

15. Filed June 2/4 1913 John S. Meyer
Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH June 21 1913
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from Mar 1 1913 to June 20 1913
that I last saw him alive on June 21 1913
and that death occurred on the date stated above, at 69 M.
The CAUSE OF DEATH* was as follows:

Laryngeal Tuberculosis

(Duration) 6 yrs. mos. ds.

Contributory (Secondary)

(Duration) yrs. mos. ds.

(Signed) C. M. Meyer M. P.

19 (Address) Calhoun, Idaho.

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death yrs. mos. days. In the State yrs. mos. days.

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL DATE OF BURIAL

Taylorville Ill. June 2 1913

20. UNDERTAKER ADDRESS

W. E. Dyer Calhoun Idaho

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Form V. S. No. 5 20M.1-16-12

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH.

Registration District No. 3County of CanyonPrimary Registration District No. 1005City of Caldwell

(No. _____, _____ St.)

File No. 5362Registered No. 95

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Mrs. Josie Kirkaid

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX

F

4. COLOR OR RACE

W.

5. SINGLE, MARRIED, WIDOWED OR DIVORCED.

Married
(Write the word.)

6. DATE OF BIRTH

11/8/90
(Month) (Day) (Year)

7. AGE

43 yrs. _____ mos. _____ ds.IF LESS than 1 day
how many _____ hrs. or
_____ mins.?

8. OCCUPATION

(a) Trade, profession or particular kind of work

Housekeeping

(b) General nature of industry business, or establishment in which employed (or employer)

9. BIRTHPLACE

(State or Country)

Missouri

10. NAME OF FATHER

John Wykoff

11. BIRTHPLACE OF FATHER

(State or Country)

Don't know

12. MAIDEN NAME OF MOTHER

Narah. Evans

13. BIRTHPLACE OF MOTHER

(State or Country)

Don't know

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Joseph Kirkaid(Address) Caldwell, Idaho

15.

Filed June 30 1913John S. Meyer
Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH

June 28 1913
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from

6/16/13 1913, to 6/28/13 1913,that I last saw h.w. alive on 6/28/13 1913,and that death occurred on the date stated above, at 5 P. M.

The CAUSE OF DEATH* was as follows:

Septicemia(Duration) _____ yrs. _____ mos. 12 ds.

Contributory (Secondary)

Miscarriage

(Duration) _____ yrs. _____ mos. _____ ds.

(Signed)

W. B. Johnson, M. D.6/27/13 (Address) Caldwell, Idaho

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death _____ yrs. _____ mos. _____ days. In the State _____ yrs. _____ mos. _____ days.

Where was disease contracted if not at place of death?

Former or usual residence _____

19. PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

Canyon Hills6/30 1913

20. UNDERTAKER

ADDRESS

W. B. Johnson June 30/13
Caldwell, Idaho

MARGIN RESERVED FOR BINDING
WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Form V. S. No. 5 20M.1-16-12

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH.

Registration District No. Zone 10

County of Idaho

Primary Registration District No. # 2042

City of Cottonwood

(No., St.)

File No. 5361

Registered No. 138

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Herman Jacks

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX

4. COLOR OR RACE

5. SINGLE, MARRIED, WIDOWED OR DIVORCED.

male white married

6. DATE OF BIRTH

may 3 - 1852
(Month) (Day) (Year)

7. AGE

61 yrs. 1 mos. 15 ds.

IF LESS than 1 day
how many hrs. or
..... mins.

8. OCCUPATION

(a) Trade, profession or particular kind of work

(b) General nature of industry, business, or establishment in which employed (or employer)

farmer

9. BIRTHPLACE

(State or Country)

Germany

10. NAME OF FATHER

John George Jacks

11. BIRTHPLACE OF FATHER

(State or Country)

Germany

12. MAIDEN NAME OF MOTHER

Berna Tellusman

13. BIRTHPLACE OF MOTHER

(State or Country)

Germany

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

Bernard Jacks

(Address)

Cottonwood, Id.

15.

Filed

June 10 1913 John E. Rains

Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH

June 17 1913
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from

June 9th, 1913, to June 9th, 1913,
that I last saw him alive on June 9th, 1913,
and that death occurred on the date stated above, at 8 P. M.

The CAUSE OF DEATH* was as follows:

Arterio-sclerosis

(Duration) Unknown yrs. mos. ds.

Contributory Intra-cranial hemorrhage
(Secondary)

(Duration) yrs. mos. 15 ds.

(Signed) J. W. Turner M. D.

6-18-1913 (Address) Cottonwood, Idaho

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death yrs. mos. days. In the State yrs. mos. days.

Where was disease contracted if not at place of death

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

Pathology Cemetery June 19 1913

20. UNDERTAKER

ADDRESS

Joseph M. Jacks Cottonwood

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Form V. S. No. 5. 12½ M. 7-24-11

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics
File No. 5362
Registered No. 139

1. PLACE OF DEATH. Registration District No. 2444 10
County of Idaho Primary Registration District No. 2044
City of Mt. Idaho (No. , St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME George Washington Dearing

If death occurred in a hospital, institution or camp give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX Male 4. COLOR OR RACE White 5. SINGLE, MARRIED, WIDOWED OR DIVORCED. Married
(Write the word.)

6. DATE OF BIRTH April 13 1896
(Month) (Day) (Year)

7. AGE 34 yrs. 2 mos. 6 ds. IF LESS than 1 day how many hrs. or min?

8. OCCUPATION
(a) Trade, profession or particular kind of work Farmer
(b) General nature of industry business or establishment in which employed (or employer)

9. BIRTHPLACE Columbus County Washington
(State or Country)

10. NAME OF FATHER J. F. Dearing

11. BIRTHPLACE OF FATHER White County Indiana
(State or Country)

12. MAIDEN NAME OF MOTHER Emma J. Parks

13. BIRTHPLACE OF MOTHER Ohio
(State or Country)

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) J. F. Dearing
(Address) Prangeville Idaho

15. Filed June 21 1913 Jesse L. Rains
Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH June 19 1913
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from held an inquest upon deceased

that I last saw him alive on June 20 1913

and that death occurred on the date stated above, at the room

The CAUSE OF DEATH* was as follows:

Homicidal Shooting
Henry B. B. B. M. D.
Coroner Idaho County
(Duration) yrs. mos. ds.

Contributory (Secondary)

(Duration) yrs. mos. ds.

(Signed) Henry B. B. B. M. D.

June 20 1913 (Address) Cottonwood Idaho

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place In the
of death yrs. mos. ds. State yrs. mos. ds.
Where was disease contracted,
If not at place of death?
Former or
usual residence.

19. PLACE OF BURIAL OR REMOVAL DATE OF BURIAL

Mt. Idaho Cemetery June 23 1913

20. UNDERTAKER ADDRESS

W. E. Abraham Prangeville

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Form V. S. No. 5 20M.1-16-12

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH
County of Idaho
City of Grangeville
Registration District No. 100
Primary Registration District No. 1001
(No. , St.)
If death occurs away from usual residence, give facts called for under special information.

File No. 5365
Registered No. 140
If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Clara Beaman

PERSONAL AND STATISTICAL PARTICULARS

3. SEX Female 4. COLOR OR RACE White 5. SINGLE, MARRIED, WIDOWED OR DIVORCED married
(Write the word.)
6. DATE OF BIRTH June 25 1894
(Month) (Day) (Year)
7. AGE 69 yrs. 11 mos. 13 ds.
IF LESS than 1 day how many hrs. or mins.?

8. OCCUPATION
(a) Trade, profession or particular kind of work
(b) General nature of industry, business, or establishment in which employed (or employer) House wife

9. BIRTHPLACE
(State or Country) Indiana

10. NAME OF FATHER John Abbott

11. BIRTHPLACE OF FATHER
(State or Country) Indiana

12. MAIDEN NAME OF MOTHER Mary

13. BIRTHPLACE OF MOTHER
(State or Country) Kentucky

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) S. L. Cowan
(Address) Grangeville, Idaho

15. Filed June 9 1933 Case P. Rains
Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH June 7 1913
(Month) (Day) (Year)
17. I HEREBY CERTIFY, That I attended deceased from June 2 1913, to June 7 1913, that I last saw her alive on June 7 1913, and that death occurred on the date stated above, at 6 A.M.
The CAUSE OF DEATH* was as follows:

acute intestinal obstruction
(Duration) yrs. mos. 5 ds.
Contributory (Secondary)
(Duration) yrs. mos. ds.
(Signed) G. S. Stinson M. D.
June 8 1913 (Address) Grangeville, Idaho

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death yrs. mos. days. In the State yrs. mos. days.
Where was disease contracted if not at place of death?
Former or usual residence

19. PLACE OF BURIAL OR REMOVAL Prarie View DATE OF BURIAL June 2 1913

20. UNDERTAKER W. A. Graham ADDRESS Grangeville

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Form V. S. No. 5 20M.1-16-12

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH.

Registration District No. 2042 10County of IdahoPrimary Registration District No. 2042

City of _____

(No. _____, _____ St.)

File No. 536Registered No. 142

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Agnes Wansman

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX

Female

4. COLOR OR RACE

white

5. SINGLE, MARRIED, WIDOWED OR DIVORCED.

Single
(Write the word.)

6. DATE OF BIRTH

May 6 1913
(Month) (Day) (Year)

7. AGE

____ yrs. ____ mos. ____ ds.

IF LESS than 1 day
how many ____ hrs. or
____ mins.?

8. OCCUPATION

(a) Trade, profession or particular kind of work
(b) General nature of industry, business, or establishment in which employed (or employer)

None

9. BIRTHPLACE

(State or Country)

New Greenerick

10. NAME OF FATHER

Carper Wansman

11. BIRTHPLACE OF FATHER

(State or Country)

Minnesota

12. MAIDEN NAME OF MOTHER

Anna Hoffman

13. BIRTHPLACE OF MOTHER

(State or Country)

Germany

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

(Address)

J. D. Shinnick
Cottonwood Idaho

15.

Filed

May 6 1913John E. Hains

Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH

May 6 1913
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from

May 6 1913, to May 6 1913,

that I last saw her alive on May 6 1913,

and that death occurred on the date stated above, at 5:20 M.

The CAUSE OF DEATH* was as follows:

Unknown Cause

____ (Duration) ____ yrs. ____ mos. ____ ds.

Contributory abnormal birth
(Secondary)

____ (Duration) ____ yrs. ____ mos. ____ ds.

(Signed) J. D. Shinnick M. D.

May 6 1913 (Address) Cottonwood Idaho

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death ____ yrs. ____ mos. ____ days. In the State ____ yrs. ____ mos. ____ days.

Where was disease contracted if not at place of death?

Former or usual residence ____

19. PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

Greenerick IdMay 7 1913

20. UNDERTAKER

ADDRESS

John McCluskeyCottonwood Id

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Form V. S. No. 5 20M.1-16-12

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH.

Registration District No. 2005 10

County of Idaho

Primary Registration District No. 25 2042

City of Green Creek, Priest (No. _____, St.)

File No. 5360

Registered No. 143

If death occurs away from usual residence, give facts called for under special information.

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME

Josephine Sophia Schmidt

PERSONAL AND STATISTICAL PARTICULARS

3. SEX

4. COLOR OR RACE

5. SINGLE, MARRIED, WIDOWED OR DIVORCED.

Female

White

Single
(Write the word.)

6. DATE OF BIRTH

May
(Month)

4
(Day)

1913
(Year)

7. AGE

1 yrs. 22 mos. 22 ds.

IF LESS than 1 day
how many hrs. or
..... mins.?

8. OCCUPATION

(a) Trade, profession or particular kind of work
(b) General nature of industry, business, or establishment in which employed (or employer)

None

9. BIRTHPLACE

(State or Country) Idaho

10. NAME OF FATHER

Henry Schmidt

11. BIRTHPLACE OF FATHER

(State or Country) Idaho

12. MAIDEN NAME OF MOTHER

Elizabeth Jansen

13. BIRTHPLACE OF MOTHER

(State or Country) Ill

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Arson Jansen
(Address) The family deceased.

15. Cottonwood Ida R.F. 20. No. 1.

Filed June 26 1913 John E. Rhine
John E. Rhine Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH

June
(Month)

26
(Day)

1913
(Year)

17. I HEREBY CERTIFY, That I attended deceased from investigation the death of deceased on the 26th June 1913, to 1913, that I last saw him alive on 1913, and that death occurred on the date stated above, at 2 P. M.

The CAUSE OF DEATH* was as follows:

Acute enteritis (from Intercutaneous)

(Duration) yrs. mos. 2 ds.

Contributory
(Secondary)

(Duration) yrs. mos. ds.

(Signed) Henry Schmidt M. D.

June 26, 1913 (Address) Corner Idaho County

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death yrs. mos. days. In the State yrs. mos. days.

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

Green Creek Cemetery

June 27 1913

20. UNDERTAKER

ADDRESS

Root & Buechele, Eng

Green Creek Idaho

MARGIN RESERVED FOR BINDING
WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
N. B.—Every item of information should be carefully supplied. AGE should be state EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Form V. S. No. 5. 10M. 6-20-11.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics
File No. 5379
Registered No. 144

1. PLACE OF DEATH.

Registration District No. 2101

County of Idaho

Primary Registration District No. 2101

City of Charleston

(No. _____ St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

John Riefenacht

If death occurred in a hospital, institution or camp give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX

4. COLOR OR RACE

5. SINGLE, MARRIED, WIDOWED OR DIVORCED.

Male

White

Single
(Write the word.)

6. DATE OF BIRTH

(Month)

(Day)

1899
(Year)

7. AGE

74

yrs.

mos.

ds.

IF LESS than 1 day
how many.....hrs. or
.....min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work

Anchor

(b) General nature of industry business or establishment in which employed (or employer)

9. BIRTHPLACE

(State or Country)

Switzerland

10. NAME OF FATHER

11. BIRTHPLACE OF FATHER

(State or Country)

—

12. MAIDEN NAME OF MOTHER

—

13. BIRTHPLACE OF MOTHER

(State or Country)

—

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

Levenhorst

(Address)

State Idaho

15.

Filed June 30 1913

J. M. Verbeekman
Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

June
(Month)

12
(Day)

1913
(Year)

17. I HEREBY CERTIFY, That I attended deceased from

1913, to

1913

that I last saw h..... alive on..... 1913,

and that death occurred on the date stated above, at..... M.

The CAUSE OF DEATH* was as follows:

Died suddenly in field.
Presumably heart failure

(Duration)

yrs.

mos.

ds.

Contributory
(Secondary)

(Duration)

yrs.

mos.

ds.

(Signed)

J. M. Verbeekman M. D.
June 12 1913 (Address) Portland Id.

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place

In the

of death..... yrs..... mos..... ds. State..... yrs..... mos..... ds.

Where was disease contracted.

If not at place of death?

Former or

usual residence.....

19. PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

Clearwater Cemetery

June 13 1913

20. UNDERTAKER

ADDRESS

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Form V. S. No. 5 20M.1-16-12

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH

Registration District No. 2101

County of Idaho

Primary Registration District No. 2101

City of Stites

(No. _____, St.)

File No. 5371

Registered No. 145

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Alexander Litherland

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX male 4. COLOR OR RACE white 5. SINGLE, MARRIED, WIDOWED OR DIVORCED. Married

6. DATE OF BIRTH

March 2 1862
(Month) (Day) (Year)

7. AGE

51 yrs. 3 mos. 25 ds.

IF LESS than 1 day
how many hrs. or
..... mins.?

8. OCCUPATION

(a) Trade, profession or particular kind of work
(b) General nature of industry, business, or establishment in which employed (or employer)

Minister of Gospel

9. BIRTHPLACE

(State or Country)

Mount Carmel - Ill

10. NAME OF FATHER

Wm Litherland

11. BIRTHPLACE OF FATHER

(State or Country)

Indiana

12. MAIDEN NAME OF MOTHER

Susan Hall

13. BIRTHPLACE OF MOTHER

(State or Country)

Ky

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

Herling Litherland

(Address)

Stites, Ida

15.

Filed June 30 1913 Jm. V. Litherland
Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

June 26 1913
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from

1913, to 1913,

that I last saw him alive on 1913,

and that death occurred on the date stated above, at M.

The CAUSE OF DEATH* was as follows:

Presumably Apoplexy
Sudden

(Duration) yrs. mos. ds.

Contributory
(Secondary)

(Duration) yrs. mos. ds.

(Signed)

A. F. Wahlenberg, D.

19 (Address) Boosker, Ida

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death yrs. mos. days. In the State yrs. mos. days.

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

Mount Carmel Ill 1913

20. UNDERTAKER

ADDRESS

Edith Litherland Idaho

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Form V. S. No. 5. 12½ M. 7-24-11

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics
File No. **5372**
Registered No. **146**

1. PLACE OF DEATH.

Registration District No. **10**

County of **Idaho**
City of **Helmer River**

Primary Registration District No. **2044**
(No. _____, _____ St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME **Forest Price**

If death occurred in a hospital, institution or camp give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX

4. COLOR OR RACE

5. SINGLE, MARRIED, WIDOWED OR DIVORCED.

Male

White

Single
(Write the word.)

6. DATE OF BIRTH

August 1
(Month) (Day)

1893
(Year)

7. AGE

19 yrs. 11 mos. 7 ds.

IF LESS than 1 day
how many hrs. or
..... min?

8. OCCUPATION

(a) Trade, profession or particular kind of work.
(b) General nature of industry business or establishment in which employed (or employer).

Laborer

9. BIRTHPLACE

(State or Country)

Idaho

10. NAME OF FATHER

E. G. Price

11. BIRTHPLACE OF FATHER

(State or Country)

Ind

12. MAIDEN NAME OF MOTHER

Annie Danley

13. BIRTHPLACE OF MOTHER

(State or Country)

Ill

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

(Address)

E. G. Price
Grangeville, Idaho

15.

Filed **July 9** 191**3**

Jose P. Pains
Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH

June

9

1913

(Month)

(Day)

(Year)

17. I HEREBY CERTIFY, That ~~I attended deceased from~~

~~191~~ **to find** ~~191~~

~~that I last saw him alive on~~ **191**

~~and that death occurred on the date stated above, at~~ **M.**

The CAUSE OF DEATH* was as follows:

Drowning (Accidental)

(Duration)

yrs.

mos.

ds.

Contributory
(Secondary)

(Duration)

yrs.

mos.

ds.

(Signed)

Henry D. Doherty M. D.

July 5 19**13** (Address) **Corner of Idaho**

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, State (1) MEANS OF INJURY; (2) whether ACCIDENTAL, SUICIDAL OR HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place

In the

of death yrs mos ds. State yrs mos ds.

Where was disease contracted,

If not at place of death?

Former or

usual residence.

19. PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

Crairie View Cemetery

July 9 191**3**

20. UNDERTAKER

ADDRESS

W. E. Graham **Grangeville**

Form V. S. No. 5. 12½ M. 7-24-11

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics
File No. 5373
Registered No. _____

1. PLACE OF DEATH. Registration District No. 25
County of Shoshone Primary Registration District No. 2108
City of Mullan (No. _____, St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

Jacob Renta

If death occurred in a hospital, institution or camp give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX Male 4. COLOR OR RACE White 5. SINGLE, MARRIED, WIDOWED OR DIVORCED. Single
(Write the word.)

6. DATE OF BIRTH Jan. 30 1891
(Month) (Day) (Year)

7. AGE 22 yrs. 3 mos. 15 ds. IF LESS than 1 day how many _____ hrs. or _____ min?

8. OCCUPATION

(a) Trade, profession or particular kind of work. Mining
(b) General nature of industry business or establishment in which employed (or employer)

9. BIRTHPLACE Finland
(State or Country)

10. NAME OF FATHER Herman Renta

11. BIRTHPLACE OF FATHER Finland
(State or Country)

12. MAIDEN NAME OF MOTHER Minie Juslin

13. BIRTHPLACE OF MOTHER Finland
(State or Country)

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) F W Rolfe mdg
(Address) Mullan Id.

15. Filed May 16 1913 F W Rolfe
Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH May 15 1913
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from May 14 1913, to May 15 1913, that I last saw him alive on May 14 1913 and that death occurred on the date stated above, at _____ M.

The CAUSE OF DEATH* was as follows:

Mine accident

_____ (Duration) _____ yrs. _____ mos. _____ ds.

Contributory (Secondary)

_____ (Duration) _____ yrs. _____ mos. _____ ds.

(Signed) F W Rolfe M. D.

May 15 1913 (Address) Mullan

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place _____ In the _____
of death _____ yrs. _____ mos. _____ ds. State _____ yrs. _____ mos. _____ ds.

Where was disease contracted,

If not at place of death?

Former or

usual residence.

19. PLACE OF BURIAL OR ~~REMOVAL~~ DATE OF BURIAL

Mullan Ida May 16 1913

20. UNDERTAKER ADDRESS

Ward & Co Valley

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Form V. S. No. 5. 12½M. 7-24-11

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics
File No. 5371
Registered No.

1. PLACE OF DEATH. Registration District No. 25
County of Shoshone Primary Registration District No. 2108
City of Mullan (No. , St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Florence Drine Otto Witto

If death occurred in a hospital, institution or camp give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX girl 4. COLOR OR RACE White 5. SINGLE, MARRIED, WIDOWED OR DIVORCED. Living (Write the word.)

6. DATE OF BIRTH June 17 1913
(Month) (Day) (Year)

7. AGE yrs. mos. 4½ ds. IF LESS than 1 day how many 37 hrs. or min?

8. OCCUPATION

- (a) Trade, profession or particular kind of work
(b) General nature of industry business or establishment in which employed (or employer)

9. BIRTHPLACE Mullan Ida
(State or Country)

10. NAME OF FATHER John Witto

11. BIRTHPLACE OF FATHER Finland
(State or Country)

12. MAIDEN NAME OF MOTHER Lizzy Hokalo

13. BIRTHPLACE OF MOTHER Finland
(State or Country)

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) F. W. Ralph
(Address) Mullan Ida

15.

Filed June 19 1913 F. W. Ralph
Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH

June 16 1913
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from June 17 1913, to June 1913 that I last saw her alive on June 1913 and that death occurred on the date stated above, at M.

The CAUSE OF DEATH* was as follows:

Failure of the fo
ovalle to elter pr

(Duration) yrs. mos. ds.

Contributory
(Secondary)

(Duration) yrs. mos. ds.

(Signed) F. W. Ralph M. D.

June 19 1913 (Address) Mullan

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place In the
of death yrs. mos. ds. State yrs. mos. ds.

Where was disease contracted,

If not at place of death?

Former or

usual residence.

19. PLACE OF BURIAL OR REMOVAL DATE OF BURIAL

Mullan Ida June 1913

20. UNDERTAKER

ADDRESS

Father Mullan

Dr. Char. A. Wittman

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Form V. S. No. 5. 12½ M. 7-24-11

CERTIFICATE OF DEATH

1. PLACE OF DEATH.
County of Shoshone
City of Mullan

Registration District No. 25
Primary Registration District No. 2108
(No. _____, _____ St.)

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics
File No. 5375
Registered No. _____

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

William S. Watkins

If death occurred in a hospital, institution or camp give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX M 4. COLOR OR RACE white 5. SINGLE, MARRIED, WIDOWED OR DIVORCED. Single
(Write the word.)

6. DATE OF BIRTH _____
(Month) (Day) (Year)

7. AGE 43 yrs. _____ mos. _____ ds. IF LESS than 1 day
how many _____ hrs. or _____ min.

8. OCCUPATION

(a) Trade, profession or particular kind of work. Mining
(b) General nature of industry business or establishment in which employed (or employer)

9. BIRTHPLACE California
(State or Country)

10. NAME OF FATHER ?

11. BIRTHPLACE OF FATHER ?
(State or Country)

12. MAIDEN NAME OF MOTHER ?

13. BIRTHPLACE OF MOTHER ?
(State or Country)

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) B. E. Yocum
(Address) Mullan

15. Filed May 16 1913 FW Ralf
Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH May 14 1913
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from _____ 1913, to _____ 1913

that I last saw h. _____ alive on _____ 1913

and that death occurred on the date stated above, at _____ M.

The CAUSE OF DEATH* was as follows:

Mine Accident

(Duration) Instant mos. _____ ds.

Contributory (Secondary) _____

(Duration) _____ yrs. _____ mos. _____ ds.

(Signed) _____ M. D.

_____ 19 _____ (Address) _____

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place _____ In the _____
of death _____ yrs. _____ mos. _____ ds. State _____ yrs. _____ mos. _____ ds.

Where was disease contracted, _____
If not at place of death? _____

Former or _____
usual residence. _____

19. PLACE OF BURIAL OR REMOVAL DATE OF BURIAL

Wallace May 15 1913

20. UNDERTAKER ADDRESS

Ward Undertaking Wallace

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Form V. S. No. 5 20M.1-16-12

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics
File No. 5372

1. PLACE OF DEATH. Registration District No. 25
County of Shoshone Primary Registration District No. 2106
City of Kellogg, Wardner (No. St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

Elizabeth Jane Rowe (Rowe)

Registered No.

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX 4. COLOR OR RACE 5. SINGLE, MARRIED, WID-
OWED OR DIVORCED.
J. White married
(Write the word.)

6. DATE OF BIRTH

July 31 1862
(Month) (Day) (Year)

7. AGE

51 yrs. 9 mos. 12 ds.

IF LESS than 1 day
how many hrs. or
mins.?

8. OCCUPATION

(a) Trade, profession or particular kind of work
(b) General nature of industry, business, or establishment in which employed (or employer).

Housewife

9. BIRTHPLACE

(State or Country)

Camborne, Cornwall, England

10. NAME OF FATHER

Do not know

11. BIRTHPLACE OF FATHER

(State or Country)

England

12. MAIDEN NAME OF MOTHER

Sarah Roberts

13. BIRTHPLACE OF MOTHER

(State or Country)

England

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

W. J. Rowe

(Address)

Wardner, Idaho

15.

Filed

July 1

1913

D. H. A. Dittman

Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH

5 191
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from

191 to 191

that I last saw h. alive on 191

and that death occurred on the date stated above, at M.

The CAUSE OF DEATH* was as follows:

Cancer of Liver.

(Duration) yrs. mos. ds.

Contributory
(Secondary)

(Duration) yrs. mos. ds.

(Signed)

J. P. Mason

M. D.

19 (Address) Kellogg

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death yrs. mos. days. In the State yrs. mos. days.

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

Greenwood Kellogg

May 14 1913

20. UNDERTAKER

ADDRESS

E. B. Thornhill

Kellogg

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Form V. S. No. 5 20M.1-16-12

CERTIFICATE OF DEATH

1. PLACE OF DEATH

Registration District No. 25

County of Shoshone

Primary Registration District No. 2105

City of Reellogg(No. 100)

St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Ma BradenState of Idaho
BOARD OF HEALTH
Bureau Vital StatisticsFile No. 5377

Registered No. _____

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX F4. COLOR OR RACE W5. SINGLE, MARRIED, WIDOWED OR DIVORCED. single

(Write the word.)

6. DATE OF BIRTH

Nov.
(Month)11
(Day)1884
(Year)

7. AGE

28 yrs. 7 mos. 17 ds.IF LESS than 1 day
how many hrs. or
..... mins.

8. OCCUPATION

(a) Trade, profession or particular kind of work

(b) General nature of industry, business, or establishment in which employed (or employer)

Dressmaker

9. BIRTHPLACE

(State or Country)

Idaho

10. NAME OF FATHER

James Braden

11. BIRTHPLACE OF FATHER

(State or Country)

Oregon

12. MAIDEN NAME OF MOTHER

Sarah Lockwood

13. BIRTHPLACE OF MOTHER

(State or Country)

Missouri

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

(Address)

James Braden
Reellogg, Ida.

15.

Filed June 16 19131913W. C. W. D. D. D.
Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

June
(Month)13
(Day)1913
(Year)

17. I HEREBY CERTIFY, That I attended deceased from

June 1st 1913, to June 17 1913that I last saw her alive on June 7 1913and that death occurred on the date stated above, at Reellogg, Ida.

The CAUSE OF DEATH* was as follows:

Pulmonary Tuberculosis(Duration) 2 yrs. — mos. — ds.Contributory
(Secondary)(Duration) — yrs. — mos. — ds.(Signed) Rev. J. Lecher M. D.6/14/1913 (Address) Reellogg, Ida.

*State the DISEASE CAUSING DEATH; or in death from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death — yrs. — mos. — days. In the State — yrs. — mos. — days.

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

Reellogg, Ida. June 17 1913

20. UNDERTAKER

ADDRESS

E. B. Harkins Reellogg, Ida.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Form V. S. No. 5, 20M.1-16-12

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH.

Registration District No. 25County of ShoshonePrimary Registration District No. 2165File No. 537City of Reelsg(No. 1 St.)

Registered No. _____

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Anna Victoria Flock

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX M4. COLOR OR RACE White5. SINGLE, MARRIED, WIDOWED OR DIVORCED. single

(Write the word.)

6. DATE OF BIRTH Jan 4 1907

(Month)

(Day)

(Year)

7. AGE 6 yrs. 6 mos. — ds.

IF LESS than 1 day
how many hrs. or
..... mins.

8. OCCUPATION

(a) Trade, profession or particular kind of work

(b) General nature of industry business, or establishment in which employed (or employer)

9. BIRTHPLACE

(State or Country) Idaho10. NAME OF FATHER A. L. Flock

11. BIRTHPLACE OF FATHER

(State or Country) Indiana12. MAIDEN NAME OF MOTHER Flavene Ashby

13. BIRTHPLACE OF MOTHER

(State or Country) Illinois

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) A. L. Flock

(Address) _____

15.

Filed July 81913

D. A. A. A. A. A.
Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH June 27 1913

(Month)

(Day)

(Year)

17. I HEREBY CERTIFY, That I attended deceased from

1913, to 1913,that I last saw him alive on 1913,and that death occurred on the date stated above, at M.

The CAUSE OF DEATH* was as follows:

Contributory
(Secondary)

(Duration) _____

yrs.

mos.

ds.

(Signed) _____

M. D.

19 (Address) _____

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death

yrs.

mos.

days.

In the State

yrs.

mos.

days.

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL Reelsg Id.DATE OF BURIAL June 27 191320. UNDERTAKER E. B. ShanklinADDRESS Reelsg

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Form V. S. No. 5 20M.1-16-12

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics
File No. 5379

1. PLACE OF DEATH

Registration District No. 28

County of

Primary Registration District No. 2105

City of

(No. St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

Baby Murphy

Registered No.

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX

4. COLOR OR RACE

5. SINGLE, MARRIED, WIDOWED OR DIVORCED.

6. DATE OF BIRTH

7. AGE

IF LESS than 1 day
how many hrs. or
..... mins.

8. OCCUPATION

(a) Trade, profession or particular kind of work

(b) General nature of industry business, or establishment in which employed (or employer)

9. BIRTHPLACE

(State or Country)

10. NAME OF FATHER

11. BIRTHPLACE OF FATHER

(State or Country)

12. MAIDEN NAME OF MOTHER

13. BIRTHPLACE OF MOTHER

(State or Country)

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

(Address)

15.

Filed

1913

Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH

17. I HEREBY CERTIFY, That I attended deceased from

191... to 191...

that I last saw him alive on 191...

and that death occurred on the date stated above, at M.

The CAUSE OF DEATH* was as follows:

(Duration) yrs. mos. ds.

Contributory
(Secondary)

(Duration) yrs. mos. ds.

(Signed) J. R. Mason M. D.

19 (Address) Kellogg

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death. yrs. mos. days. In the State. yrs. mos. days.

Where was disease contracted if not at place of death?

Former or usual residence.

19. PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

20. UNDERTAKER

ADDRESS

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Form V. S. No. 5 20M.1-16-12

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH.

Registration District No. 15

County of *Idaho*

Primary Registration District No. 2066

City of

(No. *Ida Libey* St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

Registered No.

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX

4. COLOR OR RACE

5. SINGLE, MARRIED, WIDOWED OR DIVORCED.

Female White Married

6. DATE OF BIRTH

February 11 1858
(Month) (Day) (Year)

7. AGE

*55 yrs. 6 mos. 3 ds.*IF LESS than 1 day
how many hrs. or mins.

8. OCCUPATION

(a) Trade, profession or particular kind of work
(b) General nature of industry business, or establishment in which employed (or employer)*House wife*

9. BIRTHPLACE

(State or Country)

Ohio

10. NAME OF FATHER

Jacob Peach

11. BIRTHPLACE OF FATHER

(State or Country)

Idaho

12. MAIDEN NAME OF MOTHER

Shoresmather

13. BIRTHPLACE OF MOTHER

(State or Country)

Ohio

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

J. P. Libey

(Address)

Pottlatch

15.

Filed *July 14 1913*

Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH

7 14 1913
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from

8-1 1912 to 7-14 1913
that I last saw her alive on *7-14 1913*and that death occurred on the date stated above, at *80* M.

The CAUSE OF DEATH* was as follows:

Paralysis and apoplexy(Duration) *10 mos. 14* ds.Contributory
(Secondary)(Duration) *10 mos. 14* ds.

(Signed)

J. S. Leonard M. D.
19 *Pottlatch, Ida* (Address)

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death.....yrs.....mos.....days. In the State.....yrs.....mos.....days.

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

*Viola**July 15 1913*

20. UNDERTAKER

ADDRESS

*E. Anderson**Bulawa Wash*

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
N. B.—Every item of information should be carefully supplied. AGE should be state EXACTLY. PHYSI-
CIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact state-
ment of OCCUPATION is very important. See instructions on back of certificate.

Form No. 5. 10M. 6-20-11.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics
File No. 538

1. PLACE OF DEATH Registration District No. 29
County of Minidoka Primary Registration District No. 2015
City of Rupert (No. , St.)

Registered No. 10

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Malcolm McVean

If death occurred in a hospital, institution or camp give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX 4. COLOR OR RACE 5. SINGLE, MARRIED, WID-
OWED OR DIVORCED.

male White married
(Write the word.)

6. DATE OF BIRTH

march 19 1844
(Month) (Day) (Year)

7. AGE

69 yrs. 0 mos. 12 ds. IF LESS than 1 day
how many hrs. or min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work Farmer
(b) General nature of industry business or establishment in which employed (or employer)

9. BIRTHPLACE

(State or Country) Canada

10. NAME OF FATHER

Malcolm

11. BIRTHPLACE OF FATHER

(State or Country) Scotland

12. MAIDEN NAME OF MOTHER

? McDonald

13. BIRTHPLACE OF MOTHER

(State or Country) Scotland

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Chas McVean

(Address) Rupert

15.

Filed May 11 1913

V. P. Kellen

Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

Mar 31 1913
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from

1911, to 1913

that I last saw h. alive on Mar 31 1913,

and that death occurred on the date stated above, at 11 p. M.

The CAUSE OF DEATH* was as follows:

Cancer on neck & carcinoma

(Duration) 2 yrs. mos. ds.

Contributory (Secondary)

(Duration) yrs. mos. ds.

(Signed) J. J. Kenney M. D.

Apr 21 1913 (Address) Rupert

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place In the
of death yrs. mos. ds. State yrs. mos. ds.

Where was disease contracted,

If not at place of death?

Former or

usual residence.

19. PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

Rupert

Apr 3 1913

20. UNDERTAKER

ADDRESS

W. A. Goodman Rupert

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Form V. S. No. 5 20M.1-16-12

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH

Registration District No. 2085

County of Twin Falls

Primary Registration District No.

City of Hansen

(No. St.)

Registered No.

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

Jacob A. Schaepler

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX

4. COLOR OR RACE

5. SINGLE, MARRIED, WIDOWED OR DIVORCED.

M.

white

Single (Write the word.)

6. DATE OF BIRTH

Aug. 14 1883

(Month) (Day) (Year)

7. AGE

30 yrs. — mos. 16 ds.

IF LESS than 1 day how many hrs. or mins.?

8. OCCUPATION

(a) Trade, profession or particular kind of work

(b) General nature of industry business, or establishment in which employed (or employer)

Farmer

9. BIRTHPLACE

(State or Country)

Mo

10. NAME OF FATHER

Ferdman Schaepler

11. BIRTHPLACE OF FATHER

(State or Country)

Germany

12. MAIDEN NAME OF MOTHER

Katherine Coffman

13. BIRTHPLACE OF MOTHER

(State or Country)

Mo.

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

W.E. Fernerwald

(Address)

Hansen

15.

Filed

Aug. 31 1913

John H. Bigler Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

Aug.

30

1913

(Month)

(Day)

(Year)

17. I HEREBY CERTIFY, That I attended deceased from

Aug. 28 1913, to Aug. 30 1913,

that I last saw him alive on Aug. 30 1913,

and that death occurred on the date stated above, at 11 P.M.

The CAUSE OF DEATH* was as follows:

Spinal injury (accident)

(Duration) yrs. mos. 3 ds.

Contributory (Secondary)

(Duration) yrs. mos. ds.

(Signed)

H. Wilson M. D.

Aug. 31 1913 (Address) Twin Falls, Ida.

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death. yrs. mos. days. In the State. yrs. mos. days.

Where was disease contracted if not at place of death?

Former or usual residence.

19. PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

Rich Hill Mo.

1913

20. UNDERTAKER

ADDRESS

J. J. Grossman Twin Falls

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Form V. S. No. 5 20M.1-16-12

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH.

Registration District No. 1085

County of Juin Falls

Primary Registration District No.

City of Juin Falls

(No. 461, Main Ave West St.)

File No. 5351

Registered No.

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

Boyce Franklin Miller

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX

Male

4. COLOR OR RACE

White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED.

Single

6. DATE OF BIRTH

Nov

6

1911

(Month)

(Day)

(Year)

7. AGE

1 yrs. 8 mos. 28 ds.

IF LESS than 1 day
how many hrs. or mins.?

8. OCCUPATION

(a) Trade, profession or particular kind of work

(b) General nature of industry, business, or establishment in which employed (or employer)

9. BIRTHPLACE

(State or Country)

Ohio

10. NAME OF FATHER

Miller

11. BIRTHPLACE OF FATHER

(State or Country)

Ohio

12. MAIDEN NAME OF MOTHER

Shepherd

13. BIRTHPLACE OF MOTHER

(State or Country)

Ohio

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

J. F. Shepherd

(Address)

Juin Falls Ida

15.

Filed 8-5 1913

John H. Crocker

Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH

Aug

4

1913

(Month)

(Day)

(Year)

17. I HEREBY CERTIFY, That I attended deceased from

Aug 3

1913, to

Aug 3

1913,

that I last saw him alive on Aug 3 1913,

and that death occurred on the date stated above, at 5:24 P.M.

The CAUSE OF DEATH* was as follows:

Infantile Convulsions

(Duration) yrs. mos. 1 ds.

Contributory Acute Indigestion
(Secondary)

(Duration) yrs. mos. 1 ds.

(Signed) Charles B. Scott M. D.

Aug 4 1913 (Address) Juin Falls Idaho

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death. yrs. mos. days. In the State. yrs. mos. days.

Where was disease contracted if not at place of death?

Former or usual residence.

19. PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

Juin Falls

Aug 5 1913

20. UNDERTAKER

ADDRESS

C. J. Crosby

Juin Falls

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Form V. S. No. 5 20M.1-16-12

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH.

Registration District No. 1085

County of Twin Falls

Primary Registration District No.

City of

(No. St.)

Registered No.

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

Alex Taylor

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX

4. COLOR OR RACE

5. SINGLE, MARRIED, WIDOWED OR DIVORCED.

M.

W

Single
(Write the word.)

6. DATE OF BIRTH

(Month) (Day) (Year)

7. AGE

59 yrs. mos. ds.

IF LESS than 1 day
how many hrs. or mins?

8. OCCUPATION

(a) Trade, profession or particular kind of work

(b) General nature of industry business, or establishment in which employed (or employer)

Laborer

9. BIRTHPLACE

(State or Country)

Scotland

10. NAME OF FATHER

unknown

11. BIRTHPLACE OF FATHER

(State or Country)

12. MAIDEN NAME OF MOTHER

13. BIRTHPLACE OF MOTHER

(State or Country)

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

Chas. Hudson

(Address)

Twin Falls

15.

Filed

8-8

1913

3

Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH

Aug 7 1913
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from

July 1 1913, to Aug 7 1913,
that I last saw him alive on Aug 7 1913,

and that death occurred on the date stated above, at 11 P. M.

The CAUSE OF DEATH* was as follows:

Artie Steensma

not known (Duration) yrs. mos. ds.

Contributory
(Secondary)

(Duration) yrs. mos. ds.

(Signed)

Aug 8 1913 (Address) Twin Falls, Idaho

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death. yrs. mos. days. In the State. yrs. mos. days.

Where was disease contracted if not at place of death?

Former or usual residence.

19. PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

Twin Falls

Aug 9 1913

20. UNDERTAKER

ADDRESS

J. J. Groenman

Twin Falls

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Form V. S. No. 5 20M.1-16-12

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH.

Registration District No. 1085

County of Twin Falls

Primary Registration District No.

City of Twin Falls

(No. 637, 3rd av West St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Emma Biddle Stone

File No. 3385

Registered No.

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX

4. COLOR OR RACE

5. SINGLE, MARRIED, WIDOWED OR DIVORCED.

Female White Widowed

6. DATE OF BIRTH

June 20 1845
(Month) (Day) (Year)

7. AGE

68 yrs. 1 mos. 16 ds.

IF LESS than 1 day
how many hrs. or
..... mins.?

8. OCCUPATION

(a) Trade, profession or particular kind of work

(b) General nature of industry, business, or establishment in which employed (or employer)

Seamstress

9. BIRTHPLACE

(State or Country)

England

10. NAME OF FATHER

Biddle

11. BIRTHPLACE OF FATHER

(State or Country)

England

12. MAIDEN NAME OF MOTHER

Wesley

13. BIRTHPLACE OF MOTHER

(State or Country)

England

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

(Address)

Mr. L. J. Moore
637 - 3rd av West

15.

Filed

8-4

191 3

Local Registrar

Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH

Aug 3 1913
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from

Aug 25th 1913, to Aug 3rd 1913,

that I last saw him alive on Aug 2nd 1913

and that death occurred on the date stated above, at 1406 M.

The CAUSE OF DEATH* was as follows:

Uremia

(Duration) yrs. mos. 2 ds.

Contributory (Secondary) Acute attack of chronic Bright's disease

(Duration) yrs. mos. ds.

(Signed) Dr. L. J. Alexander M. D.

Aug 3, 1913 (Address) Twin Falls Id

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death yrs. mos. days. In the State yrs. mos. days.

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

Ogden Utah

191

20. UNDERTAKER

ADDRESS

C. J. Crosby

Twin Falls Id

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Form V. S. No. 5 20M.1-16-12

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics
File No. **5387**

1. PLACE OF DEATH

Registration District No.

County of

Primary Registration District No.

City of

(No. St.)

Registered No.

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

Thelma Fredrika Hag

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX *Female* 4. COLOR OR RACE *white* 5. SINGLE, MARRIED, WIDOWED OR DIVORCED. *married*
(Write the word.)

6. DATE OF BIRTH

June 15 1885
(Month) (Day) (Year)

7. AGE

58 yrs. *2* mos. *25* ds.

IF LESS than 1 day
how many hrs. or
..... mins.?

8. OCCUPATION

(a) Trade, profession or particular kind of work
(b) General nature of industry, business, or establishment in which employed (or employer)

Housewife

9. BIRTHPLACE

(State or Country)

Sweden

10. NAME OF FATHER

Sven Magnusson

11. BIRTHPLACE OF FATHER

(State or Country)

Sweden

12. MAIDEN NAME OF MOTHER

Maria Charlotte Fredriksson

13. BIRTHPLACE OF MOTHER

(State or Country)

Sweden

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

(Address)

Edith G. Hag
Idaho Island Idaho

15.

Filed

9/16

191

E. O. Olsson

Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH

Sept. 12 1913
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from *Aug. 15*, 191³, to *Sept. 10*, 191³, that I last saw him alive on *Sept. 10*, 191³, and that death occurred on the date stated above, at *4 P.* M.

The CAUSE OF DEATH* was as follows:

Chronic Parenchymatous Nephritis

(Duration) yrs. mos. *25* ds.

Contributory
(Secondary)

(Duration) yrs. mos. ds.

(Signed)

*E. O. Olsson**Sept. 5 1913*(Address) *Oakley Idaho*

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death yrs. mos. days. In the State yrs. mos. days.

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

Idaho Island Idaho *Sept. 12 1913*

20. UNDERTAKER

ADDRESS *Idaho*

Harry L. Loomis *Idaho*

RESERVED FOR BINDING

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Form V. S. No. 5. 12½ M. 7-24-11

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH
County of Minidoka
City of Heyburn

Registration District No. 18
Primary Registration District No. _____
(No. _____, _____ St.)

File No. 5388
Registered No. _____

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

John Farrell

If death occurred in a hospital, institution or camp give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX Male 4. COLOR OR RACE White 5. SINGLE, MARRIED, WIDOWED OR DIVORCED Married

6. DATE OF BIRTH Dec. 9 1862
(Month) (Day) (Year)

7. AGE 51 yrs. 4 mos. 4 ds. IF LESS than 1 day
how many _____ hrs. or _____ min?

8. OCCUPATION

(a) Trade, profession or particular kind of work Farmer
(b) General nature of industry business or establishment in which employed (or employer) _____

9. BIRTHPLACE

(State or Country) England

10. NAME OF FATHER

James Farrell

11. BIRTHPLACE OF FATHER

(State or Country) Ireland

12. MAIDEN NAME OF MOTHER

Unknown

13. BIRTHPLACE OF MOTHER

(State or Country) Ireland

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Mrs. Emma May Farrell
(Address) Heyburn Ida.

15. Filed July 15 1913

V. P. Killen
Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH June 13 1913
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from _____ 191____, to _____ 191____

that I last saw h. _____ alive on _____ 191____

and that death occurred on the date stated above, at _____ M.

The CAUSE OF DEATH* was as follows:

Accidental
Killed by Horse

_____ (Duration) _____ yrs. _____ mos. _____ ds.

Contributory (Secondary)

_____ (Duration) _____ yrs. _____ mos. _____ ds.

(Signed) V. P. Killen M. D.

June 15 1913 (Address) Heyburn Ida.

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place _____ In the _____
of death _____ yrs. _____ mos. _____ ds. State _____ yrs. _____ mos. _____ ds.

Where was disease contracted, If not at place of death?

Former or usual residence _____

19. PLACE OF BURIAL OR REMOVAL DATE OF BURIAL

Heyburn Ida June 15 1913

20. UNDERTAKER ADDRESS

L. B. Gallagher Burley Ida.

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Form V. S. No. 5. 12½M.7-24-11

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics
File No. 2-5389
Registered No. 2

1. PLACE OF DEATH. Registration District No. 18
County of Minidoka Primary Registration District No. 2102
City of Reylburn (No. _____, _____ St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Isaac P. Carter

If death occurred in a hospital, institution or camp give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX Male 4. COLOR OR RACE white 5. SINGLE, MARRIED, WIDOWED OR DIVORCED. Married

6. DATE OF BIRTH March 11 1899
(Month) (Day) (Year)

7. AGE 87 yrs. 4 mos. 16 ds. IF LESS than 1 day how many _____ hrs. or _____ min?

8. OCCUPATION
(a) Trade, profession or particular kind of work. Farmer.
(b) General nature of industry business or establishment in which employed (or employer)

9. BIRTHPLACE (State or Country) Rutledge Co. Vt.

10. NAME OF FATHER Gideon H. Carter

11. BIRTHPLACE OF FATHER (State or Country) Unknown

12. MAIDEN NAME OF MOTHER Unknown

13. BIRTHPLACE OF MOTHER (State or Country) Unknown

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Leo V. Carter
(Address) Burley Idaho No. 2.

15. Filed July 30 1913 V. P. Killeen
Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH July 27th 1913
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from July 15th 1913 to July 27th 1913 that I last saw him alive on July 23rd 1913 and that death occurred on the date stated above, at 10:15 AM.

The CAUSE OF DEATH* was as follows:
Sypticemia (abscess) (sepsis)
to face

(Duration) _____ yrs. _____ mos. 21 ds.
Contributory (Secondary) Old age

(Duration) _____ yrs. _____ mos. _____ ds.
(Signed) J. C. Patterson M. D.
July 28th 1913 (Address) Burley, Idaho.

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place _____ In the _____
of death _____ yrs. _____ mos. _____ ds. State _____ yrs. _____ mos. _____ ds.
Where was disease contracted, _____
If not at place of death? _____
Former or _____
usual residence _____

19. PLACE OF BURIAL OR REMOVAL Midford Utah DATE OF BURIAL Aug 1 1913

20. UNDERTAKER L. B. Gallagher ADDRESS Burley Ida.

-SUPPLEMENTARY DEATH CERTIFICATE-

(Please reply on this sheet to
the registrar of Vital Statistics)

Death Certificate No.

Name Isaac P. Carter

Date of Death July 27th 1913

Cause of Death Diphtheria, & scarlet fever

Contributory Cause of death

(Sign here) J. C. Patterson M.D.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Form V. S. No. 5. 12½ M. 7-24-11

CERTIFICATE OF DEATH

1. PLACE OF DEATH. Registration District No. 18
County of Minidoka Primary Registration District No. 2102
City of Heyburn (No. _____, _____ St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

Mae Bell

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics
File No. 539
Registered No. 1

If death occurred in a hospital, institution or camp give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX 4. COLOR OR RACE 5. SINGLE, MARRIED, WIDOWED OR DIVORCED.

Female white Single
(Write the word)

6. DATE OF BIRTH

May 20 1912
(Month) (Day) (Year)

7. AGE

1 yrs. 2 mos. 3 ds.

IF LESS than 1 day
how many hrs. or
min?

8. OCCUPATION

(a) Trade, profession or particular kind of work.
(b) General nature of industry business or establishment in which employed (or employer)

At home

9. BIRTHPLACE

(State or Country)

Minidoka Co. Ida.

10. NAME OF FATHER

J. Frank Bell

11. BIRTHPLACE OF FATHER

(State or Country)

Labett Co. Kans.

12. MAIDEN NAME OF MOTHER

Mae Barker

13. BIRTHPLACE OF MOTHER

(State or Country)

Iowa

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

(Address)

J. F. Bell
Heyburn Ida.

15.

Filed

July 30 1913

Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH

July 23 1913
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from
_____ 191____, to _____ 191____

that I last saw h. 22 alive, on July 23 1913
and that death occurred on the date stated above, at 10 P. M.

The CAUSE OF DEATH* was as follows:

Broning - Accidental

_____ (Duration) _____ yrs. _____ mos. _____ ds.

Contributory
(Secondary)

_____ (Duration) _____ yrs. _____ mos. _____ ds.

(Signed) V. P. Killen M. D.

_____ 19____ (Address) Heyburn

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place _____ In the
of death _____ yrs. _____ mos. _____ ds. State _____ yrs. _____ mos. _____ ds.

Where was disease contracted,

If not at place of death?

Former or

usual residence.

19. PLACE OF BURIAL OR REMOVAL DATE OF BURIAL

Heyburn July 24 1913

20. UNDERTAKER

ADDRESS

J. F. Bell Heyburn, Ida

N. E.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Form V. S. No. 5 20M.1-16-12

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH.

Registration District No. 4116

County of Lemhi

Primary Registration District No. 2116

City of Salmon

(No. _____ St.)

File No. 5302

Registered No. 7

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

Daniel Murphy

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX

4. COLOR OR RACE

5. SINGLE, MARRIED, WIDOWED OR DIVORCED.

Male

White

Single
(Write the word.)

6. DATE OF BIRTH

Do not know
(Month) (Day) (Year)

7. AGE

70 yrs. _____ mos. _____ ds.

IF LESS than 1 day
how many _____ hrs. or
_____ mins.?

8. OCCUPATION

(a) Trade, profession or particular kind of work

(b) General nature of industry, business, or establishment in which employed (or employer)

Quartz Mines

9. BIRTHPLACE

(State or Country)

Ireland

10. NAME OF FATHER

Do not know

11. BIRTHPLACE OF FATHER

(State or Country)

Ireland

12. MAIDEN NAME OF MOTHER

Do not know

13. BIRTHPLACE OF MOTHER

(State or Country)

Ireland

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

W. Smith

(Address)

Ulysses Ida

15.

Filed 9-3 1913

Ulysses L. Smith
Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH

September 1 1913.
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from

Aug 18 1913, to Sept 1 1913,

that I last saw him alive on Sept 1 1913,

and that death occurred on the date stated above, at 10 M.

The CAUSE OF DEATH* was as follows:

Cerebral hemorrhage apoplexy
softening of brain

(Duration) 2 yrs. 2 mos. 2 ds.

Contributory (Secondary)

old age

(Duration) 3 yrs. 3 mos. 3 ds.

(Signed)

F. D. Wright M. D.

Sept 3 1913 (Address) Salmon, Ida

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death _____ yrs. _____ mos. _____ days. In the State _____ yrs. _____ mos. _____ days.

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL DATE OF BURIAL

Salmon Cemetery Sept 3 1913.

20. UNDERTAKER

ADDRESS

J. M. C. Boehl Salmon
Ida

-SUPPLEMENTARY DEATH CERTIFICATE-

(Please reply on this sheet to
the registrar of Vital Statistics)

Death Certificate No.

Name..... Daniel Murphy

Date of Death..... September 1, 1913.

Cause of Death..... Cerebral hemorrhage - apoplexy

Contributory Cause of death..... Softening of the brain

(Sign here)..... J. D. Murphy..... M.D.

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Form V. S. No. 5 20M.1-16-12

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH. Registration District No. _____
County of Bonner Primary Registration District No. _____
City of Bonner Ferry, Ida. (St.) _____

File No. 5393

Registered No. _____
If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Lola Mues

PERSONAL AND STATISTICAL PARTICULARS

3. SEX Female 4. COLOR OR RACE White 5. SINGLE, MARRIED, WIDOWED OR DIVORCED. Single
(Write the word.)

6. DATE OF BIRTH Oct 5 1911
(Month) (Day) (Year)

7. AGE 1 yrs. 11 mos. 4 ds.
IF LESS than 1 day how many _____ hrs. or _____ mins.?

8. OCCUPATION
(a) Trade, profession or particular kind of work _____
(b) General nature of industry business, or establishment in which employed (or employer) _____

9. BIRTHPLACE Idaho
(State or Country)

10. NAME OF FATHER Hermann Mues

11. BIRTHPLACE OF FATHER Germany
(State or Country)

12. MAIDEN NAME OF MOTHER Maria Laber

13. BIRTHPLACE OF MOTHER Germany
(State or Country)

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Hermann Mues

(Address) Bonner Ferry, Ida.

15. Filed Sept. 9th 1913. E. J. Moore
Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH Sept 9th 1913
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from Aug. 31st 1913, to Sept. 9th 1913, that I last saw her alive on Sept. 9th 1913, and that death occurred on the date stated above, at 9 P. M.

The CAUSE OF DEATH was as follows:
Cholera infantum.

(Duration) _____ yrs. _____ mos. 11 ds.

Contributory (Secondary) _____

(Duration) _____ yrs. _____ mos. _____ ds.

(Signed) E. J. Moore - M. D.
9/9 1913. (Address) Bonner Ferry, Ida.

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death. _____ yrs. _____ mos. _____ days. In the State. _____ yrs. _____ mos. _____ days.

Where was disease contracted if not at place of death? _____

Former or usual residence. _____

19. PLACE OF BURIAL OR REMOVAL Bonner Ferry DATE OF BURIAL Sept 10 1913

20. UNDERTAKER E. J. Moore ADDRESS Bonner Ferry, Ida.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Form V. S. No. 5. 12½ M. 7-24-11

CERTIFICATE OF DEATH

State of Idaho

BOARD OF HEALTH
Bureau of Vital Statistics

File No. 5391

Registered No.

If death occurred in a hospital, institution or camp give its NAME instead of street and number.

1. PLACE OF DEATH. Registration District No. 87
County of Washington Primary Registration District No. 2154
City of Madala (No. , St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

Jacob M. Fleener

PERSONAL AND STATISTICAL PARTICULARS

3. SEX 4. COLOR OR RACE 5. SINGLE, MARRIED, WIDOWED OR DIVORCED.

Male White Widowed
(Write the word.)

6. DATE OF BIRTH

Aug. 4 1889
(Month) (Day) (Year)

7. AGE

54 yrs. mos. ds.

IF LESS than 1 day
how many hrs. or min?

8. OCCUPATION

(a) Trade, profession or particular kind of work.
(b) General nature of industry business or establishment in which employed (or employer)

Rancher

9. BIRTHPLACE

(State or Country)

Indiana

10. NAME OF FATHER

Michael Fleener

11. BIRTHPLACE OF FATHER

(State or Country)

Indiana

12. MAIDEN NAME OF MOTHER

Rebecca Barnett

13. BIRTHPLACE OF MOTHER

(State or Country)

Indiana

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

(Address)

J. A. Hadden

15.

Filed Aug 5 1913

F. A. Schmitt
Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH

Aug 14 1913
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from

Aug 6 1913, to Aug 14 1913

that I last saw him alive on Aug 13 1913

and that death occurred on the date stated above, at 7 A.M.

The CAUSE OF DEATH* was as follows:

Softening of Brain

(Duration) yrs. 1 mos. ds.

Contributory (Secondary)

Paralysis

(Duration) yrs. mos. 5 ds.

(Signed) F. A. Schmitt M. D.

19 (Address)

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place

In the

of death yrs. mos. ds. State yrs. mos. ds.

Where was disease contracted,

If not at place of death?

Former or

usual residence.

19. PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

Madala Ida Aug 15 1913

20. UNDERTAKER

ADDRESS

L. L. Kuy Madala

DEATH CERTIFICATE
(Please reply on this sheet to
the registrar of Vital Statistics)

Death Certificate No. 5394

Name Jacob M. Flunn - Midvale, Idaho.

Date of Death Aug. 14 1913

Cause of Death ~~Softening of Brain~~ not known

Contributory Cause of death Softening of brain with Paralysis

(Sign here) F. Aschmuth M.D.

Now this is the second time I
have answered this & it is as much as
I know generally speaking softening of brain
is due to syphilis but I am not positive he
had syphilis I hope this will suffice
Yours Dr. F. Aschmuth

1. PLACE OF DEATH. Registration District No. 87
 County of Washington Primary Registration District No. 2154
 City of Medwale (No. , St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Anna Eliza ~~Pickett~~ Pickett

If death occurred in a hospital, institution or camp give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX Female 4. COLOR OR RACE White 5. SINGLE, MARRIED, WIDOWED OR DIVORCED. Married
 (Write the word.)

6. DATE OF BIRTH Mar 16 1888
 (Month) (Day) (Year)

7. AGE 25 yrs. 5 mos. ds. IF LESS than 1 day how many hrs. or min?

8. OCCUPATION

(a) Trade, profession or particular kind of work. House Wife
 (b) General nature of industry business or establishment in which employed (or employer)

9. BIRTHPLACE

(State or Country) Idaho

10. NAME OF FATHER

Thomas Mackey

11. BIRTHPLACE OF FATHER

(State or Country) Mo

12. MAIDEN NAME OF MOTHER

Anna M Moore

13. BIRTHPLACE OF MOTHER

(State or Country) Iowa

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) E Pickett
 (Address) Medwale

15.

Filed Aug 16 1913

Faschmidt
 Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH

August 16 1913
 (Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from Sept 12 1913, to Aug 16 1913, that I last saw her alive on Aug 15 1913, and that death occurred on the date stated above, at 10 AM.

The CAUSE OF DEATH* was as follows:

admission in bowels
 causing obstruction

(Duration) 1 yrs. mos. ds.

Contributory Cause (Secondary)

(Duration) yrs. mos. ds.

(Signed) Faschmidt M. D.

Aug 16 1913 (Address) Medwale

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place In the
 of death yrs. mos. ds. State yrs. mos. ds.
 Where was disease contracted,
 If not at place of death?
 Former or
 usual residence

19. PLACE OF BURIAL OR REMOVAL DATE OF BURIAL

191

20. UNDERTAKER

ADDRESS

G. Ray Medwale

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Form V. S. No. 5 20M.1-16-12

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics
File No. **5396**

1. PLACE OF DEATH

Registration District No. **87**County of **Washington**Primary Registration District No. **2154**City of **Medvale**

(No., St.)

Registered No.

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME **Sarah Della Widmer**

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX

4. COLOR OR RACE

5. SINGLE, MARRIED, WIDOWED OR DIVORCED.

Female **White** **Married**
(Write the word.)

6. DATE OF BIRTH

Mar. **23** **1883**
47
(Month) (Day) (Year)

7. AGE

61 yrs. **4** mos. **20** ds.

IF LESS than 1 day
how many hrs. or
..... mins.?

8. OCCUPATION

(a) Trade, profession or particular kind of work
(b) General nature of industry, business, or establishment in which employed (or employer)

House wife

9. BIRTHPLACE

(State or Country)

Indiana

10. NAME OF FATHER

Noah Ross

11. BIRTHPLACE OF FATHER

(State or Country)

Ohio

12. MAIDEN NAME OF MOTHER

Catherine Evans

13. BIRTHPLACE OF MOTHER

(State or Country)

Ohio

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

Herbert Widmer

(Address)

Medvale Idaho

15.

Filed

Aug 17 **1913****Faschmidt**

Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH

Aug **17** **1913**
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from

Aug 1 - 1913, to **Aug 17 - 1913**,
that I last saw him alive on **Aug 17** **1913**,

and that death occurred on the date stated above, at **7 AM**.

The CAUSE OF DEATH* was as follows:

**Obstructed chest causing
exhaustion of heart**

(Duration) **5** yrs. mos. ds.

Contributory
(Secondary)

(Duration) yrs. mos. ds.

(Signed)

Faschmidt M. D.**Aug 17 1913**(Address) **Medvale**

State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death yrs. mos. days. In the State yrs. mos. days.

Where was disease contracted
if not at place of death?

Former or
usual residence

19. PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

Medvale Idaho**Aug 18 1913**

20. UNDERTAKER

ADDRESS

V. H. Ray**Medvale**

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Form V. S. No. 5. 12½ M. 7-24-11

CERTIFICATE OF DEATH

1. PLACE OF DEATH.

County of IdahoCity of HamiahRegistration District No. 49Primary Registration District No. 2128

(No. _____, _____ St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

Josapina Samuel

State of Idaho

BOARD OF HEALTH
Bureau of Vital StatisticsFile No. 8-539Registered No. 2

If death occurred in a hospital, institution or camp give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX

Female

4. COLOR OR RACE

Indian

5. SINGLE, MARRIED, WIDOWED OR DIVORCED.

Single
(Write the word.)

6. DATE OF BIRTH

June 24
(Month) (Day) (Year)1908
(Year)

7. AGE

5 yrs. one mos. 24 ds.IF LESS than 1 day
how many.....hrs. or
.....min?

8. OCCUPATION

(a) Trade, profession or particular kind of work.....
(b) General nature of industry business or establishment in which employed (or employer).....

9. BIRTHPLACE

(State or Country)

Idaho

10. NAME OF FATHER

Jahn Samuel

11. BIRTHPLACE OF FATHER

(State or Country)

Idaho

12. MAIDEN NAME OF MOTHER

Hattie Johnson

13. BIRTHPLACE OF MOTHER

(State or Country)

don't know

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

(Address)

Katherine Edwards
Hamiah

15.

Filed Sept 17 1913E. J. Johnson
Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH

8 (Month) 17 (Day) 1913 (Year)

17. I HEREBY CERTIFY, That I attended deceased from

Jul 31 1913, to Aug 12 1913
that I last saw her alive on 12 1913and that death occurred on the date stated above, at 8 AM.

The CAUSE OF DEATH* was as follows:

Phthisis Pulmonalis(Duration) ? yrs. ? mos. ? ds.Contributory
(Secondary)(Duration) ? yrs. ? mos. ? ds.(Signed) Wilbur F. McMahon M. D.8/17 1913 (Address) Hamiah, Ida.

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place In the
of death.....yrs.....mos.....ds. State.....yrs.....mos.....ds.

Where was disease contracted,

If not at place of death?

Former or

usual residence.....

19. PLACE OF BURIAL OR REMOVAL DATE OF BURIAL

Indian Cemetery 2 Aug 18 1913

20. UNDERTAKER

ADDRESS

E. J. Johnson Hamiah, Ida.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Form V. S. No. 5. 12½M. 7-24-11

CERTIFICATE OF DEATH

1. PLACE OF DEATH. Registration District No. 49
County of Lewis Primary Registration District No. 2128
City of Kamiah (No. _____, _____ St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

Elias B. Frank

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics
File No. 7 539
Registered No. 7

If death occurred in a hospital, institution or camp give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX 4. COLOR OR RACE 5. SINGLE, MARRIED, WIDOWED OR DIVORCED.

Male Indiansingle
(Write the word.)

6. DATE OF BIRTH

Sept 17 1901
(Month) (Day) (Year)

7. AGE

11 yrs. 11 mos. 13 ds.

IF LESS than 1 day
how many.....hrs. or
.....min?

8. OCCUPATION

(a) Trade, profession or particular kind of work.

that of a child

(b) General nature of industry business or establishment in which employed (or employer)

9. BIRTHPLACE

(State or Country)

Kamiah, Ida.

10. NAME OF FATHER

Willie Frank

11. BIRTHPLACE OF FATHER

(State or Country)

Idaho

12. MAIDEN NAME OF MOTHER

Rachel Monteith

13. BIRTHPLACE OF MOTHER

(State or Country)

Idaho

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

Willie Frank

(Address)

Kamiah Idaho

15.

Filed Sept 2 1913

E. J. Taylor
Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH

Aug 30 1913
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from

Aug. 17th 1913, to Aug. 30th 1913that I last saw him alive on Aug. 30th 1913and that death occurred on the date stated above, at 9:17 P.M.

The CAUSE OF DEATH* was as follows:

Tubercular Meningitis

(Duration) about yrs. 14 ds.

Contributory (Secondary)

Predisposition(Duration) ? yrs. ? mos. ? ds.(Signed) Walker F. McManis M. D.19 (Address) Kamiah, Ida.

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place In the
of death.....yrs.....mos.....ds. State.....yrs.....mos.....ds.

Where was disease contracted,

If not at place of death?

Former or

usual residence.

19. PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

KamiahSept 2 1913

20. UNDERTAKER

ADDRESS

E. J. TaylorKamiah

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Form V. S. No. 5 20M.1-16-12

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH.

Registration District No. 96

County of Nevada

Primary Registration District No. 1009

City of Leviston(No. Hospital St.)

File No. 5394

Registered No. 10

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

Joseph C. Nachtsheim

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX

M

4. COLOR OR RACE

W

5. SINGLE, MARRIED, WIDOWED OR DIVORCED.

Single
(Write the word.)

6. DATE OF BIRTH

Sept
(Month)26
(Day)1917
(Year)

7. AGE

35 yrs. 10 mos. 7 ds.IF LESS than 1 day
how many hrs. or
..... mins.?

8. OCCUPATION

(a) Trade, profession or particular kind of work

Baker

(b) General nature of industry business, or establishment in which employed (or employer)

9. BIRTHPLACE

(State or Country)

Prussia

10. NAME OF FATHER

Joseph Nachtsheim

11. BIRTHPLACE OF FATHER

(State or Country)

Germany

12. MAIDEN NAME OF MOTHER

Gertrude Plouman

13. BIRTHPLACE OF MOTHER

(State or Country)

Germany

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

Mary M. Nachtsheim

(Address)

37 B 2 Denver Col.

15.

Filed

Sept 10

1913

R. J. Perkins

Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH

Aug.
(Month)2nd
(Day)1917
(Year)

17. I HEREBY CERTIFY, That I attended deceased from

July 13 1917, to Aug. 2 1917that I last saw him alive on Aug. 2nd 1917and that death occurred on the date stated above, at 9:30 P.M.

The CAUSE OF DEATH* was as follows:

Ephors(Duration) yrs. mos. 20 ds.Contributory
(Secondary)

(Duration) yrs. mos. ds.

(Signed)

C. Sanson

M. D.

8/3 1917 (Address) Leviston

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death yrs. mos. days. In the State yrs. mos. days.

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

LevistonAug 4 1917

20. UNDERTAKER

ADDRESS

C. J. VassarLeviston

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Form V. S. No. 5 20M.1-16-12

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH.

Registration District No. 96

County of N. 2 Range

Primary Registration District No. 1009

City of Idaho Falls

(No. 223, 4th St. St.)

File No. 540

Registered No. 11

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Mrs. Sadie Lunning

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX

4. COLOR OR RACE

5. SINGLE, MARRIED, WIDOWED OR DIVORCED.

F

W

Married
(Write the word.)

6. DATE OF BIRTH

Aug 7 1860
(Month) (Day) (Year)

7. AGE

52 yrs. 11 mos. 5 ds.

IF LESS than 1 day
how many hrs. or mins.?

8. OCCUPATION

(a) Trade, profession or particular kind of work

(b) General nature of industry business, or establishment in which employed (or employer)

Housewife

9. BIRTHPLACE

(State or Country)

Utah

10. NAME OF FATHER

F. Truher

11. BIRTHPLACE OF FATHER

(State or Country)

England

12. MAIDEN NAME OF MOTHER

Ann Truher

13. BIRTHPLACE OF MOTHER

(State or Country)

Scotland

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

(Address)

J. J. G. G.
Idaho Falls

15.

Filed Sept. 10 1918 L. J. Perkins
Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH

Aug 11 1913
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from

May 10 1913, to Aug 2 1913,
that I last saw him alive on Aug 2 1913,
and that death occurred on the date stated above, at 1:30 P. M.

The CAUSE OF DEATH* was as follows:

Cardiac dropsy

(Duration) 2 yrs. 11 mos. 5 ds.

Contributory (Secondary) Intestinal Nephritis

(Duration) 2 yrs. 11 mos. 5 ds.

(Signed) J. J. G. G. M. D.

19. (Address) Idaho Falls

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death.....yrs.....mos.....days. In the State.....yrs.....mos.....days.

Where was disease contracted if not at place of death?

Former or usual residence.....

19. PLACE OF BURIAL OR REMOVAL DATE OF BURIAL

20. UNDERTAKER ADDRESS

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Form V. S. No. 5 20M.1-16-12

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics
File No. 5409
Registered No. 13

1. PLACE OF DEATH.

Registration District No. 96
County of Keswice Primary Registration District No. 1009
City of Lauriston (No. 1503, Travis St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

J. N. Lindsay

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX

4. COLOR OR RACE

5. SINGLE, MARRIED, WIDOWED OR DIVORCED.

Male White Married
(Write the word.)

6. DATE OF BIRTH

April 12 1913
Month Day Year

7. AGE

85 yrs. 3 mos. 8 ds.

IF LESS than 1 day
how many hrs. or mins.?

8. OCCUPATION

(a) Trade, profession or particular kind of work

(b) General nature of industry business, or establishment in which employed (or employer)

retired

9. BIRTHPLACE

(State or Country)

Ohio

10. NAME OF FATHER

John Lindsay

11. BIRTHPLACE OF FATHER

(State or Country)

Scotland

12. MAIDEN NAME OF MOTHER

Nancy Miller

13. BIRTHPLACE OF MOTHER

(State or Country)

Ohio

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

(Address)

J. G. Vassar
Lauriston

15.

Filed

Sept 10 1913 L. J. Perkins
Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH

Aug. 16 1913
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from

1913, to Death 1913,
that I last saw him alive on Aug. 10 1913

and that death occurred on the date stated above, at 6 a.m.

The CAUSE OF DEATH* was as follows:

General Senility.

(Duration) yrs. mos. ds.

Contributory
(Secondary)

(Duration) yrs. mos. ds.

(Signed) R. J. Perkins M. D.

8-16-1913 (Address) R. J. Perkins

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death.....yrs.....mos.....days. In the State.....yrs.....mos.....days.

Where was disease contracted if not at place of death?

Former or usual residence.....

19. PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

Lauriston Aug 17 1913

20. UNDERTAKER

ADDRESS

J. G. Vassar Lauriston

Form V. S. No. 5 20M.1-16-12

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH

Registration District No. 96

County of Ney Perce

Primary Registration District No. 1009

City of Lawson(No. Hospital St.)

File No. 540?

Registered No. 14

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

Leta A. Keyser

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX

F

4. COLOR OR RACE

W.5. SINGLE, MARRIED, WIDOWED OR DIVORCED
married
(Write the word.)

6. DATE OF BIRTH

March 15 1913
(Month) (Day) (Year)

7. AGE

23 yrs. 5 mos. 6 ds.IF LESS than 1 day
how many hrs. or
..... mins.?

8. OCCUPATION

- (a) Trade, profession or particular kind of work
-
- (b) General nature of industry, business, or establishment in which employed (or employer)

none

9. BIRTHPLACE

(State or Country)

Fairfield Wn

10. NAME OF FATHER

L. M. Lawson

11. BIRTHPLACE OF FATHER

(State or Country)

not known

12. MAIDEN NAME OF MOTHER

" "

13. BIRTHPLACE OF MOTHER

(State or Country)

" "

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

Henry Keyser

(Address)

Priest River Idaho

15.

Filed

Sept 10 19131913L. Perkins
Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

Aug 21 1913
(Month) (Day) (Year)17. I HEREBY CERTIFY, That I attended deceased from Aug 16 1913, to Aug 21 1913, that I last saw her alive on Aug 20 1913, and that death occurred on the date stated above, at 7:40 A.M.

The CAUSE OF DEATH* was as follows:

Uremia(Duration) yrs. 1 mos. — ds.Contributory Chronic nephritis
(Secondary) unknown(Duration) yrs. 7 mos. — ds.(Signed) Edgar H. White M. D.Aug 21 1913 (Address) Lawson

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death yrs. mos. 1 1/2 days. In the State yrs. mos. 1 1/2 days.Where was disease contracted if not at place of death? Priest RiverFormer or usual residence Priest River

19. PLACE OF BURIAL OR REMOVAL

Priest River, Ida 1913

20. UNDERTAKER

Q. Vassar

ADDRESS

Lawson

13392-1-1003

Form V. S. No. 5 20M.1-16-12

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH. Registration District No. 96
County of Nez Perce Primary Registration District No. 1009
City of Lewiston (No. 816 10 th Ave St.)

File No. 5401

Registered No. 16

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

John A. Vinore

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX M 4. COLOR OR RACE W 5. SINGLE, MARRIED, WID-
OWED OR DIVORCED. married
(Write the word.)

6. DATE OF BIRTH Aug 31 - 1852
(Month) (Day) (Year)

7. AGE 56 yrs. 11 mos. 24 ds. IF LESS than 1 day
how many hrs. or
..... mins.?

8. OCCUPATION
(a) Trade, profession or particular kind of work Painter
(b) General nature of industry business, or establishment in which employed (or employer)

9. BIRTHPLACE
(State or Country) Canada

10. NAME OF FATHER John Vinore

11. BIRTHPLACE OF FATHER England
(State or Country)

12. MAIDEN NAME OF MOTHER Rebecca Truller

13. BIRTHPLACE OF MOTHER Scotland
(State or Country)

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) W. N. Green
(Address) Lewiston

15. Filed Sept 10 1913 L. J. Perkins
Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH

Aug = 24 = 1913
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from
1910, to Aug 24 1913,
that I last saw him alive on Aug 24 1913,
and that death occurred on the date stated above, at 2 A.M.

The CAUSE OF DEATH* was as follows:

Hemiplegia

(Duration) 3 yrs. - mos. - ds.

Contributory
(Secondary)

(Duration) 3 yrs. - mos. - ds.

(Signed) L. J. Perkins M. D.

8-26-1913 (Address) Lewiston Idaho

*State the DISEASE CAUSING DEATH; or if deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death yrs. mos. days. In the State yrs. mos. days.

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL DATE OF BURIAL

Lewiston Aug 25 1913

20. UNDERTAKER ADDRESS

C. J. Vassar Lewiston

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

MARGIN RESERVED FOR BINDING
WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Form V. S. No. 5. 12½ M. 7-24-11

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics
File No. 5409
Registered No. 17

1. PLACE OF DEATH. Registration District No. 76
County of Nez Perce Primary Registration District No. 1009
City of Lewiston (No. , St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

Joseph Triplett

If death occurred in a hospital, institution or camp give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX Male 4. COLOR OR RACE White 5. SINGLE, MARRIED, WIDOWED OR DIVORCED. Widower
(Write the word.)

6. DATE OF BIRTH Nov 4 1835
(Month) (Day) (Year)

7. AGE 78 yrs. mos. ds. IF LESS than 1 day how many hrs. or min?

8. OCCUPATION

(a) Trade, profession or particular kind of work.
(b) General nature of industry business or establishment in which employed (or employer).

Farmer

9. BIRTHPLACE

(State or Country)

Kentucky

10. NAME OF FATHER

Mr Triplett

11. BIRTHPLACE OF FATHER

(State or Country)

unknown

12. MAIDEN NAME OF MOTHER

unknown

13. BIRTHPLACE OF MOTHER

(State or Country)

unknown

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

C. T. Shannahan

(Address)

Lewiston

15.

Filed Sept. 10 1913

L. G. Perkins

Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH

Aug 28

(Month) (Day) (Year) 1913

17. I HEREBY CERTIFY, That I attended deceased from Oct- 1912, to Aug 28 1913 that I last saw h alive on Aug 28 1913 and that death occurred on the date stated above, at 2 P.M.

The CAUSE OF DEATH* was as follows:

Partial Paralysis for

(Duration) 7 yrs. mos. ds. Contributory old age (Secondary)

(Duration) yrs. mos. ds. (Signed) C. T. Shannahan M. D. 19 (Address) Supt. C. Hoop

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place 1912 Co Hoop In the of death yrs. mos. ds. State. yrs. mos. ds. Where was disease contracted, If not at place of death? Former or usual residence.

19. PLACE OF BURIAL OR REMOVAL DATE OF BURIAL

Lewiston

Aug 29 1913

20. UNDERTAKER

C. J. Vassar

ADDRESS

Lewiston

Form V., S. No. 5 20M.1-16-12

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH.

Registration District No. 73County of BonanzaPrimary Registration District No. 2187City of East Falls

(No., St.)

File No. 540Registered No. 5-6

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Jno. Jackline

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX

Male

4. COLOR OR RACE

White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED.

(Write the word.)

6. DATE OF BIRTH

1
(Month) (Day) (Year)

7. AGE

53 yrs. mos. ds.IF LESS than 1 day
how many hrs. or
..... mins.?

8. OCCUPATION

(a) Trade, profession or particular kind of work
(b) General nature of industry business, or establishment in which employed (or employer)Sheep Herder

9. BIRTHPLACE

(State or Country)

10. NAME OF FATHER

11. BIRTHPLACE OF FATHER

(State or Country)

12. MAIDEN NAME OF MOTHER

13. BIRTHPLACE OF MOTHER

(State or Country)

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) B. E. Dinwoody(Address) East Falls, Idaho

15.

Filed Aug 31913

Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH

Aug 2 1913
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from

one 1913 to Aug 2, 1913that I last saw him alive on Aug 2, 1913and that death occurred on the date stated above, at 10 P. M.

The CAUSE OF DEATH* was as follows:

Contusion (accidental) over grain causing strangulation of an irreducible femoral hernia(Duration) yrs. mos. 10 ds.Contributory
(Secondary)Septicemia

(Duration) yrs. mos. ds.

(Signed)

John O'Meller M. D.43 1913 (Address) East Falls, Idaho

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL OR HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death yrs. mos. days. In the State yrs. mos. days.

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

Idaho Falls8/3 1913

20. UNDERTAKER

ADDRESS

B. E. DinwoodyIdaho Falls

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Form V. S. No. 5 20M.1-16-12

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH.

Registration District No. 73

County of Bonneville

Primary Registration District No. 215-0

City of Idaho Falls

(No. _____ St.)

File No. 5409

Registration No. 57

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

William Archibald

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX

4. COLOR OR RACE

5. SINGLE, MARRIED, WIDOWED OR DIVORCED.

Male White

Married
(Write the word.)

6. DATE OF BIRTH

Feb. 18 1867
(Month) (Day) (Year)

7. AGE

46 yrs. 7 mos. 4 ds.

IF LESS than 1 day
how many _____ hrs. or
_____ mins.?

8. OCCUPATION

(a) Trade, profession or particular kind of work
(b) General nature of industry business, or establishment in which employed (or employer)

Farmer

9. BIRTHPLACE

(State or Country)

Utah

10. NAME OF FATHER

William Archibald

11. BIRTHPLACE OF FATHER

(State or Country)

Scotland

12. MAIDEN NAME OF MOTHER

Elizabeth Halliday

13. BIRTHPLACE OF MOTHER

(State or Country)

Scotland

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) A. H. Archibald

(Address) Garland Utah

15.

Filed Aug 14 - 1913

Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH

Aug 14 1913
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from

Aug. 12 1913, to Aug 14 1913,

that I last saw him alive on Aug 14 1913

and that death occurred on the date stated above, at 5 P.M.

The CAUSE OF DEATH* was as follows:

Cancer Stomach

(Duration) _____ yrs. _____ mos. _____ ds.

Contributory
(Secondary)

(Duration) _____ yrs. _____ mos. _____ ds.

(Signed) [Signature] M. D.

14 1913 (Address) Idaho Falls

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death _____ yrs. _____ mos. _____ days. In the State _____ yrs. _____ mos. _____ days.

Where was disease contracted if not at place of death?

Former or usual residence.

19. PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

Jona Idaho

Aug 16 1913

20. UNDERTAKER

ADDRESS

J. H. Hunt

Idaho Falls

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Form V. S. No. 5 20M.1-16-12

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics
File No. 5411
Registered No. 60

1. PLACE OF DEATH

Registration District No. 73

County of Bonneville

Primary Registration District No. 2150

City of Idaho Falls

(No. _____ St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

George Stanger

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX

Male

4. COLOR OR RACE

White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED.

Married
(Write the word.)

6. DATE OF BIRTH

Nov

5

1933

(Month)

(Day)

(Year)

7. AGE

80

9

yrs. 17 mos. 17 ds.

IF LESS than 1 day
how many hrs. or
..... mins.?

8. OCCUPATION

(a) Trade, profession or particular kind of work

(b) General nature of industry business, or establishment in which employed (or employer)

Farmer

9. BIRTHPLACE

(State or Country)

England

10. NAME OF FATHER

James Stanger

11. BIRTHPLACE OF FATHER

(State or Country)

England

12. MAIDEN NAME OF MOTHER

Elizabeth Thomas

13. BIRTHPLACE OF MOTHER

(State or Country)

England

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

Geo. W. Stanger

(Address)

Nealey Idaho

15.

Filed

Aug 23

1913

Local Registrar

Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH

Aug

22

1913

(Month)

(Day)

(Year)

17. I HEREBY CERTIFY, That I attended deceased from

July 8, 1913, to Aug. 22, 1913

that I last saw him alive on Aug. 19, 1913

and that death occurred on the date stated above, at 12:55 P.M.

The CAUSE OF DEATH* was as follows:

General physical collapse.
(No definite disease demonstrable)

(Duration) 1 yrs. 1 mos. 14 ds.

Contributory

(Secondary)

(Duration) yrs. mos. ds.

(Signed)

1913

(Address)

John Miller
Idaho Falls

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death yrs. mos. days. In the State yrs. mos. days.

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

Lincoln Idaho

Aug 24 1913

20. UNDERTAKER

ADDRESS

G. H. Hunt

Idaho Falls

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Form V. S. No. 5 20M.1-16-12

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH.

Registration District No. 72

County of Bonneville

Primary Registration District No. 211-0

City of Sona

(No. , St.)

File No. 5412

Registered No. 61

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Karen K. Olsen

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX

4. COLOR OR RACE

5. SINGLE, MARRIED, WID-
OWED OR DIVORCED.
married
(Write the word.)

Female

White

6. DATE OF BIRTH

March 25 1896
(Month) (Day) (Year)

7. AGE

77 yrs. 5 mos. X ds.

IF LESS than 1 day
how many hrs. or
..... mins.

8. OCCUPATION

(a) Trade, profession or
particular kind of work

at home

(b) General nature of industry
business, or establishment in
which employed (or employer)

9. BIRTHPLACE

(State or Country)

Norway

10. NAME OF
FATHER

J. Hansen

11. BIRTHPLACE
OF FATHER

(State or Country)

Norway

12. MAIDEN NAME
OF MOTHER

Dorothy

13. BIRTHPLACE
OF MOTHER

(State or Country)

Norway

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Mrs. Olette Olsen

(Address) Sona, Ida

15.

Filed Aug 24 1913

E. J. Jensen
Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH

Aug 25 1913
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from
Jan. 21, 1913 to Aug. 25, 1913

that I last saw h. at alive on Aug. 23, 1913

and that death occurred on the date stated above, at 3:30 A.M.

The CAUSE OF DEATH* was as follows:

Chronic nephritis

(Duration) Indefinite yrs. mos. ds.

Contributory Edema (General)
(Secondary)

(Duration) Indefinite yrs. mos. ds.

(Signed) John V. Miller M. D.

1913 (Address) Idaho Falls

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death yrs. mos. days. In the State yrs. mos. days.

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL DATE OF BURIAL

Sona, Ida Aug 27 1913

20. UNDERTAKER ADDRESS

B. B. Linwood Idaho Falls

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Form V. S. No. 5 20M.1-16-12

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH.

County of Bonerville
City of Idaho Falls

Registration District No. 73Primary Registration District No. 211-0(No. St.)File No. 5413Registered No. 62

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

Johanna Schwarz

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX

Female

4. COLOR OR RACE

White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED.

Married
(Write the word.)

6. DATE OF BIRTH

June 16 1865
(Month) (Day) (Year)

7. AGE

48 yrs. 2 mos. 14 ds.

IF LESS than 1 day
how many hrs. or
 mins.?

8. OCCUPATION

- (a) Trade, profession or particular kind of work
(b) General nature of industry business, or establishment in which employed (or employer)

Housewife

9. BIRTHPLACE

(State or Country)

Germany

10. NAME OF FATHER

Unknown

11. BIRTHPLACE OF FATHER

(State or Country)

Germany

12. MAIDEN NAME OF MOTHER

Unknown

13. BIRTHPLACE OF MOTHER

(State or Country)

Germany

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

(Address)

H. Schwarz
Idaho Falls, Id.

15.

Filed

Sept 31913Local Registrar

Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH

Aug 30 1913
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from

June 1913, to Aug 30 1913,
that I last saw him alive on Aug 28 1913,
and that death occurred on the date stated above, at 9:00 PM.

The CAUSE OF DEATH* was as follows:

Pneumonia Nephritis(Duration) yrs. 6 mos. ds.Contributory
(Secondary)(Duration) yrs. 6 mos. ds.

(Signed)

Sept 13 1913

(Address)

Idaho Falls, Id.

M. D.

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death yrs. mos. days. In the State yrs. mos. days.

Where was disease contracted if not at place of death?

Former or usual residence.

19. PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

Idaho FallsAug 30 1913

20. UNDERTAKER

ADDRESS

G. H. HuntIdaho Falls

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Form V. S. No. 5 20M.1-16-12

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics
File No. 5414

1. PLACE OF DEATH. Registration District No. 73
County of Bonner County Primary Registration District No. 2110
City of Shelton (No. St.)
If death occurs away from usual residence, give facts called for under special information. 2. FULL NAME Eliza Ann Lovell

Registered No. 63
If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX Female 4. COLOR OR RACE White 5. SINGLE, MARRIED, WIDOWED OR DIVORCED. Married (Write the word.)

6. DATE OF BIRTH Nov. 21 1899 (Month) (Day) (Year)

7. AGE 24 yrs. 9 mos. - ds. IF LESS than 1 day how many hrs. or mins?

8. OCCUPATION (a) Trade, profession or particular kind of work Housewife (b) General nature of industry business, or establishment in which employed (or employer)

9. BIRTHPLACE (State or Country) South Cottonwood Utah

10. NAME OF FATHER Dan. J. Heavering

11. BIRTHPLACE OF FATHER Illinois (State or Country)

12. MAIDEN NAME OF MOTHER Eliza Ann Heavering

13. BIRTHPLACE OF MOTHER Utah (State or Country)

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE (Informant) John H. Lovell (Address)

15. Filed Little 1913 Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH Sept 6 1913 (Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from June 1912, to Sept 6 1913 that I last saw her alive on Aug 20 1913 and that death occurred on the date stated above, at 10 P.M. The CAUSE OF DEATH* was as follows:

Chronic Nephritis (Duration) 2 yrs. 2 mos. 2 ds.

Contributory (Secondary) Myocarditis (Duration) 2 yrs. 2 mos. 2 ds. (Signed) J. H. Heavering M. D. (Address) Idaho Falls, Idaho

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death.....yrs.....mos.....days. In the State.....yrs.....mos.....days.

Where was disease contracted if not at place of death?

Former or usual residence?

19. PLACE OF BURIAL OR REMOVAL Sept. 9-Shelton DATE OF BURIAL Sept 9 1913

20. UNDERTAKER J. H. Heavering ADDRESS Idaho Falls

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Form V. S. No. 5 20M.1-16-12

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH.

Registration District No. 28 70

County of Shoshone

Primary Registration District No. 1011

City of Wallace

(No. Wallace, Ida., Frontier, Dist.)

File No. 5416

Registered No. 59

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

Olefred Shultz

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX

male

4. COLOR OR RACE

white

5. SINGLE, MARRIED, WIDOWED OR DIVORCED.

single
(Write the word.)

6. DATE OF BIRTH

(Month)

(Day)

(Year)

1891

7. AGE

32 yrs. 0 mos. - ds.

IF LESS than 1 day
how many hrs. or
..... mins.?

8. OCCUPATION

(a) Trade, profession or particular kind of work

Clerk

(b) General nature of industry, business, or establishment in which employed (or employer)

Mining

9. BIRTHPLACE

(State or Country)

Nebr.

10. NAME OF FATHER

Paul H. Shultz

11. BIRTHPLACE OF FATHER

(State or Country)

Germany

12. MAIDEN NAME OF MOTHER

Paulina Krause

13. BIRTHPLACE OF MOTHER

(State or Country)

Germany

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

Paul H. Shultz

(Address)

Gen

15.

Filed

Aug 1,

1913

F. Leo Ziegler

Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH

July

(Month)

28

(Day)

1913

(Year)

17. I HEREBY CERTIFY, That I attended deceased from

July 27 1913, to July 28 1913,

that I last saw him alive on July 28 1913,

and that death occurred on the date stated above, at 3 P.M.

The CAUSE OF DEATH* was as follows:

Scalded by escaping steam

(Duration)

yrs.

mos.

ds.

Contributory

(Secondary)

(Duration)

yrs.

mos.

ds.

(Signed)

L. H. Nowers

M. D.

1911

(Address)

Wallace, Ida.

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death

yrs.

mos.

days

In the

State

yrs.

mos.

days

Where was disease contracted if not at place of death?

Former or usual residence

Wallace, Ida.

19. PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

Wallace, Ida.

Aug 3 1911

20. UNDERTAKER

ADDRESS

Mark Under Co.

Wallace, Ida.

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Form V. S. No. 5 20M.1-16-12

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics
File No. 5418
Registered No. 61

1. PLACE OF DEATH. Registration District No. 2870
County of Shoshone Primary Registration District No. 1011
City of Wallace (No. _____, St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME William Bragg
If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX male 4. COLOR OR RACE white 5. SINGLE, MARRIED, WIDOWED OR DIVORCED. single
(Write the word.)

6. DATE OF BIRTH _____
(Month) (Day) (Year)

7. AGE 30 yrs. _____ mos. _____ ds.
IF LESS than 1 day how many _____ hrs. or _____ mins.?

8. OCCUPATION
(a) Trade, profession or particular kind of work miner
(b) General nature of industry, business, or establishment in which employed (or employer) _____

9. BIRTHPLACE
(State or Country) unknown

10. NAME OF FATHER _____

11. BIRTHPLACE OF FATHER
(State or Country) _____

12. MAIDEN NAME OF MOTHER _____

13. BIRTHPLACE OF MOTHER
(State or Country) _____

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Sam Kilburn
(Address) Box 107 Wallace Ida.

15. Filed Aug 4 1913 E. Geo. Young
Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH Jul 29 1913
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from _____ 191____, to _____ 191____, that I last saw him alive on _____ 191____, and that death occurred on the date stated above, at 12 M.
The CAUSE OF DEATH* was as follows:

Accidentally fell into a chute in snow storm mine at Wallace, Idaho
(Duration) _____ yrs. _____ mos. _____ ds.

Contributory (Secondary) None
(Signed) Chas. R. Montgomery M. D.
Aug 4 1913 (Address) Wallace Ida.

State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death _____ yrs. _____ mos. _____ days. In the State _____ yrs. _____ mos. _____ days.
Where was disease contracted if not at place of death? _____
Former or usual residence _____

19. PLACE OF BURIAL OR REMOVAL Wallace Ida DATE OF BURIAL Aug 4 1913

20. UNDERTAKER Edward Underleky ADDRESS Wallace Ida

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Form V. S. No. 5 20M.1-16-12

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics
File No. **5419**

1. PLACE OF DEATH.

Registration District No. **28 70**

County of **Shoshone**

Primary Registration District No. **1011**

City of **Wallace**

(No. _____ St.)

Registered No. **62**

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME **Ophia Mc Namar**

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX

4. COLOR OR RACE

5. SINGLE, MARRIED, WIDOWED OR DIVORCED.
married
(Write the word.)

Female

white

6. DATE OF BIRTH

(Month) _____ (Day) _____ (Year) _____

7. AGE

36 yrs. _____ mos. _____ ds.

IF LESS than 1 day
how many _____ hrs. or
_____ mins.?

8. OCCUPATION

(a) Trade, profession or particular kind of work
(b) General nature of industry, business, or establishment in which employed (or employer)

housewife

9. BIRTHPLACE

(State or Country)

Canada

10. NAME OF FATHER

Narcia Bellmorr

11. BIRTHPLACE OF FATHER

(State or Country)

unknown

12. MAIDEN NAME OF MOTHER

13. BIRTHPLACE OF MOTHER

(State or Country)

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

Chas A Mc Namar

(Address)

Wallace Idaho

15.

Filed

Aug 2, 1913

1913

L. Ker Lingler

Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH

July 30 191**3**
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from

July 29 191**3**, to **July 30** 191**3**
that I last saw h **alive** on **July 30** 191**3**

and that death occurred on the date stated above, at _____ M.

The CAUSE OF DEATH was as follows:

**Popliteal fracture of humerus
fracture of humerus by fractured ribs**
(Duration) _____ yrs. _____ mos. **1 1/2** ds.

Contributory
(Secondary)

(Duration) _____ yrs. _____ mos. _____ ds.

(Signed)

J. W. Smith

M. D.

Aug 2, 1913 (Address) **Wallace Idaho**

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death _____ yrs. _____ mos. **1 1/2** days In the State _____ yrs. _____ mos. _____ days.

Where was disease contracted if not at place of death?

Left Wallace

Former or usual residence

Wallace Idaho

19. PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

Wallace Idaho Aug 2 1913

20. UNDERTAKER

ADDRESS

Ward Undertaking Co Wallace

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Form V. S. No. 5 20M.1-16-12

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH.

Registration District No. 28 70

County of Shoshone

Primary Registration District No. 1011-

City of Wallace

(No. _____, _____ St.)

File No. 5420

Registered No. 63

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Lennie Benson

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX

4. COLOR OR RACE

5. SINGLE, MARRIED, WIDOWED OR DIVORCED.

Female

white

single
(Write the word.)

6. DATE OF BIRTH

(Month)

(Day)

(Year)

7. AGE

10 yrs.

— mos.

— ds.

IF LESS than 1 day
how many _____ hrs. or
_____ mins.?

8. OCCUPATION

(a) Trade, profession or particular kind of work

student

(b) General nature of industry, business, or establishment in which employed (or employer)

9. BIRTHPLACE

(State or Country)

Missouri

10. NAME OF FATHER

Fred Benson

11. BIRTHPLACE OF FATHER

(State or Country)

Missouri

12. MAIDEN NAME OF MOTHER

Carrie Hutsell

13. BIRTHPLACE OF MOTHER

(State or Country)

Kansas

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

G. L. Hutsell

(Address)

Wallace 2da

15.

Filed

Aug. 8,

1913

F. L. Hood

Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH

July Aug 8
(Month) (Day) (Year)

1913

17. I HEREBY CERTIFY, That I attended deceased from

July 1913, to Aug 8 1913,
that I last saw her alive on Aug. 8 1913,

and that death occurred on the date stated above, at 50 M.

The CAUSE OF DEATH* was as follows:

Acute pericarditis

(Duration)

yrs.

mos.

ds.

Contributory

(Secondary)

(Duration)

yrs.

mos.

ds.

(Signed)

St. Leo J. Murphy M. D.

1913

(Address)

Wallace, Idaho

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place

of death

yrs. 4

mos. _____

days _____

In the

State

yrs. _____

mos. _____

days _____

Where was disease contracted if not at place of death?

Former or

usual residence

19. PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

Wallace

July 4 1913

20. UNDERTAKER

ADDRESS

Ward Undertaking Wallace 2da

MARGIN RESERVED FOR BINDING
WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Form V. S. No. 5 20M.1-16-12

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH.

Registration District No. 70

County of Shoshone

Primary Registration District No. 1011

City of Wallace

(No. Providence Hospital St.)

File No. 5421

Registered No. 67

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME William Harrold Brown

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX

male

4. COLOR OR RACE

white

5. SINGLE, MARRIED, WID-
OWED OR DIVORCED.

single

(Write the word.)

6. DATE OF BIRTH

7 1 1905
(Month) (Day) (Year)

7. AGE

8 yrs. 1 mos. 17 ds.

IF LESS than 1 day
how many hrs. or
mins.?

8. OCCUPATION

(a) Trade, profession or
particular kind of work

none

(b) General nature of industry
business, or establishment in
which employed (or employer)

9. BIRTHPLACE

(State or Country)

Wallace, Idaho

10. NAME OF
FATHER

G. W. Brown

11. BIRTHPLACE
OF FATHER

(State or Country)

Pennsylvania

12. MAIDEN NAME
OF MOTHER

Bessie Wood

13. BIRTHPLACE
OF MOTHER

(State or Country)

Wisconsin

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

G. W. Brown
(Address) Wallace, Idaho

15.

Filed Aug 18 1913

Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH

8 17 1913
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from

Aug 11 1913 to Aug 17 1913

that I last saw him alive on Aug 16 1913

and that death occurred on the date stated above, at 2:30 M.

The CAUSE OF DEATH* was as follows:

Peritonitis

(Duration) yrs. mos. 3 ds.

Contributory
(Secondary)

(Duration) yrs. mos. ds.

(Signed)

Chas. R. Mowery M. D.

8/17 1913 (Address) Wallace, Idaho

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death Providence Hosp in the
0 yrs. 0 mos. 5 days. State Idaho yrs. mos. days.

Where was disease contracted if not at place of death? Missoula, Mont

Former or usual residence Wallace, Idaho

19. PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

Wallace, Idaho

8/19 1913

20. UNDERTAKER

ADDRESS

Bruce S. Worstell Wallace, Ida.

-SUPPLEMENTARY DEATH CERTIFICATE-

(Please reply on this sheet to
the registrar of Vital Statistics)

Death Certificate No. 5421

Name William Harold Brown

Date of Death Aug. 17 1913

Cause of Death Peritonitis

Contributory Cause of death

(Sign here) Chas. R. Mowery M.D.

DR. CHARLES R. MOWERY
DR. HERBERT C. MOWERY
PHYSICIANS AND SURGEONS

OFFICE O'NEIL-SAMUELS BUILDING
OVER WALLACE NATIONAL BANK

WALLACE, IDAHO Mar. 31, 1914.

Dr. Ralph Falk,

Boise, Ida.

My Dear Doctor:-

Your kind inquiry of recent date at hand and contents noted. Would say that it would be impossible to state the exact cause of the peritonitis in this case as there was no autopsy held and the patient had been under treatment in Missoula, Mont. before coming into our hands. When we received the patient he had a peritonitis so pronounced that we could not decide positively where the source of the infection began.

If you can advise further what you desire of us we will be pleased to assist you.

Very Respectfully,

RECEIVED

APR 2 1914

SECRETARY'S OFFICE
STATE BOARD OF HEALTH

Chas. R. Mowery MD

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Form V. S. No. 5 20M.1-16-12

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH.

Registration District No. 70County of ShoshonePrimary Registration District No. 1011City of Wallace

(No. _____, _____ St.)

File No. 5422Registered No. 65

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

Margaret Oxwang

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX

Female

4. COLOR OR RACE

white

5. SINGLE, MARRIED, WIDOWED OR DIVORCED.

single
(Write the word.)

6. DATE OF BIRTH

(Month) _____ (Day) 1 (Year) _____

7. AGE

27 yrs. _____ mos. _____ ds.IF LESS than 1 day
how many _____ hrs. or
_____ mins.

8. OCCUPATION

(a) Trade, profession or particular kind of work
(b) General nature of industry business, or establishment in which employed (for employer)nurse

9. BIRTHPLACE

(State or Country)

Iowa

10. NAME OF FATHER

Peter Oxwang

11. BIRTHPLACE OF FATHER

(State or Country)

Germany

12. MAIDEN NAME OF MOTHER

Brigitta Payson

13. BIRTHPLACE OF MOTHER

(State or Country)

Germany

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

Mrs. H. Ackley

(Address)

Denison, Iowa

15.

Filed Aug. 18, 19131913H. Leo Denison

Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH

Aug 17 1913
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from

Jan. 1913, to Aug. 17 1913that I last saw h. 16 alive on Aug 16 1913and that death occurred on the date stated above, at 3 A.M.

The CAUSE OF DEATH* was as follows:

Embolism of coronaries
by heart trouble(Duration) yrs. 8 mos. _____ ds.Contributory Heart trouble, Valvular
(Secondary)

(Duration) yrs. _____ mos. _____ ds.

(Signed) J. St. Jean M. D.Aug 16 1913. (Address) Denison, Idaho

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death _____ yrs. _____ mos. _____ days. In the State _____ yrs. _____ mos. _____ days.

Where was disease contracted if not at place of death?

Former or usual residence _____

19. PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

Denison, Iowa 19 1913

20. UNDERTAKER

ADDRESS

Wards Undertaking Co

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Form V. S. No. 5 20M.1-16-12

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics
File No. 5423

1. PLACE OF DEATH.

Registration District No. 70

County of Shoshone

Primary Registration District No. 1011

City of Wallace

(No. _____)

St.)

Registered No. 66

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

Frances Bock

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX

Female

4. COLOR OR RACE

white

5. SINGLE, MARRIED, WIDOWED OR DIVORCED.

single
(Write the word.)

6. DATE OF BIRTH

(Month)

(Day)

(Year)

7. AGE

2 yrs. 4 mos. 1 ds.

IF LESS than 1 day
how many hrs. or
..... mins.

8. OCCUPATION

(a) Trade, profession or particular kind of work
(b) General nature of industry business, or establishment in which employed (or employer)

none

9. BIRTHPLACE

(State or Country)

Wallace Ida

10. NAME OF FATHER

Charles Rock

11. BIRTHPLACE OF FATHER

(State or Country)

Tenn.

12. MAIDEN NAME OF MOTHER

Lena Simmerman

13. BIRTHPLACE OF MOTHER

(State or Country)

Germany

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

Lincoln Rock

(Address)

Burke

15.

Filed

Aug. 23

1913

F. Leo Zunker

Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH

Aug

20

1913

(Month)

(Day)

(Year)

17. I HEREBY CERTIFY, That I attended deceased from

Aug 17

1913, to

Aug 20

1913

that I last saw her alive on Aug 19 1913

and that death occurred on the date stated above, at 6 P.M.

The CAUSE OF DEATH* was as follows:

Leukaemia

(Duration)

yrs. 2 mos. ds.

Contributory
(Secondary)

(Duration)

yrs. mos. ds.

(Signed)

Aug 22 1913

(Address)

Dr. Mowery
Wallace Ida

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death

Wallace Ida

In the State

Where was disease contracted if not at place of death?

Burke Ida

Former or usual residence

Burke Ida

19. PLACE OF BURIAL OR REMOVAL

Wallace

DATE OF BURIAL

Aug 23 1913

20. UNDERTAKER

Ward Undertaking Co

ADDRESS

Wallace Idaho

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Form V. S. No. 5 20M.1-16-12

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH.

Registration District No. 70

County of Shoshone

Primary Registration District No. 1011

City of Wallace

(No. Providence Hospital St.)

File No. 5424

Registered No. 67

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME John Stone

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX

male

4. COLOR OR RACE

white

5. SINGLE, MARRIED, WID-
OWED OR DIVORCED.Married
(Write the word.)

6. DATE OF BIRTH

8 26 1913.
(Month) (Day) (Year)

7. AGE

51 yrs. 0 mos. 3 ds.

IF LESS than 1 day
how many hrs. or
mins.?

8. OCCUPATION

(a) Trade, profession or
particular kind of work

miner

(b) General nature of industry
business, or establishment in
which employed (or employer)

9. BIRTHPLACE

(State or Country)

Finland

10. NAME OF
FATHER

Isaac Stone

11. BIRTHPLACE
OF FATHER

(State or Country)

Finland

12. MAIDEN NAME
OF MOTHER

Eva Pexall

13. BIRTHPLACE
OF MOTHER

(State or Country)

Finland

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

John Stone

(Address)

Gem, Idaho.

15.

Filed

Aug 28 1913

1913

Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH

8 26 1913.
(Month) (Day) (Year)17. I HEREBY CERTIFY, That I attended deceased from
Aug 1 1913, to Aug 26 1913,
that I last saw him alive on Aug 26 1913

and that death occurred on the date stated above, at M.

The CAUSE OF DEATH* was as follows:

Tubercular Peritonitis

(Duration) 1 yrs. mos. ds.

Contributory
(Secondary)

(Duration) 1 yrs. mos. ds.

(Signed)

Dr. Mowery

M. D.

8/27/1913 (Address) Wallace, Idaho

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1)
MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.18. LENGTH OF RESIDENCE (For Hospitals, Institutions,
Transients or Recent Residents.)At place Providence Hospital
of death yrs. mos. days. State yrs. mos. days.Where was disease contracted
if not at place of death? Gem, IdahoFormer or
usual residence Gem, Idaho

19. PLACE OF BURIAL OR REMOVAL

Wallace, Idaho

DATE OF BURIAL

8/29 1913

20. UNDERTAKER

Burr L. Marshall

ADDRESS

Wallace

Form V. S. No. 5 20M.1-16-12

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH.

Registration District No. 27County of FranklinPrimary Registration District No. 2119City of Boise

(No. _____)

St.)

File No. 5425Registered No. 11

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME John Barpus

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX

4. COLOR OR RACE

5. SINGLE, MARRIED, WIDOWED OR DIVORCED.

MaleWhiteMarried
(Write the word.)

6. DATE OF BIRTH

Aug101929

(Month)

(Day)

(Year)

7. AGE

83yrs. 11mos. 28

ds.

IF LESS than 1 day
how many hrs. or
..... mins.?

8. OCCUPATION

(a) Trade, profession or particular kind of work
(b) General nature of industry, business, or establishment in which employed (or employer)Farmer

9. BIRTHPLACE

(State or Country)

Switzerland

10. NAME OF FATHER

Barpus

11. BIRTHPLACE OF FATHER

(State or Country)

Switzerland

12. MAIDEN NAME OF MOTHER

not known

13. BIRTHPLACE OF MOTHER

(State or Country)

Switzerland

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) John Barpus Jr.(Address) Preston Idaho

15.

Filed 9-2191 3Alvin R. Rutt
Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH

8291913

(Month)

(Day)

(Year)

17. I HEREBY CERTIFY, That I attended deceased from

7/2/13 1913, to 8/21/13 1913,that I last saw him alive on 8/21/13 1913,and that death occurred on the date stated above, at 2:30 P.M.

The CAUSE OF DEATH* was as follows:

Cellulitis of right leg about the knee.

(Duration)

yrs.

mos. 21

ds.

Contributory
(Secondary)Smith's disease

(Duration)

yrs.

mos.

ds.

(Signed)

Alvin R. Rutt

M. D.

19

(Address)

Preston

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place
of death

yrs.

mos.

days.

In the
State

yrs.

mos.

days.

Where was disease contracted
if not at place of death?Former or
usual residence

19. PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

Boise Idaho Aug 30 1913

20. UNDERTAKER

ADDRESS

P. J. Hansen
Preston

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Form V. S. No. 5 20M.1-16-12

CERTIFICATE OF DEATH

 State of Idaho
 BOARD OF HEALTH
 Bureau of Vital Statistics

1. PLACE OF DEATH.

Registration District No. 27County of FranklinPrimary Registration District No. 2119City of Preston

(No. _____ St.)

File No. 5426Registered No. 15-

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

Elvira Taylor

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX

Female

4. COLOR OR RACE

White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED.

(Write the word.)

6. DATE OF BIRTH

Sept 15 1912
 (Month) (Day) (Year)

7. AGE

9 yrs. 15 mos. 15 ds.

 IF LESS than 1 day
 how many hrs. or
 mins.?

8. OCCUPATION

- (a) Trade, profession or particular kind of work
 (b) General nature of industry business, or establishment in which employed (or employer)

9. BIRTHPLACE

(State or Country)

10. NAME OF FATHER

11. BIRTHPLACE OF FATHER

(State or Country)

12. MAIDEN NAME OF MOTHER

13. BIRTHPLACE OF MOTHER

(State or Country)

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

(Address)

15.

Filed

9-41913
Allen C. Cullen
 Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH

Aug 30 1913
8 (Month) 30 (Day) 18 (Year)

 17. I HEREBY CERTIFY, That I attended deceased from Aug 28 1913, to Aug 30 1913, that I last saw him alive on Aug 30 1913, and that death occurred on the date stated above, at 3 PM.

The CAUSE OF DEATH* was as follows:

Intestinal Colic(Duration) _____ yrs. _____ mos. 9 ds.Contributory
(Secondary)

(Duration) _____ yrs. _____ mos. _____ ds.

(Signed) W. H. Stanford M. D.8/30/1913 (Address) Preston, Idaho

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death _____ yrs. _____ mos. _____ days. In the State _____ yrs. _____ mos. _____ days.

Where was disease contracted if not at place of death?

Former or usual residence _____

19. PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

Preston Sept 1 1913

20. UNDERTAKER

ADDRESS

W. J. Hansen Preston

Form V. S. No. 5 20M.1-16-12

CERTIFICATE OF DEATH

 State of Idaho
 BOARD OF HEALTH
 Bureau of Vital Statistics

1. PLACE OF DEATH. Registration District No. 27
 County of Franklin Primary Registration District No. 2119
 City of Perister (No. _____, St.)
 If death occurs away from usual residence, give facts called for under special information.

File No. 5427
 Registered No. 14
 If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Ernest M. Lewis

PERSONAL AND STATISTICAL PARTICULARS

3. SEX Male 4. COLOR OR RACE White 5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.)

6. DATE OF BIRTH

Aug 26 1897
 (Month) (Day) (Year)

7. AGE

16 yrs. 3 mos. 3 ds.

IF LESS than 1 day
 how many hrs. or mins.?

8. OCCUPATION

(a) Trade, profession or particular kind of work Farmer
 (b) General nature of industry, business, or establishment in which employed (or employer)

9. BIRTHPLACE

(State or Country) Wyoming10. NAME OF FATHER David Lewis11. BIRTHPLACE OF FATHER Idaho

(State or Country)

12. MAIDEN NAME OF MOTHER Lewis13. BIRTHPLACE OF MOTHER Idaho

(State or Country)

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Annie L. Johnson

(Address) _____

15.

Filed 9-4 1913 Allen R. Cullen
 Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH

August 29 1913
 (Month) (Day) (Year)

I HEREBY CERTIFY, That I attended deceased from June 26, 1913, to Aug 29, 1913, that I last saw him alive on Aug 29, 1913, and that death occurred on the date stated above, at 5 A. M.

The CAUSE OF DEATH* was as follows:

Acute Myelogenous Leukemia

(Duration) ✓ yrs. 6 mos. ✓ ds.Contributory (Secondary) ✓

(Duration) _____ yrs. _____ mos. _____ ds.

(Signed) E. W. States M. D.19. (Address) Preston Idaho

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death. _____ yrs. _____ mos. _____ days. In the State. _____ yrs. _____ mos. _____ days.

Where was disease contracted if not at place of death? _____

Former or usual residence _____

19. PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

Preston Aug 31 1913

20. UNDERTAKER

ADDRESS

J. H. Hansen Preston

Form V. S. No. 5 20M.1-16-12

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics
File No. **5428**

1. PLACE OF DEATH.

Registration District No. **27**

County of _____

Primary Registration District No. **2119**

City of _____

(No. _____ St.)

Registered No. **13**

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

Joal H Taylor

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX

4. COLOR OR RACE

5. SINGLE, MARRIED, WIDOWED OR DIVORCED.

Male**White****Single**
(Write the word.)

6. DATE OF BIRTH

June
(Month)**17**
(Day)**1**
(Year)

7. AGE

33 yrs.

mos.

ds.

IF LESS than 1 day
how many _____ hrs. or
_____ mins.?

8. OCCUPATION

(a) Trade, profession or particular kind of work

Farmer

(b) General nature of industry, business, or establishment in which employed (or employer)

9. BIRTHPLACE

(State or Country)

Idaho

10. NAME OF FATHER

Richard M Taylor

11. BIRTHPLACE OF FATHER

(State or Country)

Idaho

12. MAIDEN NAME OF MOTHER

Richardson

13. BIRTHPLACE OF MOTHER

(State or Country)

Idaho

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

Hannah Taylor

(Address)

Weston, Ida.

15.

Filed

9-3191 **3****Allen R. Smith**
Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH

August
(Month)**15**
(Day)**1913**
(Year)17. I HEREBY CERTIFY, That I attended deceased from **Aug 15** 1913, to **Aug 15** 1913that I last saw him alive on **Aug 15** 1913, and that death occurred on the date stated above, at **7 P.M.**

The CAUSE OF DEATH* was as follows:

Killed by Derrable falling on him
Accidental

(Duration) _____ yrs. _____ mos. _____ ds.

Contributory (Secondary)

(Duration) _____ yrs. _____ mos. _____ ds.

(Signed)

G. W. State M. D.**Aug 6** 1913 (Address) **Idaho**

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death _____ yrs. _____ mos. _____ days. In the State _____ yrs. _____ mos. _____ days.

Where was disease contracted if not at place of death? _____

Former or usual residence _____

19. PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

Idaho**Aug. 17** 1913

20. UNDERTAKER

ADDRESS

P. J. Hansen**Idaho**

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Form V. S. No. 5 20M.1-16-12

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH.

Registration District No. 27County of FranklinPrimary Registration District No. 2119City of Boise

(No.)

(St.)

File No. 5424Registered No. 10

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

Susan Beekstead

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX

4. COLOR OR RACE

5. SINGLE, MARRIED, WIDOWED OR DIVORCED.

Female WhiteWidowed
(Write the word.)

6. DATE OF BIRTH

Oct211

(Month)

(Day)

(Year)

7. AGE

64

yrs.

mos.

ds.

IF LESS than 1 day
how many hrs. or
..... mins.?

8. OCCUPATION

(a) Trade, profession or particular kind of work
(b) General nature of industry, business, or establishment in which employed (or employer)

Housewife

9. BIRTHPLACE

(State or Country)

Utah

10. NAME OF FATHER

Truham

11. BIRTHPLACE OF FATHER

(State or Country)

Scatter

12. MAIDEN NAME OF MOTHER

13. BIRTHPLACE OF MOTHER

(State or Country)

Scatter

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

R. A. Beekstead

(Address)

Preston

15.

Filed

9-2191 3Alfred Beekstead

Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH

August 17

(Month)

(Day)

191 3
(Year)

17. I HEREBY CERTIFY, That I attended deceased from

Aug 2 191 3 to Aug 17 191 3that I last saw her alive on Aug 17 191 3and that death occurred on the date stated above, at 12:30 p.m.

The CAUSE OF DEATH* was as follows:

Cerebral hemorrhage (apoplexy)(Duration) 1 yrs. 15 mos. 15 ds.

Contributory (Secondary)

(Duration) 1 yrs. 15 mos. 15 ds.

(Signed)

G. W. State

M. D.

Aug 18 191 3 (Address) Preston, Idaho

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death yrs. mos. days. In the State yrs. mos. days.

Where was disease contracted if not at place of death?

Former or usual residence.

19. PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

Preston, Idaho Aug 19 191 3

20. UNDERTAKER

ADDRESS

D. J. Harman Preston

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Form V. S. No. 5 20M.1-16-12

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics
File No. 5430
Registered No. 12

1. PLACE OF DEATH. Registration District No. 27
County of Franklin Primary Registration District No. 2119
City of Preston (No. Mary Ann Wilson St.)
If death occurs away from usual residence, give facts called for under special information. 2. FULL NAME Mrs. J. J. Wilson

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX Female 4. COLOR OR RACE White 5. SINGLE, MARRIED, WIDOWED OR DIVORCED. Married
(Write the word.)

6. DATE OF BIRTH June 21st 1853
(Month) (Day) (Year)

7. AGE 60 yrs. 9 mos. ds.
IF LESS than 1 day how many hrs. or mins.?

8. OCCUPATION
(a) Trade, profession or particular kind of work Housewife
(b) General nature of industry business, or establishment in which employed (or employer)

9. BIRTHPLACE Leeds England
(State or Country)

10. NAME OF FATHER Not known

11. BIRTHPLACE OF FATHER England
(State or Country)

12. MAIDEN NAME OF MOTHER Mary Ann McCarrie

13. BIRTHPLACE OF MOTHER Leeds England
(State or Country)

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Mrs. J. J. Parkman
(Address) Preston Ida.

15. Filed 9-3 1913 Allen B. Galt
Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH Mar 31 1913
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from Mar 30 1913, to Mar 31 1913, that I last saw her alive on Mar 31 1913, and that death occurred on the date stated above, at 10:20 AM
The CAUSE OF DEATH* was as follows:
acute dilatation of heart

(Duration) yrs. mos. ds.

Contributory (Secondary)

(Duration) yrs. mos. ds.

(Signed) G. J. Parkman D.
19 (Address) Preston Ida.

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death yrs. mos. days. In the State yrs. mos. days.

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL Local DATE OF BURIAL Apr 3 1913

20. UNDERTAKER J. J. Parkman ADDRESS Preston

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Form V. S. No. 5. 10M. 6-20-11.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH.

Registration District No. 21County of BlainePrimary Registration District No. 2072City of Belevue

(No. _____, _____ St.)

File No. 5431Registered No. 34

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

Margarett Day

If death occurred in a hospital, institution or camp give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX

4. COLOR OR RACE

5. SINGLE, MARRIED, WIDOWED OR DIVORCED.

6. DATE OF BIRTH

7. AGE

IF LESS than 1 day

how many _____ hrs. or _____ min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work

(b) General nature of industry business or establishment in which employed (or employer)

9. BIRTHPLACE

(State or Country)

10. NAME OF FATHER

11. BIRTHPLACE OF FATHER

(State or Country)

12. MAIDEN NAME OF MOTHER

13. BIRTHPLACE OF MOTHER

(State or Country)

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

(Address)

15.

Filed

Aug 10 1913Robert H. Wright

Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

Aug 1 1913
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from

July 15 1913, to Aug 1 1913that I last saw her alive on July 31 1913and that death occurred on the date stated above, at 10:45 M.

The CAUSE OF DEATH* was as follows:

Rocky Mountain tick
fever(Duration) 7 yrs. 20 mos. 20 ds.

Contributory (Secondary)

(Duration) 7 yrs. 20 mos. 20 ds.

(Signed)

Aug 1 1913 J. J. Rasmussen M. D.(Address) Hailey
*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death _____ yrs. _____ mos. _____ ds. State _____ yrs. _____ mos. _____ ds.

Where was disease contracted,

If not at place of death?

Former or

usual residence.

19. PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

Belevue IdaAug 3 1913

20. UNDERTAKER

ADDRESS

R. D. HarrisHailey

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. N. B.—Every item of information should be carefully supplied. AGE should be state EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Form V. S. No. 5. 10M. 6-20-11.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics
File No. 5432
Registered No. 35

1. PLACE OF DEATH.

Registration District No. 21

County of Blaine

Primary Registration District No. 2022

City of Hailey

(No. _____, _____ St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

Paul McMaster

If death occurred in a hospital, institution or camp give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX

Male

4. COLOR OR RACE 5. SINGLE, MARRIED, WIDOWED OR DIVORCED.

White

Single
(Write the word.)

6. DATE OF BIRTH

_____ 1 _____
(Month) (Day) (Year)

7. AGE

68 yrs. _____ mos. _____ ds.

IF LESS than 1 day
how many _____ hrs. or
_____ min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work
(b) General nature of industry business or establishment in which employed (or employer)

miner

9. BIRTHPLACE

(State or Country)

Canada

10. NAME OF FATHER

FATHER

11. BIRTHPLACE OF FATHER

(State or Country)

12. MAIDEN NAME OF MOTHER

13. BIRTHPLACE OF MOTHER

(State or Country)

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

G. H. Jacobs
Hailey, Ida

(Address)

15.

Filed Aug 20 1913

Robert H. Wright
Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

August 17 1913
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from

Aug 12 1911, to Aug 19 1913
that I last saw him alive on Aug 19 1913
and that death occurred on the date stated above, at 11 A.M.

The CAUSE OF DEATH* was as follows:

Tuberculosis
Consumption
(Duration) 10 yrs. _____ mos. _____ ds.

Contributory (Secondary)

(Duration) 10 yrs. _____ mos. _____ ds.

(Signed)

Aug 19 1913 (Address) Hailey, Ida

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place _____ yrs. _____ mos. _____ ds. State _____ yrs. _____ mos. _____ ds.

Where was disease contracted,

If not at place of death?

Former or usual residence.

19. PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

Hailey

Aug 19 1913

20. UNDERTAKER

ADDRESS

R. W. Harris

Hailey

-SUPPLEMENTARY DEATH CERTIFICATE-

(Please reply on this sheet to
the registrar of Vital Statistics)

Death Certificate No. 35

Name Paul mc master

Date of Death Aug 17th 13

Cause of Death Pulmonary Tuberculosis

Contributory Cause of death Mining -

(Sign here) Robert H. Wright. M.D.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. N. B.—Every item of information should be carefully supplied. AGE should be state EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Form V. S. No. 5. 10M. 6-20-11.

CERTIFICATE OF DEATH

1. PLACE OF DEATH.

Registration District No. 21

County of Blaine

Primary Registration District No. 2022

City of Oriley

(No. , St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

Oscar Lugoall

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics
File No. 5433

Registered No. 36

If death occurred in a hospital, institution or camp give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX

Male

4. COLOR OR RACE 5. SINGLE, MARRIED, WIDOWED OR DIVORCED.

White

Single
(Write the word.)

6. DATE OF BIRTH

(Month) (Day) (Year)

7. AGE

About 49 yrs.

mos.

ds.

IF LESS than 1 day
how many hrs. or
min.?

8. OCCUPATION

- (a) Trade, profession or particular kind of work
(b) General nature of industry business or establishment in which employed (or employer)

Miner -

9. BIRTHPLACE

(State or Country)

Owenden

10. NAME OF FATHER

11. BIRTHPLACE OF FATHER
(State or Country)

12. MAIDEN NAME OF MOTHER

13. BIRTHPLACE OF MOTHER
(State or Country)

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

Geo H. Jacobs

(Address)

Oriley, Ida

15.

Filed Aug. 12 1913

Robert H. Wright

Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

Aug 10 1913
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from

Aug 3 1913, to Aug 10 1913

that I last saw him alive on Aug 10 1913

and that death occurred on the date stated above, at 10 P. M.

The CAUSE OF DEATH* was as follows:

Spotted fever

(Duration) yrs. mos. 13 ds.

Contributory
(Secondary)

(Duration) yrs. mos. ds.

(Signed) Robert H. Wright M. D.

Aug 11 1913 (Address) Oriley, Ida

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted.

If not at place of death?

Former or

usual residence

19. PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

Oriley

Aug 12 1913

20. UNDERTAKER

ADDRESS

R. W. Harris

Oriley

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Form V. S. No. 5 20M.1-16-12

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics
File No. **5434**
Registered No. **421**

1. PLACE OF DEATH. Registration District No. **5**
County of **Bonner** Primary Registration District No. **2083**
City of **Sandpoint** (No. _____, St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME **Mary Anna Hansen**

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX **♀** 4. COLOR OR RACE _____ 5. SINGLE, MARRIED, WIDOWED OR DIVORCED.
(Write the word.)

6. DATE OF BIRTH **Oct 17 1902**
(Month) (Day) (Year)

7. AGE **10 yrs. 7 mos. 16 ds.** IF LESS than 1 day how many hrs. or mins.?

8. OCCUPATION
(a) Trade, profession or particular kind of work **none**
(b) General nature of industry, business, or establishment in which employed (or employer)

9. BIRTHPLACE **This**
(State or Country)

10. NAME OF FATHER **John Hansen**

11. BIRTHPLACE OF FATHER **Denmark**
(State or Country)

12. MAIDEN NAME OF MOTHER **Anna Falk**

13. BIRTHPLACE OF MOTHER **Denmark**
(State or Country)

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) **Anna Hansen**
(Address) **Harlem Idaho**

15. Filed **6/4** 1913 **M. McKinnon**
Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH **June 3 1913**
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from **June 1** 1913, to **June 3** 1913, that I last saw her alive on **June 2** 1913, and that death occurred on the date stated above, at **8** M.
The CAUSE OF DEATH* was as follows:

Diabetes

(Duration) **yes** mos. ds.

Contributory (Secondary)

(Duration) **yes** mos. ds.

(Signed) **C. P. Staehle** M. D.

9/8 1913. (Address) **Sandpoint**

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death. yrs. mos. days. In the State. yrs. mos. days.

Where was disease contracted if not at place of death?

Former or usual residence.

19. PLACE OF BURIAL OR REMOVAL **Lakeview** DATE OF BURIAL **6/4** 1913

20. UNDERTAKER **C. M. Braver** ADDRESS **Sandpoint**

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Form V. S. No. 5. 10M. 6-20-11.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics
File No. **5435**

1. PLACE OF DEATH.
County of Bonner
City of Hope

Registration District No. _____
Primary Registration District No. 2035
(No. _____ St.)

Registered No. 422

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

If death occurred in a hospital, institution or camp give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX Male 4. COLOR OR RACE White 5. SINGLE, MARRIED, WIDOWED OR DIVORCED. unknown
(Write the word.)

6. DATE OF BIRTH unknown
(Month) (Day) (Year)

7. AGE unknown IF LESS than 1 day
yrs. mos. ds. how many hrs. or min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work unknown

(b) General nature of industry business or establishment in which employed (or employer) "

9. BIRTHPLACE
(State or Country) unknown

10. NAME OF FATHER unknown

11. BIRTHPLACE OF FATHER
(State or Country) "

12. MAIDEN NAME OF MOTHER "

13. BIRTHPLACE OF MOTHER
(State or Country) "

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Wm R. Knapp
(Address) Hope

15. Filed June 9 1913 M. McKinnon
Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH June 8 1913
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from 191 to 191
that I last saw h. alive on 191,
and that death occurred on the date stated above, at M.

The CAUSE OF DEATH* was as follows:

Ran over by R.R. train No. 4
N.P. road 4 miles East of
town of Hope

(Duration) yrs. mos. ds.
Contributory Wm. R. Knapp
(Secondary)

(Duration) yrs. mos. ds.
(Signed) Wm. R. Knapp M. D.
4/8 1913 (Address) Hope

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place In the
of death yrs. mos. ds. State yrs. mos. ds.
Where was disease contracted,
If not at place of death?
Former or
usual residence.

19. PLACE OF BURIAL OR REMOVAL DATE OF BURIAL

Sandpoint June 10 1913

20. UNDERTAKER ADDRESS
E. M. Brower Sand Point

WRITE INFORMATION, WITH UNFADING INK—THIS IS A PERMANENT RECORD. N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Form V. S. No. 5 20M.1-16-12

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics
File No. **5436**
Registered No. **423**

1. PLACE OF DEATH. Registration District No. **8**
County of **Banner** Primary Registration District No. **2033**
City of **Sandpoint** (No. _____ St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME **Esther Kolstad**

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX **Female** 4. COLOR OR RACE **White** 5. SINGLE, MARRIED, WIDOWED OR DIVORCED. **Married**
(Write the word.)

6. DATE OF BIRTH **Febr 12 1895**
(Month) (Day) (Year)

7. AGE **18** yrs. **1** mos. **1** ds. IF LESS than 1 day how many _____ hrs. or _____ mins.

8. OCCUPATION
(a) Trade, profession or particular kind of work **None.**
(b) General nature of industry business, or establishment in which employed (or employer)

9. BIRTHPLACE **Minne.**
(State or Country)

10. NAME OF FATHER **Andrew Kolstad.**

11. BIRTHPLACE OF FATHER **Norway.**
(State or Country)

12. MAIDEN NAME OF MOTHER **Anna Hegstron**

13. BIRTHPLACE OF MOTHER **Sweden**
(State or Country)

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) **Mrs. Anna Kolstad.**
(Address) **Sandpoint**

15. Filed **6/1 1913** **M. M. McKinnon**
Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH **June 10 1913**
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from **Death on 1st July about** 191**3**,
that I last saw h. **alive on June 15 -** 191**3**
and that death occurred on the date stated above, at **M.**

The CAUSE OF DEATH* was as follows:
Pulmonary tuberculosis

about (Duration) **1** yrs. **1** mos. **1** ds.

Contributory (Secondary)

(Signed) **M. D.**
(Duration) **1** yrs. **1** mos. **1** ds.

19. (Address) **Sandpoint Ida**

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death. _____ yrs. _____ mos. _____ days. In the State. _____ yrs. _____ mos. _____ days.

Where was disease contracted if not at place of death? _____

Former or usual residence. _____

19. PLACE OF BURIAL OR REMOVAL **Sandpoint** DATE OF BURIAL **6/10 1913**

20. UNDERTAKER **E. W. Brainerd** ADDRESS **Sandpoint**

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Form V. S. No. 5 20M.1-16-12

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics
File No. **5438**
Registered No. **425**

1. PLACE OF DEATH. Registration District No. **5**
County of **Bonner** Primary Registration District No. **2533**
City of **Sandpoint** (No. _____, St.)
If death occurs away from usual residence, give facts called for under special information. 2. FULL NAME **Fred Ames**

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX **Male** 4. COLOR OR RACE **White** 5. SINGLE, MARRIED, WIDOWED OR DIVORCED. **Single**
(Write the word.)
6. DATE OF BIRTH **Mar 3 1885**
(Month) (Day) (Year)

7. AGE **9** yrs. **9** mos. **9** ds. IF LESS than 1 day how many _____ hrs. or _____ mins.?

8. OCCUPATION
(a) Trade, profession or particular kind of work **Laborer**
(b) General nature of industry business, or establishment in which employed (or employer) **Woods - P.R.**

9. BIRTHPLACE (State or Country) **Mich.**

10. NAME OF FATHER **G. L. Ames.**

11. BIRTHPLACE OF FATHER (State or Country) **N. Y.**

12. MAIDEN NAME OF MOTHER **Mary A. Kerber**

13. BIRTHPLACE OF MOTHER (State or Country) **N. Y.**

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) **Mary Ames**
(Address) **Sandpoint.**

15. Filed **June 18 1913** **M. McMillan**
Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH **June 18 1913**
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from **June 18 1913**, to **June 18 1913**, that I last saw him alive on **June 18 1913**, and that death occurred on the date stated above, at **10 A.M.**

The CAUSE OF DEATH* was as follows:

Result of a crushing injury sustained while working on Northern Pacific Railroad.

(Duration) **7 hours** ds.
Contributory (Secondary)

(Duration) _____ yrs. _____ mos. _____ ds.
(Signed) **O. J. Payne** M. D.
19 _____ (Address) **Sandpoint Idaho**

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death. _____ yrs. _____ mos. _____ days. In the State. _____ yrs. _____ mos. _____ days.

Where was disease contracted if not at place of death? _____

Former or usual residence. _____

19. PLACE OF BURIAL OR REMOVAL **Sandpoint.** DATE OF BURIAL **6/20 1913**

20. UNDERTAKER **E. M. Brown** ADDRESS **Sandpoint**

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Form V. S. No. 5 20M.1-16-12

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics
File No. **5439**
Registered No. **426**

1. PLACE OF DEATH. Registration District No. **8**
County of **Bonner** Primary Registration District No. **2033**
City of **Landpoint** (No. _____ St.)
If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME **James Albert Robbins**

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX **Male** 4. COLOR OR RACE **White** 5. SINGLE, MARRIED, WIDOWED OR DIVORCED. **Married**
(Write the word.)

6. DATE OF BIRTH **June 6 1860**
(Month) (Day) (Year)

7. AGE **51** yrs. mos. ds. IF LESS than 1 day how many hrs. or mins.

8. OCCUPATION
(a) Trade, profession or particular kind of work **Hatchman**
(b) General nature of industry business, or establishment in which employed (or employer) **N. RR Co**

9. BIRTHPLACE (State or Country) **Ill.**

10. NAME OF FATHER **Henry Robbins**

11. BIRTHPLACE OF FATHER (State or Country) **(Nebraska)**

12. MAIDEN NAME OF MOTHER **Deceased**

13. BIRTHPLACE OF MOTHER (State or Country) **Unknown**

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) **Mrs. Emma Robbins**
(Address) **Clarks Fork**

15. Filed **6/27** 191 **M. McKinn**
Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH **June 26 1913**
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from 191 to 191, that I last saw him alive on 191, and that death occurred on the date stated above, at M.

The CAUSE OF DEATH* was as follows:

Struck by Train
(Duration) yrs. mos. ds.
Contributory (Secondary)
(Duration) yrs. mos. ds.
(Signed) **H. M. Knapp** M. D.
19 (Address) **Spice Idaho**

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death yrs. mos. days. In the State yrs. mos. days.
Where was disease contracted if not at place of death?
Former or usual residence

19. PLACE OF BURIAL OR REMOVAL **Landed Idaho** DATE OF BURIAL **6/28 1913**

20. UNDERTAKER **E. M. Brower** ADDRESS **Landpoint**

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Form V. S. No. 5 20M.1-16-12

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics
File No. **5440**

1. PLACE OF DEATH.

Registration District No. **8**County of **Blaine**Primary Registration District No. **2036**City of **Blain**

(No. _____ St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME **Ed Gastrop**Registered No. **427**

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX **M**4. COLOR OR RACE **W**5. SINGLE, MARRIED, WIDOWED OR DIVORCED. **S.** (Write the word.)

6. DATE OF BIRTH

(Month)

(Day)

(Year)

7. AGE

45 yrs. **0** mos. **0** ds.IF LESS than 1 day
how many hrs. or
..... mins.?

8. OCCUPATION

(a) Trade, profession or particular kind of work **Paucker**

(b) General nature of industry, business, or establishment in which employed (or employer)

9. BIRTHPLACE

(State or Country) **Mass.**

10. NAME OF FATHER

11. BIRTHPLACE OF FATHER

(State or Country)

12. MAIDEN NAME OF MOTHER

13. BIRTHPLACE OF MOTHER

(State or Country)

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) **Beck**(Address) **Paucker**

15.

Filed **June 25** 191 **3****M. M. M. M. M.**

Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH

(Month)

(Day)

June 26 191 **3**
(Year)

17. I HEREBY CERTIFY, That I attended deceased from

191... to 191...

that I last saw h... alive on 191...

and that death occurred on the date stated above, at **M.**

The CAUSE OF DEATH* was as follows:

There is Pulmonary
Had no phlegm
(Duration) yrs. mos. ds.

Contributory
(Secondary)

(Duration)

yrs.

mos.

ds.

(Signed) **Ed Gastrop**

M. D.

6/27 191 **3** (Address) **Paucker**

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death... yrs. mos. days.

In the State... yrs. mos. days.

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

Paucker**6/27** 191 **3**

20. UNDERTAKER

ADDRESS

Beck**Paucker**

Form V. S. No. 5 20M.1-16-12

CERTIFICATE OF DEATH

 State of Idaho
 BOARD OF HEALTH
 Bureau of Vital Statistics

1. PLACE OF DEATH.

Registration District No. 4County of BonnerPrimary Registration District No. 2034City of naples(No. St.)File No. 5441Registered No. 427

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

Phelps P. Dayton

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX

4. COLOR OR RACE

5. SINGLE, MARRIED, WIDOWED OR DIVORCED.

Female WhiteWidow
(Write the word.)

6. DATE OF BIRTH

Nov. 14 1829
 (Month) (Day) (Year)

7. AGE

84 yrs. mos. ds.
 IF LESS than 1 day
 how many hrs. or
 mins.

8. OCCUPATION

(a) Trade, profession or particular kind of work

Housewife

(b) General nature of industry business, or establishment in which employed (or employer)

9. BIRTHPLACE

(State or Country)

N.Y.

10. NAME OF FATHER

J. Barwell

11. BIRTHPLACE OF FATHER

(State or Country)

N.Y.

12. MAIDEN NAME OF MOTHER

unknown

13. BIRTHPLACE OF MOTHER

(State or Country)

Ido

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

Phelps P. Dayton

(Address)

Naples Idaho

15.

Filed

July 1st1913
M. M. McKeen
 Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH

June 29 1913
 (Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from

191 , to 191 ,that I last saw him alive on 191 ,and that death occurred on the date stated above, at M.

The CAUSE OF DEATH* was as follows:

Found dead with Cause not known(Duration) yrs. mos. ds.

Contributory

(Secondary)

(Duration) yrs. mos. ds.

(Signed)

June 29 1913 (Address) Naples Idaho
Wm Knapp M. D.

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

 At place of death yrs. mos. days. In the State yrs. mos. days.

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

SandpointJuly 1st 1913

20. UNDERTAKER

ADDRESS

C. M. BrowerIdo

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Form V. S. No. 5 20M.1-16-12

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH.

Registration District No. 8

County of Bonner

Primary Registration District No. 2033

City of Sandpoint

(No. St.)

File No. 5442

Registered No. 428

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

Willard Alanzo Benson

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX

4. COLOR OR RACE

5. SINGLE, MARRIED, WIDOWED OR DIVORCED.

(Write the word.)

6. DATE OF BIRTH

Feb. 16 1876
(Month) (Day) (Year)

7. AGE

37 yrs. 4 mos. 13 ds.

IF LESS than 1 day
how many hrs. or mins.?

8. OCCUPATION

(a) Trade, profession or particular kind of work

Freder

(b) General nature of industry, business, or establishment in which employed (or employer)

Planing mill

9. BIRTHPLACE

(State or Country)

N. C.

10. NAME OF FATHER

William Benson

11. BIRTHPLACE OF FATHER

(State or Country)

N. C.

12. MAIDEN NAME OF MOTHER

Eveline Cook

13. BIRTHPLACE OF MOTHER

(State or Country)

N. C.

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

Minnie Benson

(Address)

Donner Idaho

15.

Filed

June 30 1913

M. McKeiv

Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH

June 20 1913
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from June 20 1913, to June 30 1913, that I last saw him alive on June 30 1913, and that death occurred on the date stated above, at 9.0 M.

The CAUSE OF DEATH* was as follows:

Letanus

(Duration) yrs. mos. 3 ds.

Contributory (Secondary)

Loss of right arm

(Duration) yrs. mos. 7 ds.

(Signed)

E. B. Hatten M. D.

711 1913 (Address) Sandpoint Idaho

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death. yrs. mos. days. In the State. yrs. mos. days.

Where was disease contracted if not at place of death?

Former or usual residence.

19. PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

Mountain City Idaho

7/2 1913

20. UNDERTAKER

ADDRESS

Ernest Brown

S.P.

MARGIN RESERVED FOR BINDING
WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
N. B.—Every item of information should be carefully supplied. AGE should be state EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Form V. S. No. 5. 10M. 6-20-11.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics
File No. 5443

1. PLACE OF DEATH.

Registration District No. 8

County of Bonner

Primary Registration District No. 2036

City of Priest River

(No. , St.)

Registered No. 429

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

Margaret Sarah Schaefer

If death occurred in a hospital, institution or camp give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX

Female

4. COLOR OR RACE

white

5. SINGLE, MARRIED, WIDOWED OR DIVORCED.

(Write the word.) Single

6. DATE OF BIRTH

July 4 1913
(Month) (Day) (Year)

7. AGE

yrs. 3 mos. 13 ds.

IF LESS than 1 day
how many hrs. or
..... min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work

(b) General nature of industry business or establishment in which employed (or employer)

9. BIRTHPLACE

(State or Country)

Sandpoint, Idaho

10. NAME OF FATHER

Jno E. Schaefer

11. BIRTHPLACE OF FATHER

(State or Country)

Marathon County Wisconsin

12. MAIDEN NAME OF MOTHER

Margaret Breesendorf

13. BIRTHPLACE OF MOTHER

(State or Country)

Rockford Iowa

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

Fredrick W. Didier M.D.

(Address)

haclade, Idaho

15.

Filed

July 3 1913 M. McKinnis

Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

July 4 1913
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from

March Apr 1913, to July 4 1913

that I last saw her alive on July 4 1913

and that death occurred on the date stated above, at 6:45 AM.

The CAUSE OF DEATH* was as follows:

Non - Closure Foramen ovale

(Duration) yrs. 3 mos. 13 ds.

Contributory (Secondary)

Mal Nutrition

(Duration) yrs. mos. ds.

(Signed) Fredrick W. Didier M. D.

July 4 1913 (Address) haclade, Idaho

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death yrs. mos. ds. State yrs. mos. ds.

Where was disease contracted,

If not at place of death?

Former or

usual residence

19. PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

Priest River, Ida. July 8 1913

20. UNDERTAKER

ADDRESS

R. H. Ludwig Priest River, Ida.

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Form V. S. No. 5 20M.1-16-12

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics
File No. **5445**
Registered No. **431**

1. PLACE OF DEATH.

Registration District No. **8**

County of **Bonner**

Primary Registration District No. **2033**

City of **Sandpoint**

(No. _____, St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME **Jessie F. Dunlap**

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX

4. COLOR OR RACE

5. SINGLE, MARRIED, WIDOWED OR DIVORCED.

Male **White** **Single** (Write the word.)

6. DATE OF BIRTH

July 14 1869
(Month) (Day) (Year)

7. AGE

44 yrs. **1** mos. **1** ds.

IF LESS than 1 day
how many hrs. or mins.?

8. OCCUPATION

(a) Trade, profession or particular kind of work

(b) General nature of industry business, or establishment in which employed (or employer)

Farmer

9. BIRTHPLACE

(State or Country)

Mo.

10. NAME OF FATHER

Wm. J. Dunlap

11. BIRTHPLACE OF FATHER

(State or Country)

Kentucky

12. MAIDEN NAME OF MOTHER

Synthia L. Harrison

13. BIRTHPLACE OF MOTHER

(State or Country)

Mo.

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

(Address)

J. H. Graves
Sagle, Idaho

15.

Filed

July 16 1913 **3 Mm** **Edman**

Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

July 15 1913
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from

April 15 1913, to **July 4 1913**

that I last saw him alive on **July 4 1913**

and that death occurred on the date stated above, at **4 A.M.**

The CAUSE OF DEATH* was as follows:

Pulmonary tuberculosis and intestinal tuberculosis

(Duration) yrs. mos. ds.

Contributory

(Secondary)

(Duration) yrs. mos. ds.

(Signed)

Wm. J. Harrison M. D.
July 16 1913 (Address) **Sandpoint**

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death yrs. mos. days. In the State yrs. mos. days.

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL DATE OF BURIAL

Westonwood, Ida **7/16 1913**

20. UNDERTAKER

ADDRESS

E. M. R. **Sagle, Idaho**

MARGIN RESERVED FOR BINDING
WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Form V. S. No. 5 20M.1-16-12

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH.

Registration District No. 8

County of _____

Primary Registration District No. 2036

City of _____

(No. _____ St.)

File No. 5446

Registered No. 431

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

Robert G. Radcliff

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX

male

4. COLOR OR RACE

white

5. SINGLE, MARRIED, WIDOWED OR DIVORCED.

married
(Write the word.)

6. DATE OF BIRTH

Mar 27 1877
(Month) (Day) (Year)

7. AGE

41 yrs. 4 mos. 15 ds.

IF LESS than 1 day
how many hrs. or mins.?

8. OCCUPATION

(a) Trade, profession or particular kind of work

Merchant

(b) General nature of industry business, or establishment in which employed (or employer)

9. BIRTHPLACE

(State or Country)

S. Carolina

10. NAME OF FATHER

Geo. J. Radcliff

11. BIRTHPLACE OF FATHER

(State or Country)

S. C.

12. MAIDEN NAME OF MOTHER

Sarah Robinson

13. BIRTHPLACE OF MOTHER

(State or Country)

S. C.

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

Minnie Radcliff

(Address)

15.

Filed July 27 1913

W. M. McKeown

Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

July 27 1913
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from

1913, to 1913,

that I last saw him alive on 1913,

and that death occurred on the date stated above, at M.

The CAUSE OF DEATH was as follows:

Aortic Regurgitation

(Duration) yrs. mos. ds.

Contributory

(Secondary)

(Duration) yrs. mos. ds.

(Signed)

July 27 1913 (Address) Superior, Idaho

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death yrs. mos. days. In the State yrs. mos. days.

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

Charleston S. Car. 7/28 1913

20. UNDERTAKER

ADDRESS

E. M. Brown S. P.

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Form V. S. No. 5 20M.1-16-12

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics
File No. **5447**
Registered No. **432**

1. PLACE OF DEATH. Registration District No. **8**
County of **Bonner** Primary Registration District No. **2036**
City of _____ (No. _____, St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME **Berna Ella Reed**

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX **Female** 4. COLOR OR RACE **White** 5. SINGLE, MARRIED, WIDOWED OR DIVORCED **Married**
(Write the word.)

6. DATE OF BIRTH **March 2, 1882**
(Month) (Day) (Year)

7. AGE **31 yrs.** mos. _____ ds. _____
IF LESS than 1 day how many _____ hrs. or _____ mins.?

8. OCCUPATION
(a) Trade, profession or particular kind of work **Housewife**
(b) General nature of industry, business, or establishment in which employed (or employer) _____

9. BIRTHPLACE **This**
(State or Country)

10. NAME OF FATHER **C. O. Ralph**

11. BIRTHPLACE OF FATHER **Vermont**
(State or Country)

12. MAIDEN NAME OF MOTHER **Melissa J. J. J.**

13. BIRTHPLACE OF MOTHER **Ohio**
(State or Country)

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) **J. J. J.**
(Address) **Clark's Fork**

15. Filed **Aug 3, 1913** **M. W. McKinnis**
Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH **Aug 2nd, 1913**
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from **Aug 25, 1913**, to **Aug 1st, 1913**, that I last saw her alive on **Aug 1, 1913**, and that death occurred on the date stated above, at **2 P. M.**

The CAUSE OF DEATH* was as follows:
Cardiac incontinence due to Rheumatism & Paralytic Strokes with effusion

(Duration) _____ yrs. _____ mos. _____ ds.
Contributory (Secondary) **Rheumatism**

(Signed) **M. W. McKinnis** M. D.
Aug 3, 1913 (Address) **Paulson**

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death _____ yrs. _____ mos. _____ days. In the State _____ yrs. _____ mos. _____ days.

Where was disease contracted if not at place of death? _____
Former or usual residence _____

19. PLACE OF BURIAL OR REMOVAL **T. B. Idaho** DATE OF BURIAL **Aug 4, 1913**

20. UNDERTAKER **E. M. Brown** ADDRESS **84/123**

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFAADING INK—THIS IS A PERMANENT RECORD. N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Form V. S. No. 5 20M.1-16-12

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH.

Registration District No. 8

County of Bonner

Primary Registration District No. 2033

City of Landpoint

(No. _____ St.)

File No. 544

Registered No. 433

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

Opel M. Nelson

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX

Male

4. COLOR OR RACE

White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED.

Married

6. DATE OF BIRTH

Dec. 13 1938
(Month) (Day) (Year)

7. AGE

55 yrs. 7 mos. 20 ds.

IF LESS than 1 day
how many _____ hrs. or
_____ mins.?

8. OCCUPATION

(a) Trade, profession or particular kind of work

Labor

(b) General nature of industry business, or establishment in which employed (or employer)

Lumberman

9. BIRTHPLACE

(State or Country)

Sweden

10. NAME OF FATHER

Nels Peterson

11. BIRTHPLACE OF FATHER

(State or Country)

Sweden

12. MAIDEN NAME OF MOTHER

13. BIRTHPLACE OF MOTHER

(State or Country)

Sweden

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

Steve Nelson

(Address)

Landpoint

15.

Filed

Aug. 3 1938 M. McMillin

Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

Aug. 3 1939
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from

July 15 1938, to Aug. 2 1938,
that I last saw him alive on Aug. 2nd 1938

and that death occurred on the date stated above, at 7 A.M.

The CAUSE OF DEATH* was as follows:

Heart failure and
Pleurisy with effusion

(Duration) _____ yrs. _____ mos. _____ ds.

Contributory
(Secondary)

(Duration) _____ yrs. _____ mos. _____ ds.

(Signed) M. M. Brown M. D.

Aug. 19 1938 (Address) Landpoint

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death _____ yrs. _____ mos. _____ days. In the State _____ yrs. _____ mos. _____ days.

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL DATE OF BURIAL

Landpoint, Idaho Aug. 5 1938

20. UNDERTAKER

ADDRESS

C. M. Brown A. P.

1. PLACE OF DEATH		Registration District No. <u>2033</u>		Bureau of Vital Statistics	
County of <u>Bonner</u>		Primary Registration District No. <u>2033</u>		File No. <u>5449</u>	
City of <u>Sandpoint</u>		(No. _____, _____ St.)		Registered No. <u>434</u>	
If death occurs away from usual residence, give facts called for under special information.		2. FULL NAME <u>Fredstrom</u>		If death occurred in a hospital, institution or camp give its NAME instead of street and number.	

PERSONAL AND STATISTICAL PARTICULARS		
3. SEX <u>M</u>	4. COLOR OR RACE <u>white</u>	5. SINGLE/MARRIED, WIDOWED/OR DIVORCED. <u>8</u> (Write the word.)
6. DATE OF BIRTH <u>Mar 22 1913</u> (Month) (Day) (Year)		
7. AGE <u>27</u> yrs. <u>7</u> mos. <u>29</u> ds.	IF LESS than 1 day how many _____ hrs. or _____ min.?	
8. OCCUPATION (a) Trade, profession, or particular kind of work (b) General nature of industry business, or establishment in which employed (or employer) <u>Infant</u>		
9. BIRTHPLACE (State or Country) <u>Sandpoint - Ida</u>		
10. NAME OF FATHER <u>Alex Fredstrom</u>		
11. BIRTHPLACE OF FATHER (State or Country) <u>Sweden</u>		
12. MAIDEN NAME OF MOTHER <u>Carlina Nelson</u>		
13. BIRTHPLACE OF MOTHER (State or Country) <u>Sweden</u>		
14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE		
(Informant) <u>Alex Fredstrom</u>		
(Address) <u>S.P. Ida</u>		
15. Filed <u>8/11</u> 191 <u>3</u>	<u>M. McKinnon</u> Local Registrar	

MEDICAL CERTIFICATE OF DEATH		
16. DATE OF DEATH <u>Aug 11 1913</u> (Month) (Day) (Year)		
17. I HEREBY CERTIFY, That I attended deceased from <u>Aug 9 1913</u> , to <u>Aug 11 1913</u> , that I last saw him alive on <u>Aug 11 1913</u> , and that death occurred on the date stated above, at <u>7. P. M.</u>		
The CAUSE OF DEATH* was as follows: <u>Gastro-Enteritis</u>		
(Duration) _____ yrs. _____ mos. <u>2</u> ds.		
Contributory (Secondary) <u>Artificial feeding</u>		
(Duration) _____ yrs. _____ mos. _____ ds.		
(Signed) <u>R. H. Jackson</u> M. D.		
19. (Address) <u>Sandpoint</u>		
*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.		
18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)		
At place _____ In the _____		
of death _____ yrs. _____ mos. _____ ds. State _____ yrs. _____ mos. _____ ds.		
Where was Disease contracted, _____		
If not at place of death? _____		
Former or usual residence _____		
19. PLACE OF BURIAL OR REMOVAL <u>Sandpoint</u>		DATE OF BURIAL <u>Aug 12 1913</u>
20. UNDERTAKER <u>E. W. Brown</u>		ADDRESS <u>S.P.</u>

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
N. B.—Every item of information should be carefully supplied. AGE should be state EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

1. PLACE OF DEATH.
County of Bonner
City of Priest River

Registration District No. _____
Primary Registration District No. 208
(No. _____, St.)

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

File No. 5454
Registered No. 436

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

John Florence

If death occurred in a hospital, institution or camp give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX

male

4. COLOR OR RACE

white

5. SINGLE, MARRIED, WIDOWED OR DIVORCED.

unknown
(Write the word.)

6. DATE OF BIRTH

August 9 1913
(Month) (Day) (Year)

7. AGE

apparently about 40 years
_____ yrs. _____ mos. _____ ds.

IF LESS than 1 day
how many _____ hrs. or
_____ min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work

laborer in logging camp

(b) General nature of industry business or establishment in which employed (or employer)

9. BIRTHPLACE

(State or Country)

unknown

10. NAME OF FATHER

unknown

11. BIRTHPLACE OF FATHER

(State or Country)

unknown

12. MAIDEN NAME OF MOTHER

unknown

13. BIRTHPLACE OF MOTHER

(State or Country)

unknown

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Fred W. Didier M.D.

(Address) Priest River, Idaho

15.

Filed 8/9 1913 M. Mc Kinn
Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

August 9 1913
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I ~~attended~~ saw deceased ~~from~~ Aug 9 1913, to 1913

that I last saw him alive on 9 Aug 1913, and that death occurred on the date stated above, at 8:10 P. M.

The CAUSE OF DEATH* was as follows:

Struck by train #263 while in an intoxicated condition, and killed about 1/4 mile from Priest River, Idaho

(Duration) _____ yrs. _____ mos. _____ ds.

Contributory (Secondary)

alcoholism

(Duration) _____ yrs. _____ mos. _____ ds.

(Signed) Fred W. Didier M. D.

Aug 10, 1913 (Address) Priest River, Idaho

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state 1) MEANS OF INJURY; and 2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death _____ yrs. _____ mos. _____ ds. State _____ yrs. _____ mos. _____ ds.

Where was disease contracted,

If not at place of death?

Former or

usual residence.

19. PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

Laborer St. 8/12 1913

20. UNDERTAKER

ADDRESS

E. M. Brower St.

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Form V. S. No. 5 20M.1-16-12

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH.

Registration District No. 8

County of Banner

Primary Registration District No. 2033

City of Sandpoint

(No. St.)

File No. 5451

Registered No. 437

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Herman H. Ellerick

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX

Male

4. COLOR OR RACE

White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED.

Married
(Write the word.)

6. DATE OF BIRTH

Aug
(Month)

11
(Day)

1825
(Year)

7. AGE

88 yrs.

25 mos.

ds.

IF LESS than 1 day
how many hrs. or mins.?

8. OCCUPATION

(a) Trade, profession or particular kind of work

Lumberman

(b) General nature of industry business, or establishment in which employed (or employer)

9. BIRTHPLACE

(State or Country)

Germany

10. NAME OF FATHER

Deceased

11. BIRTHPLACE OF FATHER

(State or Country)

Germany

12. MAIDEN NAME OF MOTHER

Deceased

13. BIRTHPLACE OF MOTHER

(State or Country)

Germany

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

John Ellerick

(Address)

Riverside T. C. Ida

15.

Filed

Sept 5

191

M. McKinn

Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

Sept 4
(Month) (Day)

1913
(Year)

17. I HEREBY CERTIFY, That I attended deceased from

Aug 11 1913, to Sept 4 1913,

that I last saw him alive on Sept 4 1913,

and that death occurred on the date stated above, at M.

The CAUSE OF DEATH* was as follows:

Pneumonia
pleurisy

(Duration) yrs. mos. 3 wks. ds.

Contributory
(Secondary)

(Duration) yrs. mos. ds.

(Signed)

Wm. H. M. D.

Sept 1913 (Address) Sandpoint

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death.....yrs.....mos.....days. In the State.....yrs.....mos.....days.

Where was disease contracted if not at place of death?.....

Former or usual residence.....

19. PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

Spokane 21st Sept 1913

20. UNDERTAKER

ADDRESS

Ernest Brown S.P.

-SUPPLEMENTARY DEATH CERTIFICATE-

(Please reply on this sheet to
the registrar of Vital Statistics)

Death Certificate No. 437

Name Herman H. Ellersick

Date of Death Sept. 6, 1913.

Cause of Death Pleurisy with effusion - followed by Pneumonia Lobor

Contributory Cause of death Pleurisy

RECEIVED

DEC 15 1913

(Sign here)

M. M. McKimmon

M.D.

SECRETARY'S OFFICE
STATE BOARD OF HEALTH

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Form V. S. No. 5 20M.1-16-12

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

File No. **5452**Registered No. **158**

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

1. PLACE OF DEATH.

Registration District No. **10**County of **Blaine**Primary Registration District No. **2044**City of **Grangerville**

(No. _____ St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

Charles Carothers

PERSONAL AND STATISTICAL PARTICULARS

3. SEX

4. COLOR OR RACE

5. SINGLE, MARRIED, WIDOWED OR DIVORCED.

Male**White****Married**
(Write the word.)

6. DATE OF BIRTH

Dec. 6th 1879
(Month) (Day) (Year)

7. AGE

33 yrs. 8 mos. 15 ds.

IF LESS than 1 day
how many _____ hrs. or
_____ mins.?

8. OCCUPATION

(a) Trade, profession or particular kind of work

Farming

(b) General nature of industry, business, or establishment in which employed (or employer)

9. BIRTHPLACE

(State or Country)

Shelby Co. Ind.

10. NAME OF FATHER

Thomas H. Carothers

11. BIRTHPLACE OF FATHER

(State or Country)

Shelby Co. Ind.

12. MAIDEN NAME OF MOTHER

Amanda J. Gear

13. BIRTHPLACE OF MOTHER

(State or Country)

Texas

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

E. H. Carothers

(Address)

15.

Filed

Sept 2

1913

Joe P. Rains

Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH

August 11 1913
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from

Deceased died suddenly
that I last saw him alive on **1913**

and that death occurred on the date stated above, at **2 P.M.**

The CAUSE OF DEATH* was as follows:

Shock, probably from a bolt of lightning.
(Duration) **Died instantly.**

Contributory (Secondary)

(Duration) _____ yrs. _____ mos. _____ ds.

(Signed) **W. H. Warner** M. D.Aug 11 1913 (Address) **Grangerville**

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death _____ yrs. _____ mos. _____ days. In the State _____ yrs. _____ mos. _____ days.

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL DATE OF BURIAL

Prairie View **Aug 14 1913**

20. UNDERTAKER

ADDRESS

W. E. Graham Grangerville

Form V. S. No. 5 20M.1-16-12

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH.

Registration District No. 10County of IdahoPrimary Registration District No. 2044City of Granger

(No. _____, _____ St.)

File No. 5153Registered No. 159

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Minnie Jones

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX

female

4. COLOR OR RACE

White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED.

Married
(Write the word.)

6. DATE OF BIRTH

April 8 1876
(Month) (Day) (Year)

7. AGE

37 yrs. 3 mos. 6 ds.IF LESS than 1 day
how many _____ hrs. or
_____ mins.?

8. OCCUPATION

(a) Trade, profession or particular kind of work

House Wife

(b) General nature of industry business, or establishment in which employed (or employer)

9. BIRTHPLACE

(State or Country)

Ind

10. NAME OF FATHER

W. H. Wright

11. BIRTHPLACE OF FATHER

(State or Country)

12. MAIDEN NAME OF MOTHER

Mary E. Jones

13. BIRTHPLACE OF MOTHER

(State or Country)

Ind

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

C. H. Jones

(Address)

Granger

15.

Filed

Sept 21913Geo L Rains

Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH

Aug 13 1913
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from

Jan 1 1911, to Jan 1 1912that I last saw him alive on Jan 1 1912and that death occurred on the date stated above, at 7:30 P.M.

The CAUSE OF DEATH* was as follows:

Pulmonary Tuberculosis(Duration) 2 1/2 yrs. — mos. — ds.Contributory
(Secondary)

(Duration) _____ yrs. _____ mos. _____ ds.

(Signed) G. S. Strickland M. D.Aug 14 1913 (Address) Granger Idaho

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death _____ yrs. _____ mos. _____ days. In the State _____ yrs. _____ mos. _____ days.

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL DATE OF BURIAL

Fair ViewAug 15 1913

20. UNDERTAKER

ADDRESS

W. E. Graham Granger

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Form V. S. No. 5 20M.1-16-12

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH.

Registration District No. 2042 10County of IdahoPrimary Registration District No. 2042City or Kenterville, Prunella (No. _____, St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Hedvig Gustaf FritschFile No. 5455Registered No. 161

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX

4. COLOR OR RACE

5. SINGLE, MARRIED, WIDOWED OR DIVORCED.

Female White (Single) (Widow)

6. DATE OF BIRTH

July 17 1913
(Month) (Day) (Year)

7. AGE

____ yrs. 1 mos. 5 ds.

IF LESS than 1 day
how many _____ hrs. or
_____ mins.

8. OCCUPATION

(a) Trade, profession or particular kind of work

None

(b) General nature of industry business, or establishment in which employed (or employer)

9. BIRTHPLACE

(State or Country)

Kenterville, Ida

10. NAME OF FATHER

Jos Fritsch

11. BIRTHPLACE OF FATHER

(State or Country)

Germany

12. MAIDEN NAME OF MOTHER

Annie Brooks

13. BIRTHPLACE OF MOTHER

(State or Country)

Germany

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

Jos & Fritsch

(Address)

Kenterville, Idaho

15.

Filed

Aug 231913Jos E. Rainsper Order Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH

Aug 22 1913
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from marked the death of deceased
1913 to 1913
that I last saw him alive on Aug 23 1913.

and that death occurred on the date stated above, at 12 M.

The CAUSE OF DEATH* was as follows:

Dysentery

(Duration) ____ yrs. ____ mos. ____ ds.

Contributory
(Secondary)

(Duration) ____ yrs. ____ mos. ____ ds.

(Signed)

Aug 23 1913 (Address) Kenterville, Idaho

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place

of death

____ yrs. ____ mos. ____ days.

In the

State

____ yrs. ____ mos. ____ days.

Where was disease contracted if not at place of death?

Former or

usual residence

19. PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

Kenterville, Ida.Aug 23 1913

20. UNDERTAKER

ADDRESS

Joseph McBlashyButterworth

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. N. B.—Every item of information should be carefully supplied. AGE should be state EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Form V. S. No. 5. 16M. 6-20-11.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics
File No. 5456
Registered No. 162

1. PLACE OF DEATH. Registration District No. 10
County of Idaho Primary Registration District No. 2044
City of Grangeville (No. _____, St.)
If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

Arthur Lewis

If death occurred in a hospital, institution or camp give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX Male 4. COLOR OR RACE White 5. SINGLE, MARRIED, WIDOWED OR DIVORCED. Single
(Write the word.)

6. DATE OF BIRTH 1887
don't know, (Month) (Day) (Year)

7. AGE 62 yrs. 6 mos. 2 ds. IF LESS than 1 day how many 6 hrs. or 2 min.?

8. OCCUPATION Carpenter
(a) Trade, profession or particular kind of work
(b) General nature of industry business or establishment in which employed (or employer)

9. BIRTHPLACE Summit Ohio
(State or Country)

10. NAME OF FATHER Silas Lewis

11. BIRTHPLACE OF FATHER England
(State or Country)

12. MAIDEN NAME OF MOTHER Emma Season

13. BIRTHPLACE OF MOTHER England
(State or Country)

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Ralph A. Lewis
(Address) Grangeville

15. Filed Aug 31 1913 Reverend L. Rains
Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH August 31 1913
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That ~~I attended deceased from~~
1913, to 1913
that I last saw ~~him~~ alive on 1913
and that death occurred on the date stated above, at 4 a M.

The CAUSE OF DEATH* was as follows:

Cancer of scalp

(Duration) _____ yrs. _____ mos. _____ ds.

Contributory (Secondary) _____
(Duration) _____ yrs. _____ mos. _____ ds.

(Signed) Reverend L. Rains M. D.
Aug. 31 1913 (Address) Grangeville

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death _____ yrs. _____ mos. _____ ds. State _____ yrs. _____ mos. _____ ds.

Where was disease contracted?
If not at place of death?
Former or usual residence _____

19. PLACE OF BURIAL OR REMOVAL Prairie View Cemetery DATE OF BURIAL Aug. 31 1913

20. UNDERTAKER E. S. Hancock ADDRESS Grangeville

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. N. B.—Every item of information should be carefully supplied. AGE should be state EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Form V. S. No. 5. 10M. 6-20-11.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics
File No. 5477
Registered No. 163

1. PLACE OF DEATH.

Registration District No. 10

County of Idaho

Primary Registration District No. 2089

City of Grangerville

(No. , St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

Marion Jane Whitekneet

If death occurred in a hospital, institution or camp give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX

Female

4. COLOR OR RACE

White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED.

Widow
(Write the word.)

6. DATE OF BIRTH

Not obtainable

(Month)

(Day)

(Year)

7. AGE

57

yrs.

mos.

ds.

IF LESS than 1 day
how many hrs. or
..... min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work

Cook

(b) General nature of industry business or establishment in which employed (or employer)

9. BIRTHPLACE

(State or Country)

Indiana

10. NAME OF

FATHER

Bowden

11. BIRTHPLACE OF FATHER

(State or Country)

Not obtainable

12. MAIDEN NAME OF MOTHER

13. BIRTHPLACE OF MOTHER

(State or Country)

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

(Address)

15.

Filed

August 31 1913

Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

August 31

(Month)

(Day)

1913 (Year)

17. I HEREBY CERTIFY, That I attended deceased from

191 to 191

that I last saw him alive on 191

and that death occurred on the date stated above, at M.

The CAUSE OF DEATH* was as follows:

Chronic Heart disease

(Duration) yrs. mos. ds.

Contributory (Secondary)

(Duration) yrs. mos. ds.

(Signed) Jesse L. Rains M. D.

Aug 31 1913 (Address) Grangerville

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death. yrs. mos. ds. State. yrs. mos. ds.

Where was disease contracted,

If not at place of death?

Former or

usual residence.

19. PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

Prairie View Cemetery

Aug 31 1913

20. UNDERTAKER

ADDRESS

E. S. Hancock

Grangerville

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Form V, S. No. 5. 12½ M. 7-24-11

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics
File No. 5458
Registered No. 38

1. PLACE OF DEATH
County of Clearwater
City of _____

Registration District No. 90
Primary Registration District No. 2168
(No. _____, St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

John J. Pool

If death occurred in a hospital, institution or camp give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX Male 4. COLOR OR RACE White 5. SINGLE, MARRIED, WIDOWED OR DIVORCED Married

6. DATE OF BIRTH

June (Month) 1863 (Year)

7. AGE

50 yrs. 2 mos. ds. IF LESS than 1 day how many _____ hrs. or _____ min?

8. OCCUPATION

(a) Trade, profession or particular kind of work
(b) General nature of industry business or establishment in which employed (or employer)

Farmer

9. BIRTHPLACE

(State or Country)

Germany

10. NAME OF FATHER

11. BIRTHPLACE OF FATHER

(State or Country)

12. MAIDEN NAME OF MOTHER

13. BIRTHPLACE OF MOTHER

(State or Country)

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

(Address)

Frank Harrison
Fraser Idaho

15.

Filed

Sept 1 1913

J. M. Fairly
Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH

August 17 1913
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from August 5 1913, to Aug 10 1913

that I last saw him alive on Aug 16 1913

and that death occurred on the date stated above, at 89 M.

The CAUSE OF DEATH* was as follows:

Pneumonia terminating in abscess + gangrene of lung

(Duration) _____ yrs. _____ mos. 14 ds.

Contributory An alcoholic
(Secondary)

(Duration) 20 yrs. _____ mos. _____ ds.

(Signed) Eile W. Hargraves M. D.

August 18 1913 (Address) Fraser Idaho

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place _____ In the _____
of death _____ yrs. _____ mos. _____ ds. State _____ yrs. _____ mos. _____ ds.

Where was disease contracted,

If not at place of death?

Former or

usual residence.

19. PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

Fraser Idaho

Aug 18 1913

20. UNDERTAKER

ADDRESS

W. C. Stoddard

Gifford
Idaho

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Form V. S. No. 5. 12½ M. 7-24-11

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics
File No. 5459
Registered No. 73

1. PLACE OF DEATH. Registration District No. 26
County of Oneida Primary Registration District No. 2069
City of Malad (No. , St.)

If death occurs away from usual residence, give facts called for under special instruction.

2. FULL NAME

Julia Margaret Thomas

If death occurred in a hospital, institution or camp give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX Female 4. COLOR OR RACE White 5. SINGLE, MARRIED, WIDOWED OR DIVORCED. Write the word.

6. DATE OF BIRTH October 13 1906
(Month) (Day) (Year)

7. AGE 6 yrs. 10 mos. 7 ds. IF LESS than 1 day how many hrs. or min?

8. OCCUPATION

- (a) Trade, profession or particular kind of work
(b) General nature of industry business or establishment in which employed (or employer)

Student

9. BIRTHPLACE

(State or Country)

Malad Idaho

10. NAME OF FATHER

Joseph S. Thomas

11. BIRTHPLACE OF FATHER

(State or Country)

Brigham City Utah

12. MAIDEN NAME OF MOTHER

Margaret S. Monovich

13. BIRTHPLACE OF MOTHER

(State or Country)

Salt Lake City Utah

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Mrs. J. H. Chafferton
(Address) Malad Idaho

15.

Filed Aug 21 1913 J. C. Ray
Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH

August 20 1913
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from Aug 19 1913, to Aug 20 1913 that I last saw her alive on Aug 20 1913 and that death occurred on the date stated above, at 3:26 AM.

The CAUSE OF DEATH* was as follows:

Acute Diphtheria

(Duration) yrs. mos. ds.

Contributory
(Secondary)

(Duration) yrs. mos. ds.

(Signed) J. C. Ray M. D.

Aug 21 1913 (Address) Malad City, Idaho

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place In the
of death yrs. mos. ds. State yrs. mos. ds.

Where was disease contracted,
If not at place of death?
Former or usual residence.

19. PLACE OF BURIAL OR REMOVAL DATE OF BURIAL

Malad Idaho Aug 22 1913

20. UNDERTAKER ADDRESS

D. E. Johnson Malad Idaho

MARGIN RESERVED FOR BINDING
WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Form V. S. No. 5. 10M. 6-20-11.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH. Registration District No. 26
County of Oneida Primary Registration District No. 2069
City of Malad (No. _____ St.)

File No. 5469
Registered No. 74

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

Unmailed

If death occurred in a hospital, institution or camp give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX 4. COLOR OR RACE 5. SINGLE, MARRIED, WIDOWED OR DIVORCED.

Female White (Write the word.)

6. DATE OF BIRTH

Aug 24 1913
(Month) (Day) (Year)

7. AGE

IF LESS than 1 day
how many 1/2 hrs. or
_____ yrs. _____ mos. _____ ds. _____ min.

8. OCCUPATION

(a) Trade, profession, or particular kind of work
(b) General nature of industry, business, or establishment in which employed (or employer)

9. BIRTHPLACE
(State or Country)

Malad

10. NAME OF FATHER

Gao Harnem

11. BIRTHPLACE OF FATHER
(State or Country)

Idaho

12. MAIDEN NAME OF MOTHER

Ada Harvey

13. BIRTHPLACE OF MOTHER
(State or Country)

Oregon

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

(Address)

Gao Harnem
Malad

15.

Filed 8-24 1913

D. C. Ray

Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

Aug 24 1913
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from _____ 191____, to _____ 191____

that I last saw her alive on Aug 24 1913, and that death occurred on the date stated above, at 3:20 P.M.

The CAUSE OF DEATH* was as follows:

Atelctasis

(Duration) One Day mos. _____ ds. _____
Contributory (Secondary) Premature Labor

(Duration) _____ yrs. _____ mos. _____ ds. _____
(Signed) J. F. Patton M. D.
8/24 1913 (Address) Malad Ida

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place _____ In the _____
of death _____ yrs. _____ mos. _____ ds. State _____ yrs. _____ mos. _____ ds.
Where was Disease contracted,
If not at place of death?
Former or
usual residence _____

19. PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

Malad Ida Aug 25 1913

20. UNDERTAKER

ADDRESS

Name

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Form V. S. No. 5 20M.1-16-12

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH.

Registration District No. 26

County of OneidaPrimary Registration District No. 2069City of Manalo

(No. _____ St.)

File No. 5461

Registered No. _____

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

Melvin Moser

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX

4. COLOR OR RACE

5. SINGLE, MARRIED, WID-
OWED OR DIVORCED.MaleWhiteSingle (Write the word.)

6. DATE OF BIRTH

July251911

(Month)

(Day)

(Year)

7. AGE

2 yrs. 1 mos. _____ ds.

IF LESS than 1 day
how many _____ hrs. or
_____ mins.?

8. OCCUPATION

- (a) Trade, profession or particular kind of work
(b) General nature of industry, business, or establishment in which employed (or employer)

None
None

9. BIRTHPLACE

(State or Country)

Logan Utah.

10. NAME OF FATHER

Earnest R Moser.

11. BIRTHPLACE OF FATHER

(State or Country)

Switzerland

12. MAIDEN NAME OF MOTHER

Mannah Kummer

13. BIRTHPLACE OF MOTHER

(State or Country)

Switzerland

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

(Address)

J. H. Moser
Logan Utah.

15.

Filed

Aug 28 1913J. H. Moser
Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH

Aug.271913

(Month)

(Day)

(Year)

17. I HEREBY CERTIFY, That I attended deceased from

191____, to

191____,

that I last saw h_____ alive on _____ 191____,

and that death occurred on the date stated above, at _____ M.

The CAUSE OF DEATH* was as follows:

accidental drowningNo physician in attendance

(Duration) _____ yrs. _____ mos. _____ ds.

Contributory
(Secondary)

(Duration) _____ yrs. _____ mos. _____ ds.

(Signed)

J. H. Moser

M. D.

8-28-1913 (Address) Malad City Idaho

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL OR HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death _____ yrs. _____ mos. _____ days. In the State _____ yrs. _____ mos. _____ days.

Where was disease contracted if not at place of death?

Former or usual residence _____

19. PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

St John IdahoAug. 28 1913

20. UNDERTAKER

ADDRESS

W. S. JohnsonMalad Idaho

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Form V. S. No. 5 20M.1-16-12

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics
File No. 5462

1. PLACE OF DEATH.

Registration District No. 4

County of Canyon

Primary Registration District No. 1008

City of Payette

(No. , St.)

Registered No. 98

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

Minerva L Carter

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX

Female

4. COLOR OR RACE

White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED

Married

6. DATE OF BIRTH

March 15 1890
(Month) (Day) (Year)

7. AGE

23 yrs. 5 mos. 10 ds.

IF LESS than 1 day
how many hrs. or
..... mins.?

8. OCCUPATION

(a) Trade, profession or particular kind of work

(b) General nature of industry business, or establishment in which employed (or employer)

Housewife

9. BIRTHPLACE

(State or Country)

Missouri

10. NAME OF FATHER

Frank S Morrison

11. BIRTHPLACE OF FATHER

(State or Country)

Missouri

12. MAIDEN NAME OF MOTHER

Bertha Durett

13. BIRTHPLACE OF MOTHER

(State or Country)

Missouri

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

(Address)

M. L. Carter
Payette

15.

Filed

Aug 25 1913 J. C. Woodward
Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH

Aug. 25 1913
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from Aug. 11 1913, to Aug. 25 1913, that I last saw her alive on Aug. 25 1913, and that death occurred on the date stated above, at 1:30 P.M.

The CAUSE OF DEATH* was as follows:

Septicemia

(Duration) yrs. mos. 14 ds.

Contributory Self induced abortion (Secondary)

(Duration) yrs. mos. ds.

(Signed) O. H. Avery M. D.

19 (Address) Payette Ida

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death yrs. mos. days. In the State yrs. mos. days.

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL DATE OF BURIAL

Richland Ore Aug 26 1913

20. UNDERTAKER

ADDRESS

J. W. Adair Payette Ida

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK. THIS IS A PRELIMINARY REPORT. N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Form V. S. No. 5 20M.1-16-12

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH.

Registration District No. 3

County of Canyon

Primary Registration District No. 2005

City of Chalawell

(No. St.)

File No. 5464

Registered No. 84

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME William O. Stockham

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX

male

4. COLOR OR RACE

white

5. SINGLE, MARRIED, WIDOWED OR DIVORCED
married
(Write the word.)

6. DATE OF BIRTH

August 9 1883
(Month) (Day) (Year)

7. AGE

Fifty yrs. mos. Two ds.

IF LESS than 1 day
how many hrs. or
..... mins.?

8. OCCUPATION

(a) Trade, profession or particular kind of work
(b) General nature of industry, business, or establishment in which employed (or employer)

Farming

9. BIRTHPLACE

(State or Country)

Missouri

10. NAME OF FATHER

John Albert Stockham

11. BIRTHPLACE OF FATHER

(State or Country)

Missouri

12. MAIDEN NAME OF MOTHER

Sarah Johnson

13. BIRTHPLACE OF MOTHER

(State or Country)

Missouri

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

(Address) Mrs. Sarah O. Stockham

15.

Filed

Aug 12th 1913

1913

J. Meyer MD
by W. C. Dyer
Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

August 11 1913
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from

Aug 3 1913, to Aug 11 1913

that I last saw him alive on Aug 11 1913

and that death occurred on the date stated above, at 12 M.

The CAUSE OF DEATH* was as follows:

Valvular disease of heart & congestion of liver

(Duration) not known yrs. mos. ds.

Contributory (Secondary)

(Duration) yrs. mos. ds.

(Signed) W. C. Dyer M. D.

Aug 12 1913 (Address) Chalawell Id.

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death yrs. mos. days. In the State yrs. mos. days.

Where was disease contracted if not at place of death? Myssa

Former or usual residence Myssa

19. PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

Canyon Hill

Aug 12 1913

20. UNDERTAKER

ADDRESS

W. C. Dyer

Chalawell

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Form V. S. No. 5. 10M. 6-20-11.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics
File No. 5465
Registered No. 85

1. PLACE OF DEATH.
County of Canyon
City of Caldwell

Registration District No. 3
Primary Registration District No. 2005
(No. _____ St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Louise Spacht

If death occurred in a hospital, institution or camp give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX Female 4. COLOR OR RACE white 5. SINGLE, MARRIED, WIDOWED OR DIVORCED. married
(Write the word.)

6. DATE OF BIRTH Feb. 18th 1896
(Month) (Day) (Year)

7. AGE 77 yrs. 5 mos. 26 ds. IF LESS than 1 day how many _____ hrs. or _____ min.

8. OCCUPATION
(a) Trade, profession or particular kind of work. House wife.
(b) General nature of industry business or establishment in which employed (or employer)

9. BIRTHPLACE Germany.
(State or Country)

10. NAME OF FATHER Fred Spacht.

11. BIRTHPLACE OF FATHER Germany.
(State or Country)

12. MAIDEN NAME OF MOTHER Christianna Libes

13. BIRTHPLACE OF MOTHER Germany
(State or Country)

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Nick Wagner
(Address) Caldwell

15. Filed Aug 16 1913 John S Meyer Registrar
by J. P. Beckham

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH Aug 14 1913
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from July 24 1913, to Aug 10 1913
that I last saw h. er alive on Aug 5 1913
and that death occurred on the date stated above, at _____ M.

The CAUSE OF DEATH* was as follows:

Accidental Struck

(Duration) Not known yrs. mos. ds.

Contributory (Secondary)

(Duration) _____ yrs. mos. ds.

(Signed) J. P. Beckham M. D.
Aug 15 1913 (Address) Caldwell Idaho

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death _____ yrs. mos. ds. State _____ yrs. mos. ds.

Where was disease contracted,

If not at place of death?

Former or

usual residence.

19. PLACE OF BURIAL OR REMOVAL Parma cem. DATE OF BURIAL Aug 16 1913

20. UNDERTAKER Blatt Beckham ADDRESS Caldwell

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Form V. S. No. 5 20M.1-16-12

CERTIFICATE OF DEATH

1. PLACE OF DEATH

Registration District No.

County of

Primary Registration District No.

City of

(No.

St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics
File No. 5466

Registered No. 87

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX *Female* 4. COLOR OR RACE *W* 5. SINGLE, MARRIED, WIDOWED OR DIVORCED.
Married
(Write the word.)

6. DATE OF BIRTH

March 17th 18*76*
(Month) (Day) (Year)

7. AGE

37 yrs. *5* mos. *8* ds.

IF LESS than 1 day
how many hrs. or
..... mins.

8. OCCUPATION

(a) Trade, profession or particular kind of work
(b) General nature of industry business, or establishment in which employed (or employer)

Housewife

9. BIRTHPLACE

(State or Country)

Millwaukie Wis

10. NAME OF FATHER

Martin O'Leary

11. BIRTHPLACE OF FATHER

(State or Country)

Does know

12. MAIDEN NAME OF MOTHER

Julia O'Leary

13. BIRTHPLACE OF MOTHER

(State or Country)

Does know

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

Fred Lohline

(Address)

Caldwell R 4

15.

Filed

Aug. 27- 1913

J. S. Myers

Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

Aug 25 191*3*
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from

Aug 24 191*3*, to *Aug 25* 191*3*,
that I last saw her alive on *Aug 25* 191*3*

and that death occurred on the date stated above, at *4 P.M.*

The CAUSE OF DEATH* was as follows:

Embolic

(Duration) yrs. mos. *5* hrs. ds.

Contributory

(Secondary)

Fracture of leg
Rheumatism

(Duration) yrs. mos. ds.

(Signed)

J. S. Miller M. D.

Aug 27 1913 (Address) *Caldwell Idaho*

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place

of death yrs. mos. days.

In the

State yrs. mos. days.

Where was disease contracted
if not at place of death?

Former or
usual residence

19. PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

Canyon Hill

Aug 27 191*3*

20. UNDERTAKER

ADDRESS

W. B. Dyer

Caldwell

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Form V. S. No. 5. 10M. 6-20-11.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH.

Registration District No. 59

County of Blaine

Primary Registration District No. 215-9

City of Moore

(No. _____ St.)

Registered No. _____

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

Ethel Wood Mann

If death occurred in a hospital, institution or camp give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX F 4. COLOR OR RACE W 5. SINGLE, MARRIED, WIDOWED OR DIVORCED. Married
(Write the word.)

6. DATE OF BIRTH

Jan 13 1883
(Month) (Day) (Year)

7. AGE

30 yrs. 7 mos. 17 ds.

IF LESS than 1 day
how many hrs. or
..... min.?

8. OCCUPATION

(a) Trade, profession, or particular kind of work
(b) General nature of industry business, or establishment in which employed (or employer)

H.W.

9. BIRTHPLACE

(State or Country)

Utah

10. NAME OF FATHER

Joseph P. Woods

11. BIRTHPLACE OF FATHER

(State or Country)

Utah

12. MAIDEN NAME OF MOTHER

Josephine Chase

13. BIRTHPLACE OF MOTHER

(State or Country)

Utah

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

E. S. Mann

(Address)

Moore, Ida.

15.

Filed

Aug 30 1913

J. W. Maathae
Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

Aug 30 1913
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from

Aug 26 1913, to Aug 30 1913

that I last saw her alive on Aug 30 1913,

and that death occurred on the date stated above, at 4:50 P. M.

The CAUSE OF DEATH* was as follows:

Puerperal Septicemia.

(Duration) yrs. mos. 7 ds.

Contributory
(Secondary)

(Duration) yrs. mos. ds.

(Signed) Dr. Maathae M. D.

Aug 30 1913 (Address) Moore, Ida.

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place In the
of death yrs. mos. ds. State yrs. mos. ds.

Where was Disease contracted,
If not at place of death?

Former or
usual residence.

19. PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

Woods' Cms. Id. Sept. 1 1913

20. UNDERTAKER

ADDRESS

W. W. Peck Blackfoot

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Form V. S. No. 5. 10M. 6-20-11.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital StatisticsFile No. 25468

Registered No. _____

If death occurred in a hospital, institution or camp give its NAME instead of street and number.

1. PLACE OF DEATH.

Registration District No. 59County of BlainePrimary Registration District No. 2159City of Moore

(No. _____, St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

Cora King

PERSONAL AND STATISTICAL PARTICULARS

3. SEX

F.

4. COLOR OR RACE

W.

5. SINGLE, MARRIED, WIDOWED OR DIVORCED.

Single
(Write the word.)

6. DATE OF BIRTH

July 2 1913
(Month) (Day) (Year)

7. AGE

16 yrs. 16 mos. 16 ds.
IF LESS than 1 day how many hrs. or min.?

8. OCCUPATION

- (a) Trade, profession, or particular kind of work
(b) General nature of industry, business, or establishment in which employed (or employer)

None

9. BIRTHPLACE

(State or Country)

Ida.

10. NAME OF FATHER

David Reese King

11. BIRTHPLACE OF FATHER

(State or Country)

Utah

12. MAIDEN NAME OF MOTHER

Cora Anna Kidd

13. BIRTHPLACE OF MOTHER

(State or Country)

Tenn.

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

Darrell King
Moore, Ida.

(Address)

15.

Filed

Aug 19 1913 D. W. Mattheis
Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

Aug 18 1913
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from

July 2 1913, to Aug 18 1913
that I last saw her alive on Aug 17 1913,
and that death occurred on the date stated above, at 4:45 P. M.

The CAUSE OF DEATH* was as follows:

Transition(Duration) yrs. 1 mos. 16 ds.Contributory
(Secondary)

(Duration) yrs. mos. ds.

(Signed) D. W. Mattheis M. D.Aug 18 1913 (Address) Moore Ida.

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place In the
of death yrs. mos. ds. State yrs. mos. ds.

Where was Disease contracted,

If not at place of death?

Former or
usual residence.

19. PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

MooreAug 19 1913

20. UNDERTAKER

ADDRESS

None

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Form V. S. No. 5. 10M. 6-20-11.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics
File No. 15469

1. PLACE OF DEATH.
County of Blaine
City of Moore

Registration District No. 59
Primary Registration District No. 2159
(No. _____, St.)

Registered No. _____
If death occurred in a hospital, institution or camp give its NAME instead of street and number.

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

Bona Alma King

PERSONAL AND STATISTICAL PARTICULARS

3. SEX F 4. COLOR OR RACE W. 5. SINGLE, MARRIED, WIDOWED OR DIVORCED.
Married
(Write the word.)

6. DATE OF BIRTH Sept. 15 1885
(Month) (Day) (Year)

7. AGE 27 yrs. 10 mos. 17 ds. IF LESS than 1 day how many hrs. or min.?

8. OCCUPATION
(a) Trade, profession, or particular kind of work Housewife
(b) General nature of industry business, or establishment in which employed (or employer)

9. BIRTHPLACE (State or Country) Tenn.

10. NAME OF FATHER George Kidd

11. BIRTHPLACE OF FATHER (State or Country) Tenn.

12. MAIDEN NAME OF MOTHER Mary E. Morrow

13. BIRTHPLACE OF MOTHER (State or Country) Tenn.

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Elizabeth Harris
(Address) Moore, Id.

15. Aug 4 3 D. W. Matthews
Filed _____ 1913 _____
Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH Aug 2 1913
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from July 2 1913, to Aug 2 1913 that I last saw her alive on Aug 2 1913, and that death occurred on the date stated above, at 3:35 P.M.

The CAUSE OF DEATH* was as follows:

Puerperal septicemia

(Duration) _____ yrs. _____ mos. 8 ds.
Contributory (Secondary) Uremia

(Duration) _____ yrs. _____ mos. _____ ds.
(Signed) D. W. Matthews M. D.
Aug 4 1913 (Address) Brev. Id.

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place _____ In the _____
of death _____ yrs. _____ mos. _____ ds. State _____ yrs. _____ mos. _____ ds.
Where was Disease contracted, _____
If not at place of death? _____
Former or _____
usual residence _____

19. PLACE OF BURIAL OR REMOVAL Moore DATE OF BURIAL Aug 8 1913

20. UNDERTAKER None ADDRESS _____

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Form V. S. No. 5. 10M. 6-20-11.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH.
County of Ada
City of Meridian

Registration District No. 1
Primary Registration District No. 2003
(No. _____, St.)

File No. 5479
Registered No. _____

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Edwin Malvin Barber

If death occurred in a hospital, institution or camp give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX Male 4. COLOR OR RACE White 5. SINGLE, MARRIED, WIDOWED OR DIVORCED. Single
(Write the word.)
6. DATE OF BIRTH May-23-1913
(Month) (Day) (Year)
7. AGE 3 yrs. 13 mos. 13 ds.
IF LESS than 1 day how many _____ hrs. or _____ min.

8. OCCUPATION

(a) Trade, profession or particular kind of work none
(b) General nature of industry business or establishment in which employed (or employer) none

9. BIRTHPLACE

(State or Country) 3 1/2 mi. N. M. & W. M.

10. NAME OF FATHER

John Barber

11. BIRTHPLACE OF FATHER

(State or Country) Kansas

12. MAIDEN NAME OF MOTHER

Lydia M. Masters

13. BIRTHPLACE OF MOTHER

(State or Country) Missouri

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) John I. Barber
(Address) Meridian R. S. No. 1

15.

Filed Sep-6-1913 C. L. Sutton
Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

Sep-6-1913
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from Aug-29-1913 to Sep-4-1913
that I last saw him alive on Sep-4-1913
and that death occurred on the date stated above, at 6 A. M.

The CAUSE OF DEATH* was as follows: -

Enterocolitis

(Duration) _____ yrs. _____ mos. _____ ds.

Contributory (Secondary)

(Duration) _____ yrs. _____ mos. _____ ds.

(Signed) C. L. Sutton M. D.

Sep-6-1913 (Address) Meridian

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death _____ yrs. _____ mos. _____ ds. In the State _____ yrs. _____ mos. _____ ds.
Where was disease contracted?
If not at place of death?
Former or usual residence _____

19. PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

Meridian Cemetery Sep-6-1913

20. UNDERTAKER

ADDRESS

None #

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Form V. S. No. 5. 12½ M. 7-24-11

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics
File No. 3411
Registered No. 1

1. PLACE OF DEATH. Registration District No. 48
County of Lemhi Primary Registration District No. 2127
City of Winchester (No. , St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Elizabeth Kriebel

If death occurred in a hospital, institution or camp give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX Female 4. COLOR OR RACE White 5. SINGLE, MARRIED, WIDOWED OR DIVORCED Widowed (Write the word.)
6. DATE OF BIRTH Feb 11th 1892
(Month) (Day) (Year)

7. AGE 81 yrs. 6 mos. 4 ds. IF LESS than 1 day how many hrs. or min?

8. OCCUPATION

(a) Trade, profession or particular kind of work. Housewife
(b) General nature of industry business or establishment in which employed (or employer)

9. BIRTHPLACE

(State or Country) Penna

10. NAME OF FATHER

Mailin Bailey

11. BIRTHPLACE OF FATHER

(State or Country) Penna

12. MAIDEN NAME OF MOTHER

Keeper

13. BIRTHPLACE OF MOTHER

(State or Country) Penna

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) W. B. Kriebel
(Address) Winchester

15.

Filed 8-11-1913 E. W. Leonard Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH

August 13 1913
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from June 1913, to August 15 1913 that I last saw her alive on July 31 1913 and that death occurred on the date stated above, at 8 P. M. The CAUSE OF DEATH* was as follows:

Pneumonia
Hobart F.

(Duration) yrs. 4 mos. ds.
Contributory (Secondary) Family

(Duration) yrs. mos. ds.
(Signed) E. W. Leonard M. D.
8-13-1913 (Address) Winchester

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place In the
of death yrs. mos. ds. State yrs. mos. ds.
Where was disease contracted,
If not at place of death?
Former or
usual residence.

19. PLACE OF BURIAL OR REMOVAL DATE OF BURIAL

Pullman, Wash. 8-18 1913

20. UNDERTAKER

ADDRESS

E. W. Leonard Pullman, Ida

-SUPPLEMENTARY DEATH CERTIFICATE-

(Please reply on this sheet to
the registrar of Vital Statistics)

Death Certificate No. 1

Name Elizabeth Kiebel

Date of Death August 15, 1913.

Cause of Death Lobar Pneumonia

Contributory Cause of death Tricility

(Sign here) Ellen B. Rogers M.D.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH

County of West
City of Lapwai

Registration District No. _____

Primary Registration District No. 2174

(No. _____ St.)

File No. 5472

Registered No. _____

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

Lulu E. Mc Bride

PERSONAL AND STATISTICAL PARTICULARS

3. SEX

F

4. COLOR OR RACE

W

5. SINGLE, MARRIED, WIDOWED OR DIVORCED.

(Write the word.)

6. DATE OF BIRTH.

May21911

(Month)

(Day)

(Year)

7. AGE

2 Yrs. 3 Mos. 23 ds.IF LESS than 1 day
how many _____ hrs. or
_____ min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work...
(b) General nature of industry, business, or establishment in which employed (or employer).....None

9. BIRTHPLACE

(State or Country)

Ida

10. NAME OF FATHER

Wm McBride

11. BIRTHPLACE OF FATHER

(State or Country)

Ida

12. MAIDEN NAME OF MOTHER

Mary A Hayden

13. BIRTHPLACE OF MOTHER

(State or Country)

Wash

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant)

Wm McBride
Shady Ida

(Address)

15.

Filed Aug 26 1913

Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

Aug253

(Month)

(Day)

(Year)

17. I HEREBY CERTIFY, That I attended deceased from

Aug 24 1913, to Aug 25 1913that I last saw her alive on Aug 25 1913and that death occurred on the date stated above, at 12 M.

The CAUSE OF DEATH* was as follows:

Gastroenteritis(Duration) _____ Yrs. _____ mos. 4 ds.Contributory
(Secondary)none known

(Duration) _____ yrs. _____ mos. _____ ds.

(Signed)

Wm D. Kappel

M. D.

(Address) Lapwai Ida

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death.....yrs.....mos.....days In the State.....yrs.....mos.....days

Where was disease contracted if not at place of death?.....

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

Joseph & Lu Aug 26 1913

20. UNDERTAKER

ADDRESS

E. Wallace Lapwai Ida

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

FORM V. S. No. 5-25 M. 1-16-13

CERTIFICATE OF DEATH.

1. PLACE OF DEATH.

County of *King Perce*
City of *Lapwai*

Registration District No. *97*Primary Registration District No. *2174*

(No. _____ St.)

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

File No. *5473*

Registered No. _____

If death occurs away from
usual residence, give facts
called for under special
information.

2. FULL NAME

Peron Henry Black

If death occurred in a hos-
pital, institution or camp,
give its NAME instead of
street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX

MO

4. COLOR OR RACE

*W*5. SINGLE, MARRIED, WID-
OWED OR DIVORCED.*Married*
(Write the word.)

6. DATE OF BIRTH.

*Sept 2**23**1863*

(Month)

(Day)

(Year)

7. AGE

49 Yrs. *11* Mos. *7* ds.

IF LESS than 1 day
how many _____ hrs. or
_____ min.?

8. OCCUPATION

(a) Trade, profession or
particular kind of work...
(b) General nature of in-
dustry, business, or estab-
lishment in which employ-
ed (or employer).....

Owner

9. BIRTHPLACE

(State or Country)

*Ill*10. NAME OF
FATHER*John Black*11. BIRTHPLACE
OF FATHER

(State or Country)

*Ill*12. MAIDEN NAME
OF MOTHER*Walter Brown*13. BIRTHPLACE
OF MOTHER

(State or Country)

Ill

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant)

(Address)

John M. Alley
Lapwai

15.

Filed

*Sept 2**1913**John M. Alley*
Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

*Sept**2**1913*

(Month)

(Day)

(Year)

I HEREBY CERTIFY, That I attended deceased from
Sept 1 1913, to *Sept 2* 1913

that I last saw him alive on *Sept 2* 1913
and that death occurred on the date stated above, at *5 P.* M.

The CAUSE OF DEATH* was as follows:

Hemiplegia(Duration) Yrs. _____ mos. *2* ds.Contributory
(Secondary)*Probable Septicemia*

(Duration) Yrs. _____ mos. _____ ds.

(Signed)

John M. Alley M. D.*Sept 2, 1913* (Address) *Lapwai*

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1)
MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions,
Transients or Recent Residents.)

At place of death.....yrs.....mos.....days In the State.....yrs.....mos.....days

Where was disease contracted
if not at place of death?.....

Former or
usual residence

19. PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

*Joseph**Sept 3* 1913

Local Registrar

J. E. Wallace

ADDRESS

Lapwai

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Form V. S. No. 5. 12½ M. 7-24-11

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH. Registration District No.
County of Custer Primary Registration District No.
City of Challis (No., St.)

File No. 5475
Registered No. 66

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

Harvey Lester

If death occurred in a hospital, institution or camp give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX male 4. COLOR OR RACE white 5. SINGLE, MARRIED, WIDOWED OR DIVORCED. single
(Write the word.)

6. DATE OF BIRTH Don't Know 1830
(Month) (Day) (Year)

7. AGE 83 yrs. 0 mos. 0 ds. IF LESS than 1 day how many 0 hrs. or 0 min?

8. OCCUPATION

(a) Trade, profession or particular kind of work. miner
(b) General nature of industry business or establishment in which employed (or employer)

9. BIRTHPLACE (State or Country) Don't Know

10. NAME OF FATHER Don't Know

11. BIRTHPLACE OF FATHER (State or Country) Don't Know

12. MAIDEN NAME OF MOTHER Don't Know

13. BIRTHPLACE OF MOTHER (State or Country) Don't Know

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE (Informant) J. W. Kelley
(Address) Challis

15. Filed 9/10 1913 H. H. H. H. Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH Sept 9 1913
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from Sept 1 1913, to Sept 9 1913, that I last saw him alive on Sept 8 1913, and that death occurred on the date stated above, at 1 P.M.

The CAUSE OF DEATH* was as follows:

Myocarditis

(Duration) 1 1/2 yrs. 0 mos. 0 ds.
Contributory old age
(Secondary)

(Duration) 1 1/2 yrs. 0 mos. 0 ds.
(Signed) J. W. Kelley M. D.
Sept 9 1913 (Address) Challis

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death 1 1/2 yrs. 0 mos. 0 ds. In the State 25 yrs. 0 mos. 0 ds.
Where was disease contracted, If not at place of death?
Former or usual residence Challis

19. PLACE OF BURIAL OR REMOVAL Challis DATE OF BURIAL Sept 10 1913

20. UNDERTAKER J. W. Helly ADDRESS Challis

MARGIN RESERVED FOR BINDING
WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Form V. S. No. 5 20M.1-16-12

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics
File No. 5486
Registered No. 55

1. PLACE OF DEATH
County of Custer
City of _____
Registration District No. 14
Primary Registration District No. 2061
(No. _____, _____ St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME George R. Dearden

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX Male 4. COLOR OR RACE White 5. SINGLE, MARRIED, WIDOWED OR DIVORCED. Single
(Write the word.)

6. DATE OF BIRTH

April 16th 1865
(Month) (Day) (Year)

7. AGE

48 yrs. 3 mos. 27 ds.

IF LESS than 1 day
how many hrs. or
..... mins.?

8. OCCUPATION

(a) Trade, profession or particular kind of work Merchant
(b) General nature of industry business, or establishment in which employed (or employer)

9. BIRTHPLACE

(State or Country) California

10. NAME OF FATHER

Robert Dearden

11. BIRTHPLACE OF FATHER

(State or Country) Canada

12. MAIDEN NAME OF MOTHER

Jeannette Turner

13. BIRTHPLACE OF MOTHER

(State or Country) England

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) G. R. Dearden

(Address) Mackay Oda.

15.

Filed Aug. 14th. 1913

G. R. Dearden
Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH

Aug. 13th 1913
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from Oct. 21 1912 to Aug. 13th 1913, that I last saw him alive on Aug. 13 1913 and that death occurred on the date stated above, at 6:30 P.

The CAUSE OF DEATH* was as follows:

Aneurism of ascending Aorta

(Duration) yrs. mos. ds.

Contributory Rupture of aneurism into
(Secondary) left lung.

(Duration) yrs. mos. ds.

(Signed) C. L. Heston M. D.

8/14/1913 (Address) C. L. Heston, Ida.

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death yrs. mos. days. In the State yrs. mos. days.

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL

Challis

DATE OF BURIAL

Aug. 15 1913

20. UNDERTAKER

Friends

ADDRESS

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. N. B.—Every item of information should be carefully supplied. AGE should be state EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Form V. S. No. 5. 10M. 6-20-11.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics
File No. 54811
Registered No. 23

1. PLACE OF DEATH. Registration District No. 31
County of Cassia Primary Registration District No. 2424
City of Burley (No. , St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Mark Preece

If death occurred in a hospital, institution or camp give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX Male 4. COLOR OR RACE white 5. SINGLE, MARRIED, WIDOWED OR DIVORCED. Married

6. DATE OF BIRTH Jan. 19th 1911
(Month) (Day) (Year)

7. AGE 2 yrs. 1 mos. 20 ds. IF LESS than 1 day how many hrs. or min.?

8. OCCUPATION
(a) Trade, profession, or particular kind of work
(b) General nature of industry, business, or establishment in which employed (or employer)

9. BIRTHPLACE (State or Country) Heyburn, Idaho.

10. NAME OF FATHER Peter R. Preece

11. BIRTHPLACE OF FATHER Idaho.
(State or Country)

12. MAIDEN NAME OF MOTHER Julia Pope

13. BIRTHPLACE OF MOTHER Utah
(State or Country)

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Mrs. P. R. Preece
(Address) Adairfort, Ida

15. Filed May 12 1913 R. B. Strickland
Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH Apr. 10th 1913
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from Apr. 10th 1913, to Apr. 10th 1913, that I last saw him alive on Apr. 10th 1913, and that death occurred on the date stated above, at 8 P. M.

The CAUSE OF DEATH* was as follows:
Broncho-Pneumonia

(Duration) yrs. mos. 7 ds.

Contributory (Secondary) Measles

(Duration) yrs. mos. 21 ds.

(Signed) J. C. Patterson M. D.
Apr. 10th 1913 (Address) Burley, Ida.

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place In the
of death.....yrs.....mos.....ds State.....yrs.....mos.....ds.
Where was Disease contracted,
If not at place of death?
Former or usual residence.

19. PLACE OF BURIAL OR REMOVAL DATE OF BURIAL
Burley, Idaho. Apr. 11th 1913

20. UNDERTAKER ADDRESS
H. D. Stone

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Form V. S. No. 5 20M.1-16-12

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics
File No. 485481

1. PLACE OF DEATH.

Registration District No. 1County of AdaPrimary Registration District No. 2004City of Bosse(No. Soldiers Home St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

Edward R TaylorRegistered No. 40

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX

Male

4. COLOR OR RACE

white American

5. SINGLE, MARRIED, WIDOWED OR DIVORCED.

(Write the word.)

6. DATE OF BIRTH

not obtainable

(Month)

(Day)

(Year)

7. AGE

74 yrs. — mos. — ds.IF LESS than 1 day
how many hrs. or
..... mins.?

8. OCCUPATION

(a) Trade, profession or particular kind of work

Civil War Vet

(b) General nature of industry business, or establishment in which employed (or employer)

9. BIRTHPLACE

(State or Country)

not obtainable

10. NAME OF FATHER

11. BIRTHPLACE OF FATHER

(State or Country)

12. MAIDEN NAME OF MOTHER

13. BIRTHPLACE OF MOTHER

(State or Country)

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

E. G. Burnett

(Address)

Soldiers Home

15.

Filed

May 10th1913J. M. Taylor

Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH

May
(Month)9
(Day)1913
(Year)

17. I HEREBY CERTIFY, That I attended deceased from

June 20 1913, to May 8 1913,that I last saw him alive on 1913,and that death occurred on the date stated above, at M.

The CAUSE OF DEATH* was as follows:

of old age

(Duration) yrs. mos. ds.

Contributory
(Secondary)

(Duration) yrs. mos. ds.

(Signed)

E. G. Burnett M. D.

19. (Address)

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place

of death yrs. mos. days.

In the

State yrs. mos. days.

Where was disease contracted
if not at place of death?Former or
usual residence

19. PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

Morris Hill CemMay 11 1913

20. UNDERTAKER

ADDRESS

Taylor & SummersBoise

RECORDED FOR BINDING
Every
COUNTY
ment of CO

Form V. S. No. 5. 12½ M. 7-24-11

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics
File No. 5453
Registered No. 2.

1. PLACE OF DEATH, Registration District No. 117
County of Cassia Primary Registration District No. 2196
City of Burley (No. , St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Earnest Elvin Monsen

If death occurred in a hospital, institution or camp give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX Male 4. COLOR OR RACE white 5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Married)

6. DATE OF BIRTH

July 31 1911
(Month) (Day) (Year)

7. AGE

2 yrs. 0 mos. 18 ds.

IF LESS than 1 day
how many hrs. or min?

8. OCCUPATION

(a) Trade, profession or particular kind of work
(b) General nature of industry business or establishment in which employed (or employer)

At home

9. BIRTHPLACE

(State or Country)

Garfield Co. Oklahoma

10. NAME OF FATHER

Fred W. Monsen

11. BIRTHPLACE OF FATHER

(State or Country)

South Dakota

12. MAIDEN NAME OF MOTHER

Jennie Edith Klingenberg

13. BIRTHPLACE OF MOTHER

(State or Country)

Iowa

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

(Address)

Fred W. Monsen
Burley Idaho

15.

Filed

Aug. 19 1913

H. J. C. Patterson
Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH

Aug. 18th 1913
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from Aug. 18th 1913, to Aug. 18th 1913 that I last saw him alive on Aug. 18th 1913 and that death occurred on the date stated above, at P. M.

The CAUSE OF DEATH* was as follows:

Cholera Infantum.

(Duration) yrs. mos. 1 ds.

Contributory (Secondary)

(Duration) yrs. mos. ds.

(Signed)

J. C. Patterson M. D.
Aug. 19 1913 (Address) Burley, Ida.

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place In the
of death yrs. mos. ds. State yrs. mos. ds.

Where was disease contracted,

If not at place of death?

Former or

usual residence.

19. PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

Burley Ida.

Aug. 23 1913.

20. UNDERTAKER

ADDRESS

L. B. Gallagher

Burley
Ida.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Form V. S. No. 5 20M.1-16-12

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH.

Registration District No. 117County of CassiaPrimary Registration District No. 2196City of Burley

(No. _____, _____ St.)

File No. 5484Registered No. 3

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Jamies Harold Anderson

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX

4. COLOR OR RACE

5. SINGLE, MARRIED, WIDOWED OR DIVORCED.

M.whiteSingle

6. DATE OF BIRTH

Aug.26th1913

(Month)

(Day)

(Year)

7. AGE

_____ yrs. _____ mos. 5 ds.IF LESS than 1 day
how many _____ hrs. or
_____ mins.?

8. OCCUPATION

(a) Trade, profession or particular kind of work

(b) General nature of industry business, or establishment in which employed (or employer)

9. BIRTHPLACE

(State or Country)

Burley, Ida.

10. NAME OF FATHER

Harold Herring

11. BIRTHPLACE OF FATHER

(State or Country)

Unknown

12. MAIDEN NAME OF MOTHER

Ila Anderson

13. BIRTHPLACE OF MOTHER

(State or Country)

Idaho

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

Aleck Anderson

(Address)

Burley, Ida.

15.

Filed

Aug-31st1913H. J. C. Patterson

Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH

Aug.31st1913

(Month)

(Day)

(Year)

17. I HEREBY CERTIFY, That I attended deceased from

Aug. 261913,to Aug. 311913that I last saw him alive on Aug. 301913and that death occurred on the date stated above, at 2:00 PM.

The CAUSE OF DEATH* was as follows:

Malnutrition, Premature Birth(Duration) _____ yrs. _____ mos. 5 ds.Contributory
(Secondary)

(Duration) _____ yrs. _____ mos. _____ ds.

(Signed)

J. C. Patterson

M. D.

8-31-1913 (Address) Burley, Ida.

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place

of death. _____ yrs. _____ mos. _____ days.

In the

State. _____ yrs. _____ mos. _____ days.

Where was disease contracted if not at place of death?

Former or

usual residence.

19. PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

Burley, Ida.9-11913

20. UNDERTAKER

ADDRESS

J. C. Patterson

Form V. S. No. 5 20M.1-16-12

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics1. PLACE OF DEATH. Registration District No. 5
County of Canyon Primary Registration District No. 1009
City of New Plymouth No. _____ St.)File No. 5485

Registered No. _____

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Columbus French

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX Male 4. COLOR OR RACE White 5. SINGLE, MARRIED, WID-
OWED OR DIVORCED. married
(Write the word.)6. DATE OF BIRTH Nov 25 1836
(Month) (Day) (Year)7. AGE 76 yrs. 7 mos. 22 ds.IF LESS than 1 day
how many _____ hrs. or
_____ mins.?8. OCCUPATION Carpenter(a) Trade, profession or
particular kind of work
(b) General nature of industry
business, or establishment in
which employed (or employer)9. BIRTHPLACE New York

(State or Country)

10. NAME OF
FATHER French11. BIRTHPLACE
OF FATHER Not known

(State or Country)

12. MAIDEN NAME
OF MOTHER Not known13. BIRTHPLACE
OF MOTHER Not known

(State or Country)

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) J. D. French(Address) New Plymouth Ida

15.

Filed _____

191 _____

Wm J. Drysdale
Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH Aug 17 1913
(Month) (Day) (Year)17. I HEREBY CERTIFY, That I attended deceased from June 1912, to Aug 17 1913,
that I last saw him alive on Aug 16 1913,
and that death occurred on the date stated above, at 5 PM.The CAUSE OF DEATH* was as follows:
Uremia(Duration) _____ yrs. _____ mos. 14 ds.Contributory Prostatic hypertrophy
(Secondary)(Duration) Several yrs. yrs. _____ mos. _____ ds.(Signed) Wm J. Drysdale M. D.Aug 18 1913 (Address) New Plymouth Ida*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1)
MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.18. LENGTH OF RESIDENCE (For Hospitals, Institutions,
Transients or Recent Residents.)

At place of death _____ yrs. _____ mos. _____ days. In the State _____ yrs. _____ mos. _____ days.

Where was disease contracted
if not at place of death? _____Former or
usual residence _____

19. PLACE OF BURIAL OR REMOVAL DATE OF BURIAL

New Plymouth Ida Aug 18 1913

20. UNDERTAKER

ADDRESS

W. H. Adair Payette Ida

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics
File No. 5486
Registered No. 12

1. PLACE OF DEATH. Registration District No. 32
County of Idaho Primary Registration District No. 2119
City of Hammar (No. _____, St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Perseic William E Coy

If death occurred in a hospital, institution or camp give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX Female 4. COLOR OR RACE White 5. SINGLE, MARRIED, WIDOWED OR DIVORCED. Single
(Write the word.)
6. DATE OF BIRTH May 4 1913
(Month) (Day) (Year)

7. AGE 10 mos. 29 ds. IF LESS than 1 day how many _____ hrs. or _____ min?

8. OCCUPATION

- (a) Trade, profession or particular kind of work.
(b) General nature of industry business or establishment in which employed (or employer)

9. BIRTHPLACE

(State or Country)

10. NAME OF FATHER

11. BIRTHPLACE OF FATHER

(State or Country)

12. MAIDEN NAME OF MOTHER

13. BIRTHPLACE OF MOTHER

(State or Country)

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) E. N. McElroy

(Address) Hammar Idaho

15.

Filed April 8 1913

E. N. McElroy
Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH

April 6 1913
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from Mar 26th 1913, to Apr 6th 1913 that I last saw her alive on Apr 6th 1913 and that death occurred on the date stated above, at 1:00 P.M.

The CAUSE OF DEATH* was as follows:

Bronchopneumonia

(Duration) _____ yrs. _____ mos. _____ ds.

Contributory (Secondary)

Pertussis

(Duration) _____ yrs. _____ mos. _____ ds.

(Signed) W. F. McMahon M. D.

4/6 1913 (Address) Hammar, Ida.

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death _____ yrs. _____ mos. _____ ds. State _____ yrs. _____ mos. _____ ds.

Where was disease contracted,

If not at place of death?

Former or

usual residence.

19. PLACE OF BURIAL OR REMOVAL DATE OF BURIAL

U. S. Cemetery April 7th 1913

20. UNDERTAKER

ADDRESS

E. F. Johnson Hammar, Ida.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. PHYSICIANS—Every item of information should be carefully supplied. AGE should be stated EXACTLY. Exact state-ment of OCCUPATION is very important. See instructions on back of certificate.

Form V. S. No. 5. 10M. 6-20-11.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics
File No. 5488

1. PLACE OF DEATH.

Registration District No. 23County of LincolnPrimary Registration District No. 1017-2017City of Jerome

(No. _____, _____ St.)

Registered No. _____

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

Unnamed M.^c Cabe

If death occurred in a hospital, institution or camp give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX

M

4. COLOR OR RACE

White5. SINGLE, MARRIED, WID-
OWED OR DIVORCED.Single
(Write the word.)

6. DATE OF BIRTH

Aug
(Month)6
(Day)1913
(Year)

7. AGE

2 yrs. 2 mos. 2 ds.

IF LESS than 1 day
how many _____ hrs. or
_____ min.

8. OCCUPATION

(a) Trade, profession or
particular kind of workInfant(b) General nature of industry
business or establishment in
which employed (or employer)

9. BIRTHPLACE

(State or Country)

Lincoln Co Ida10. NAME OF
FATHERChas M.^c Cabe11. BIRTHPLACE
OF FATHER

(State or Country)

Nebraska12. MAIDEN NAME
OF MOTHERDeborah Wilson13. BIRTHPLACE
OF MOTHER

(State or Country)

Ireland

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

Deborah Wilson M.^c Cabe

(Address)

Jerome Ida by E.D.P.

15.

Filed

Aug 8 1913E.D. Piper

Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

Aug
(Month)8
(Day)1913
(Year)

17. I HEREBY CERTIFY, That I attended deceased from

Aug 61913to Aug 81913that I last saw him alive on Aug 8 1913,and that death occurred on the date stated above, at 9 9 M.

The CAUSE OF DEATH* was as follows:

Premature Birth

(Duration)

yrs.

mos.

2 ds.Contributory
(Secondary)6 moDoctor

(Duration)

yrs.

mos.

2 ds.

(Signed)

E. D. Piper M.D. M. D.Aug 8 1913

(Address)

Jerome Ida

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions,
Transients or Recent Residents.)

At place

In the

of death. _____ yrs. _____ mos. _____ ds. State. _____ yrs. _____ mos. _____ ds.

Where was disease contracted.

If not at place of death?

Former or

usual residence.

19. PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

Home acreAug 8 1913

20. UNDERTAKER

ADDRESS

Chas M.^c Cabe (Father)Jerome Ida

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Form V. S. No. 5. 10M. 6-20-11.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics
File No. 5129

1. PLACE OF DEATH.

Registration District No. 23County of LincolnPrimary Registration District No. 1017-2017City of Jerome

(No. _____, _____ St.)

Registered No. _____

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

unnamed Mr. & Cobe

If death occurred in a hospital, institution or camp give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX

Fr.

4. COLOR OR RACE

White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED.

Single
(Write the word.)

6. DATE OF BIRTH

Aug
(Month)6
(Day)1913
(Year)

7. AGE

_____ yrs.

_____ mos.

_____ ds.

IF LESS than 1 day
how many _____ hrs. or
_____ min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work

(b) General nature of industry business or establishment in which employed (or employer)

Infant

9. BIRTHPLACE

(State or Country)

Lincoln Co Idaho

10. NAME OF FATHER

Chas M. & Cobe

11. BIRTHPLACE OF FATHER

(State or Country)

Nebraska

12. MAIDEN NAME OF MOTHER

Deborah Wilson

13. BIRTHPLACE OF MOTHER

(State or Country)

Ireland

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

Deborah Wilson M. & Cobe

(Address)

Jerome Ida by E. D. P.

15.

Filed

Aug 8 1913E. D. Phe M.D.

Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

Aug
(Month)7
(Day)1913
(Year)

17. I HEREBY CERTIFY, That I attended deceased from

Aug 61913,to Aug 71913that I last saw her alive on Aug 7 1913,and that death occurred on the date stated above, at 6 P. M.

The CAUSE OF DEATH* was as follows:

Immature Birth(Duration) _____ yrs. _____ mos. 1 ds.Contributory
(Secondary)6 mo Foster(Duration) _____ yrs. _____ mos. 1 ds.

(Signed)

E. D. Piper M. D.Aug 8 1913 (Address) Jerome Ida

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death _____ yrs. _____ mos. _____ ds. State _____ yrs. _____ mos. _____ ds.

Where was disease contracted.

If not at place of death?

Former or

usual residence.

19. PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

Home LatAug 8 1913

20. UNDERTAKER

ADDRESS

Chas M. & Cobe. (Father) Jerome Ida

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIAN should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

1. PLACE OF DEATH.		Registration District No.		Bureau of Vital Statistics	
County of <u>Canyon</u>		Primary Registration District No.		File No. <u>5490</u>	
City of		(No., St.)		Registered No.	
If death occurs away from usual residence, give facts called for under special information.		2. FULL NAME <u>Michael Hestriter</u>		If death occurred in a hospital, institution or camp give its NAME instead of street and number.	
PERSONAL AND STATISTICAL PARTICULARS					
3. SEX	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED OR DIVORCED			
<u>Male</u>	<u>White</u>	<u>Married</u> (Write the word.)			
6. DATE OF BIRTH					
<u>July</u> (Month)		<u>4</u> (Day)	<u>1849</u> (Year)		
7. AGE		IF LESS than 1 day			
<u>64</u> yrs. <u>1</u> mos. <u>16</u> ds.		how many hrs. or min.?			
8. OCCUPATION					
(a) Trade, profession, or particular kind of work <u>Farmer</u>					
(b) General nature of industry business, or establishment in which employed (or employer)					
9. BIRTHPLACE (State or Country) <u>Chicago, Ill</u>					
10. NAME OF FATHER <u>Don't know</u>					
11. BIRTHPLACE OF FATHER (State or Country) <u>Seamney</u>					
12. MAIDEN NAME OF MOTHER <u>Seamney</u>					
13. BIRTHPLACE OF MOTHER (State or Country) <u>Don't know</u>					
14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE					
(Informant) <u>F. R. Odle</u>					
(Address) <u>Nampa, Idaho</u>					
15. Filed <u>8/21</u> 191 <u>3</u> <u>P. D. Calange, M.D.</u> Local Registrar					
MEDICAL CERTIFICATE OF DEATH					
16. DATE OF DEATH					
<u>Aug-</u> (Month)		<u>20</u> (Day)	<u>1913</u> (Year)		
17. I HEREBY CERTIFY, That I attended deceased from <u>Jan 28</u> 191 <u>3</u> , to <u>Aug 20</u> 191 <u>3</u> , that I last saw him alive on <u>Aug 18</u> 191 <u>3</u> , and that death occurred on the date stated above, at <u>M.</u>					
The CAUSE OF DEATH* was as follows: <u>Peritis</u>					
(Duration) <u>1</u> yrs. <u>3</u> mos. <u>—</u> ds.					
Contributory (Secondary)					
(Duration) <u>—</u> yrs. <u>—</u> mos. <u>—</u> ds.					
(Signed) <u>P. L. Payne</u> M. D. <u>Aug 21</u> 191 <u>3</u> (Address) <u>Kamper</u>					
*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.					
18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)					
At place		In the			
of death <u>8</u> yrs. <u>—</u> mos. <u>—</u> ds.		State <u>—</u> yrs. <u>—</u> mos. <u>—</u> ds.			
Where was Disease contracted, If not at place of death? <u>Cared not say</u>					
Former or usual residence					
19. PLACE OF BURIAL OR REMOVAL				DATE OF BURIAL	
<u>Hoklarlawer Cen.</u>				<u>Aug 24</u> 191 <u>3</u>	
20. UNDERTAKER				ADDRESS	
<u>215 Roberts</u>				<u>Nampa</u>	

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Form V. S. No. 5. 10M. 6-20-11.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH.

Registration District No.

County of Canyon

Primary Registration District No.

City of Naupaka

(No. St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

Clara DealFile No. 5491

Registered No.

If death occurred in a hospital, institution or camp give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX

Female

4. COLOR OR RACE

White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED.

Married
(Write the word.)

6. DATE OF BIRTH

836
(Month) (Day) (Year)

7. AGE

77 yrs. — mos. — ds.

IF LESS than 1 day
how many hrs. or
..... min.?

8. OCCUPATION

(a) Trade, profession, or particular kind of work

(b) General nature of industry business, or establishment in which employed (or employer)

Housewife

9. BIRTHPLACE

(State or Country)

Ohio

10. NAME OF FATHER

Cornelius Haight

11. BIRTHPLACE OF FATHER

(State or Country)

Don't know

12. MAIDEN NAME OF MOTHER

Don't know

13. BIRTHPLACE OF MOTHER

(State or Country)

Don't know

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

W. H. Deal

(Address)

Naupaka Ida

15.

Filed 8/21 1913

B. D. Calange
Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

8 21 1913
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from

Aug 16 - 1913, to Aug 21 - 1913

that I last saw him alive on Aug 20 - 1913,

and that death occurred on the date stated above, at 3 P. M.

The CAUSE OF DEATH* was as follows:

Acute Bright's Disease

(Duration) yrs. mos. ds.

Contributory (Secondary)

(Duration) yrs. mos. ds.

(Signed)

A. B. Beller M. D.
Aug 21 1913 (Address) Naupaka Ida

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place In the
of death yrs. mos. ds. State yrs. mos. ds.

Where was Disease contracted,

If not at place of death?

Former or

usual residence.

19. PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

Kohlerstown Cem8/22 1913

20. UNDERTAKER

ADDRESS

W. C. RobinsonNaupaka Ida

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Form V. S. No. 5. 10M. 6-20-11.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH. Registration District No.
County of Canyon Primary Registration District No.
City of _____ (No. _____, St.)

File No. 5492

Registered No.

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Armitie C. Crayne

If death occurred in a hospital, institution or camp give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX Female 4. COLOR OR RACE White 5. SINGLE, MARRIED, WIDOWED OR DIVORCED. Married

6. DATE OF BIRTH April 25 1876
(Month) (Day) (Year)

7. AGE 37 yrs. 4 mos. 4 ds. IF LESS than 1 day how many hrs. or min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work Farmer wife
(b) General nature of industry business or establishment in which employed (or employer)

9. BIRTHPLACE
(State or Country) Missouri

10. NAME OF FATHER Wm Thomson

11. BIRTHPLACE OF FATHER
(State or Country) Ohio

12. MAIDEN NAME OF MOTHER Matilda J. Newman

13. BIRTHPLACE OF MOTHER
(State or Country) Ohio

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) S. H. Crayne
(Address) Hampt Idaho

15. Filed Aug 30 1913 P. D. Calonge
Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH August 28th 1913
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from May 12th 1913, to Aug 29th 1913, that I last saw h. alive on Aug 10th 1913, and that death occurred on the date stated above, at 10:30 P.M.
The CAUSE OF DEATH* was as follows:

Pulmonary tuberculosis

(Duration) 1 yrs. 4 mos. — ds.
Contributory (Secondary) Pyæmia from mixed infection

(Duration) — yrs. 2 mos. — ds.
(Signed) Geo. D. Killozy, M. D.
8/29/1913 (Address) Hampt Ida

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death yrs. mos. ds. In the State yrs. mos. ds.
Where was disease contracted? Missouri
If not at place of death?
Former or usual residence Missouri

19. PLACE OF BURIAL OR REMOVAL Missouri DATE OF BURIAL ✓ 191...

20. UNDERTAKER E. B. Shellaker ADDRESS Hampt Ida

Form V. S. No. 5. 10M. 6-20-11.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital StatisticsFile No. 5493

Registered No. _____

If death occurred in a hospital, institution or camp give its NAME instead of street and number.

1. PLACE OF DEATH.

Registration District No. _____

County of CanyonPrimary Registration District No. 7City of Nampa

(No. _____, St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

Claude H. Diggs

PERSONAL AND STATISTICAL PARTICULARS

3. SEX

Male

4. COLOR OR RACE

White(Write the word.) ☒

6. DATE OF BIRTH

Aug 3

(Month)

(Day)

1912
(Year)

7. AGE

1 yrs. 20 mos. 0 ds.IF LESS than 1 day
how many 1 hrs. or
2 min.?

8. OCCUPATION

- (a) Trade, profession, or particular kind of work
-
- (b) General nature of industry business, or establishment in which employed (or employer)

Infant

9. BIRTHPLACE

(State or Country)

Deer Flat

10. NAME OF FATHER

Harmon H. Diggs

11. BIRTHPLACE OF FATHER

(State or Country)

Idaho

12. MAIDEN NAME OF MOTHER

Lattie Cole

13. BIRTHPLACE OF MOTHER

(State or Country)

Cato, Mich

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

Harmon H. Diggs

(Address)

Deer Flat Ida

15.

Filed

Aug 23 1912

Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

Aug 23

(Month)

(Day)

1912
(Year)

17. I HEREBY CERTIFY, That I attended deceased from

Aug 17 1912 to Aug 23 1912that I last saw him alive on Aug 22 1912and that death occurred on the date stated above, at 11 PM

The CAUSE OF DEATH* was as follows:

Acute Illness Caused
complicated by Pul-
monary Hypertension(Duration) 1 yrs. 6 mos. 0 ds.Contributory
(Secondary)(Duration) 1 yrs. 0 mos. 0 ds.

(Signed)

Aug 23 1912 (Address) Nampa, Ida

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place

In the

of death. 1 yrs. 0 mos. 0 ds. State 1 yrs. 0 mos. 0 ds.

Where was Disease contracted,

If not at place of death?

Former or

usual residence.

19. PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

Public BurialAug 23 1912

20. UNDERTAKER

ADDRESS

512 Shellabarger Nampa, Ida

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Form V. S. No. 5. 10M. 6-20-11.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH. Registration District No.
County of Canyon Primary Registration District No.
City of Nampa (No., St.)

File No. 5494

Registered No.

If death occurs away from usual residence, give facts called for under special information.

If death occurred in a hospital, institution or camp give its NAME instead of street and number.

2. FULL NAME Gustav Zeyer

PERSONAL AND STATISTICAL PARTICULARS

3. SEX 4. COLOR OR RACE 5. SINGLE, MARRIED, WIDOWED OR DIVORCED.

Male White Married
(Write the word.)

6. DATE OF BIRTH

Feb 5 1871
(Month) (Day) (Year)

7. AGE

42 yrs. 6 mos. 10 ds. IF LESS than 1 day how many hrs. or min.?

8. OCCUPATION

(a) Trade, profession, or particular kind of work Farmer
(b) General nature of industry business, or establishment in which employed (or employer)

9. BIRTHPLACE

(State or Country) Germany

10. NAME OF FATHER

Fred'k Zeyer

11. BIRTHPLACE OF FATHER

(State or Country) Germany

12. MAIDEN NAME OF MOTHER

Caroline Bale

13. BIRTHPLACE OF MOTHER

(State or Country) Germany

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Freda Zeyer

(Address) Nampa Ida

15.

Filed Aug 17 1913 P.D. Calange
Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

Aug 17 1913
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from

Aug 10 1913, to Aug 17 1913
that I last saw him alive on Aug 17 1913,
and that death occurred on the date stated above, at 1 A.M.

The CAUSE OF DEATH* was as follows:

Typhoid fever complicated by pneumonia.
(From history of case by Dr. ...)
(Duration) yrs. mos. ds.

Contributory (Secondary)

(Duration) yrs. mos. ds.

(Signed) P.D. Calange M. D.

1913 (Address) Nampa Ida

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place In the
of death yrs. mos. ds. State yrs. mos. ds.
Where was Disease contracted on ranch
If not at place of death?
Former or usual residence Near Guffy Idaho

19. PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

Hollerlawn Cemetery Aug 19 1913

20. UNDERTAKER

ADDRESS

H. Robinson Nampa Ida

Form V. S. No. 5. 10M. 6-20-11.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
 Department of Vital Statistics
 File No. 5495
 Registered No. _____

1. **PLACE OF DEATH.** Registration District No. _____
 County of Boise Primary Registration District No. _____
 City of Boise (No. _____, _____ St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

Wm Betts

If death occurred in a hospital, institution or camp give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX 4. COLOR OR RACE 5. SINGLE, MARRIED, WID-
 OWED OR DIVORCED.

Male White Single
 (Write the word.)

6. DATE OF BIRTH

1885
 (Month) (Day) (Year)

7. AGE

28 yrs. mos. ds. IF LESS than 1 day
 how many hrs. or min.?

8. OCCUPATION

(a) Trade, profession, or particular kind of work RR Fireman
 (b) General nature of industry, business, or establishment in which employed (or employer)

9. BIRTHPLACE

(State or Country)

Ohio

10. NAME OF FATHER

Frank Betz

11. BIRTHPLACE OF FATHER

(State or Country)

Ohio

12. MAIDEN NAME OF MOTHER

Anna Homan

13. BIRTHPLACE OF MOTHER

(State or Country)

Ohio

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) George E. Betz
 (Address) Portland Oregon

15.

Filed Sept 2 1913 S.D. Calver MD
 Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

Aug 31 1913
 (Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from

Killed in car accident 1913
 that I last saw him alive on Sept 1 1913

and that death occurred on the date stated above, at 7 P. M.

The CAUSE OF DEATH* was as follows:

Fatalment by engine on
which he was riding
Instant
 (Duration) yrs. mos. ds.

Contributory (Secondary)

(Duration) yrs. mos. ds.

(Signed) J. H. Murray M. D.

Sept 2, 1913 (Address) Idaho

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place In the
 of death yrs. mos. ds. State yrs. mos. ds.

Where was Disease contracted,
 If not at place of death?
 Former or usual residence.

19. PLACE OF BURIAL OR REMOVAL DATE OF BURIAL

Bellevue Ohio 1913

20. UNDERTAKER

F. H. Robinson ADDRESS Idaho

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Form V. S. No. 5. 10M. 6-20-11.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH.

Registration District No.

County of Boise

Primary Registration District No.

City of Boise

(No. St.)

Registered No.

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

Cliff T Scott

If death occurred in a hospital, institution or camp give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX

Male

4. COLOR OR RACE 5. SINGLE, MARRIED, WIDOWED OR DIVORCED.

white

(Write the word.)

6. DATE OF BIRTH

1888
(Month) (Day) (Year)

7. AGE

25

yrs.

mos.

ds.

IF LESS than 1 day
how many hrs. or
..... min.?

8. OCCUPATION

- (a) Trade, profession, or particular kind of work
(b) General nature of industry business, or establishment in which employed (or employer)

Brakeman

9. BIRTHPLACE

(State or Country)

10. NAME OF FATHER

11. BIRTHPLACE OF FATHER

(State or Country)

12. MAIDEN NAME OF MOTHER

13. BIRTHPLACE OF MOTHER

(State or Country)

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

(Address)

15.

Filed

Sept 2 1913P. D. Calverly
Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

Aug 31 1913
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from

Pulled in rail road 1913
accident
that I last saw alive on 1913and that death occurred on the date stated above, at 7 P. M.

The CAUSE OF DEATH* was as follows:

Derailment of engine on which he was riding(Duration) Instant yrs. mos. ds.Contributory (Secondary) L

(Duration) yrs. mos. ds.

(Signed) J. P. Murray M. D.Sept 2 1913 (Address) Nashua, Idaho

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place In the

of death yrs. mos. ds. State yrs. mos. ds.

Where was Disease contracted,

If not at place of death?

Former or

usual residence

19. PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

Hazen Co1913

20. UNDERTAKER

ADDRESS

J. K. RoleNashua

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Form V. S. No. 5. 10M. 6-20-11.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

File No. **5497**

Registered No. _____

If death occurred in a hospital, institution or camp give its NAME instead of street and number.

1. PLACE OF DEATH.

Registration District No. _____

County of Canyon

Primary Registration District No. _____

City of Nampa

(No. _____, _____ St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

Thomas W Brown

PERSONAL AND STATISTICAL PARTICULARS

3. SEX

4. COLOR OR RACE 5. SINGLE, MARRIED, WIDOWED OR DIVORCED.

Male WhiteMarried
(Write the word.)

6. DATE OF BIRTH

✓ May 20 1854
(Month) (Day) (Year)

7. AGE

✓ 59 yrs. 3 mos. 12 ds. IF LESS than 1 day
how many _____ hrs. or
_____ min.?

8. OCCUPATION

(a) Trade, profession, or particular kind of work

(b) General nature of industry, business, or establishment in which employed (or employer)

Farmer

9. BIRTHPLACE

(State or Country)

Iowa

10. NAME OF FATHER

Isaac Brown

11. BIRTHPLACE OF FATHER

(State or Country)

Illinois

12. MAIDEN NAME OF MOTHER

Wilson

13. BIRTHPLACE OF MOTHER

(State or Country)

Illinois

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Clara D. Brown

(Address)

Nampa,

15.

Filed Sept. 3 1913P. D. Calonge M.
Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

Sept 2 1913
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from

Sept 1 1913, to Sept 2 1913.that I last saw him alive on Sept 2 1913,and that death occurred on the date stated above, at 10 P. M.

The CAUSE OF DEATH* was as follows:

accidental
Throat cut by being dragged
on barbed wire - by train
(Duration) 36 hrs. 00 mos. 00 ds.Contributory
(Secondary)(Duration) 00 yrs. 00 mos. 00 ds.(Signed) J. H. Murray M. D.Sept 5 1913 (Address) Nampa, Idaho

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place _____ In the _____
of death _____ yrs. _____ mos. _____ ds. State _____ yrs. _____ mos. _____ ds.

Where was Disease contracted,

If not at place of death?

Former or

usual residence.

19. PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

Kohlerlawn Cem9/5 1913

20. UNDERTAKER

ADDRESS

Fix RobmanNampa, Ida

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Form V. S. No. 5 20M.1-16-12

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics
File No. **5498**

1. PLACE OF DEATH. Registration District No. **1**
County of **Bear Lake** Primary Registration District No. **1**
City of **Montpelier Ida** (No. **1**, _____ St.)

Registered No. _____
If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME **Norman M. Pratt**

PERSONAL AND STATISTICAL PARTICULARS

3. SEX **Male** 4. COLOR OR RACE **White** 5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.)

6. DATE OF BIRTH **9** **6** **1894**
(Month) (Day) (Year)

7. AGE **78** yrs. **10** mos. **25** ds. IF LESS than 1 day how many hrs. or mins.?

8. OCCUPATION
(a) Trade, profession or particular kind of work **no occupation**
(b) General nature of industry business, or establishment in which employed (or employer)

9. BIRTHPLACE (State or Country) **not obtainable** ✓

10. NAME OF FATHER **Didney Pratt**

11. BIRTHPLACE OF FATHER (State or Country) **not obtainable** ✓

12. MAIDEN NAME OF MOTHER **not obtainable** ✓

13. BIRTHPLACE OF MOTHER (State or Country) **not obtainable** ✓

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) **Joseph Wilcox**
(Address) **Montpelier Ida**

15. Filed **Aug 1st** 1913 **E. F. Guyon**
Deputy Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH **7** **31** **1913**
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from **July 31st** 1913, to **1913**, that I last saw him alive on **July 31st** 1913, and that death occurred on the date stated above, at **11 A.M.**

The CAUSE OF DEATH* was as follows:
apoplexy

(Duration) _____ yrs. _____ mos. _____ ds.
Contributory (Secondary)

(Duration) _____ yrs. _____ mos. _____ ds.
(Signed) **E. F. Guyon** M. D.
8/1 1913 (Address) **Montpelier Ida**

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death _____ yrs. _____ mos. _____ days. In the State _____ yrs. _____ mos. _____ days.

Where was disease contracted if not at place of death?
Former or usual residence **Montpelier Ida**

19. PLACE OF BURIAL OR REMOVAL **Montpelier Cemetery** DATE OF BURIAL **Aug. 2nd 1913**

20. UNDERTAKER **None** ADDRESS _____

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIAN should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact state of OCCUPATION is very important. See instructions on back of certificate.

1. PLACE OF DEATH County of <u>Bear Lake</u> City of <u>Bennington</u>		Registration District No. <u>2136</u> (No. <u> </u> , St. <u> </u>)		BOARD OF HEALTH Bureau of Vital Statistics File No. <u>5499</u> Registered No. <u> </u>	
If death occurs away from usual residence, give facts calling for under special information.					
2. FULL NAME <u>George Perkins</u> If death occurred in a hospital, institution or camp give its NAME instead of street and number.					
PERSONAL AND STATISTICAL PARTICULARS					
3. SEX <u>Male</u>		4. COLOR OR RACE <u>White</u>		5. SINGLE, MARRIED, WIDOWED OR DIVORCED. <u>Married</u> (Write the word.)	
6. DATE OF BIRTH <u>May 25, 1845</u> (Month) (Day) (Year)					
7. AGE <u>68</u> yrs. <u>2</u> mos. <u>8</u> ds.		IF LESS than 1 day how many hrs. or min?			
8. OCCUPATION (a) Trade, profession or particular kind of work. <u>Rancher</u> (b) General nature of industry business or establishment in which employed (or employer)					
9. BIRTHPLACE (State or Country) <u>Hancock county Illinois</u>					
10. NAME OF FATHER <u>William Lewis Perkins</u>					
11. BIRTHPLACE OF FATHER (State or Country) <u>White County Tennessee</u>					
12. MAIDEN NAME OF MOTHER <u>Marian Brown</u>					
13. BIRTHPLACE OF MOTHER (State or Country) <u>New York</u>					
14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE (Informant) <u>George Perkins</u> (Address) <u>Bear Lake Co Idaho</u>					
15. <u>Aug 16th 1913</u> <u>St. Anthony</u> Local Registrar					
MEDICAL CERTIFICATE OF DEATH.					
16. DATE OF DEATH <u>Aug 16</u> 191 <u>3</u> (Month) (Day) (Year)					
17. I HEREBY CERTIFY, That I attended deceased from <u>Aug 11</u> 191 <u>3</u> , to <u>Aug 16</u> 191 <u>3</u> that I last saw him alive on <u>Aug 10</u> 191 <u>3</u> and that death occurred on the date stated above, at <u>M.</u> The CAUSE OF DEATH* was as follows: <u>Pneumonia lobar</u>					
18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.) At place <u>35</u> yrs. In the <u>35</u> yrs. State <u>Idaho</u> mos. ds. of death yrs. mos. ds. Where was disease contracted, <u>Bennington Idaho</u> If not at place of death? Former or usual residence. <u>Bennington Idaho</u>					
19. PLACE OF BURIAL OR REMOVAL <u>Bennington Idaho</u>				DATE OF BURIAL <u>8-18-1913</u>	
20. UNDERTAKER <u>None</u>				ADDRESS	

-SUPPLEMENTARY DEATH CERTIFICATE-

(Please reply on this sheet to
the registrar of Vital Statistics)

Death Certificate No.

Name.....George Perkins.....

Date of Death.....Oct. 16, 1913.....

Cause of Death *Lobar Pneumonia*.....

Contributory Cause of death *accident, fell from*.....

hay stack and fractured 6 ribs

(Sign here) *Geo F Ashley* M.D.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Form V. S. No. 5 20M.1-16-12

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics
File No. **5509**

1. PLACE OF DEATH.

Registration District No.

County of Cassia

Primary Registration District No.

City of Carey

(No., St.)

Registered No.

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Annie Durfee Fairchild

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX

Female

4. COLOR OR RACE

White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED.

married
(Write the word.)

6. DATE OF BIRTH

December 11 1887
(Month) (Day) (Year)

7. AGE

25 yrs. 8 mos. 6 ds.

IF LESS than 1 day
how many hrs. or
..... mins.?

8. OCCUPATION

- (a) Trade, profession or particular kind of work
(b) General nature of industry, business, or establishment in which employed (or employer)

Housewife

9. BIRTHPLACE

(State or Country)

Carey Idaho

10. NAME OF FATHER

Arthur Durfee

11. BIRTHPLACE OF FATHER

(State or Country)

Idaho

12. MAIDEN NAME OF MOTHER

Elizabeth J. Reader

13. BIRTHPLACE OF MOTHER

(State or Country)

Texas

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Mrs. H. Fairchild

(Address)

15.

Filed 191

Blankenship
Jas

Local R

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH

August 17 1913
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from

Aug. 13 1913 to Aug 17 1913

that I last saw her alive on on 4^{30th} 1913

and that death occurred on the date stated above, at 5⁰ M.

The CAUSE OF DEATH* was as follows:

Hemorrhage from stomach

(Duration) yrs. mos. 6 ds.

Contributory (Secondary) Gastric ulcer

(Duration) 4 yrs. mos. ds.

(Signed) E. P. O'Hara M. D.

Aug 18 1913 (Address) Carey Idaho

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death yrs. mos. days. In the State yrs. mos. days.

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

Carey Idaho Aug 19 1913

20. UNDERTAKER

ADDRESS

Wright & Carey

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Form V. S. No. 5 20M.1

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics
File No. **5501**

1. PLACE OF DEATH

Registration District No.

County of

Primary Registration District No.

City of

(No.

St.)

Registered No.

If death occurs away from usual residence, give facts called for under special information. 2.

NAME

Willard Willard Adams

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND PHYSICAL PARTICULARS

3. SEX

4. COLOR OF

5. SINGLE, MARRIED, WIDOWED OR DIVORCED.

Male

White

Single
(Write the word.)

6. DATE OF BIRTH

Oct. 14 1903
(Month) (Day) (Year)

7. AGE

9 yrs. 8 mos. 29 ds.

IF LESS than 1 day
how many hrs. or
..... mins.

8. OCCUPATION

(a) Trade, profession or particular kind of work
(b) General nature of industry business, or establishment in which employed (or employer)

Farmer

Student

9. BIRTHPLACE

(State or Country)

Idaho

10. NAME OF FATHER

George A. Adams

11. BIRTHPLACE OF FATHER

(State or Country)

Utah

12. MAIDEN NAME OF MOTHER

Sarah Saddleston

13. BIRTHPLACE OF MOTHER

(State or Country)

England

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

Mrs. Sarah Adams

(Address)

Marion Idaho

15.

Filed

191

L. Blocklager
Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

July 13 1913
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from

July 7 1913 to July 13 1913
that I last saw him alive on *July 12 1913*

and that death occurred on the date stated above, at *5:30 M.*

The CAUSE OF DEATH* was as follows:

General Peritonitis following Operation

(Duration) yrs. mos. *4* ds.

Contributory (Secondary)

Appendicitis

(Duration) yrs. mos. *9* ds.

(Signed)

E. Polsham M. D.
7.12.1913 (Address) *Polsham*

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death yrs. mos. days. In the State yrs. mos. days.

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

Harvey Sessions

July 13 1913

20. UNDERTAKER

ADDRESS

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Form V. S. No. 5. 12½ M. 7-24-11

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics
File No. 5502
Registered No.

1. PLACE OF DEATH. Registration District No.
County of Cassia Primary Registration District No.
City of Albion (No. , St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Nellie Elida Parke

If death occurred in a hospital, institution or camp give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX 4. COLOR OR RACE 5. SINGLE, MARRIED, WIDOWED OR DIVORCED.

Female white Single (Write the word.)

6. DATE OF BIRTH Dec 10 1897
(Month) (Day) (Year)

7. AGE 16 yrs. 7 mos. 17 ds. IF LESS than 1 day how many hrs. or min?

8. OCCUPATION
(a) Trade, profession or particular kind of work. At home
(b) General nature of industry business or establishment in which employed (or employer)

9. BIRTHPLACE
(State or Country) Albion Ida. Prussia

10. NAME OF FATHER Chester Parke

11. BIRTHPLACE OF FATHER
(State or Country) Davis Co. Utah

12. MAIDEN NAME OF MOTHER Adelaid Pierce

13. BIRTHPLACE OF MOTHER
(State or Country) Utah

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) B. C. Parke
(Address) Albion

15. Filed 191 L. B. Stockslager
Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH July 27 1913
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from 191 to 191 that I last saw him alive on 191 and that death occurred on the date stated above, at M.

The CAUSE OF DEATH* was as follows:
Suicide, Lysol poisoning

(Duration) yrs. mos. ds.

Contributory (Secondary)

(Duration) yrs. mos. ds.

(Signed) L. B. Gallagher, Coroner M.D.
July 25, 1913. (Address) Blaine, Ida.

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place In the
of death yrs. mos. ds. State yrs. mos. ds.
Where was disease contracted,
If not at place of death?
Former or
usual residence.

19. PLACE OF BURIAL OR REMOVAL DATE OF BURIAL

Albion Ida July 28 1913

20. UNDERTAKER ADDRESS

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Form V. S. No. 5. 12½ M. 7-24-11

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH. Registration District No.
County of Cassia Primary Registration District No.
City of Burley (No., St.)

File No. 5503
Registered No.

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Chas. Nelson

If death occurred in a hospital, institution or camp give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX 4. COLOR OR RACE 5. SINGLE, MARRIED, WIDOWED OR DIVORCED.

Male white Single
6. DATE OF BIRTH Unknown
(Month) (Day) (Year)

7. AGE IF LESS than 1 day
16 yrs. mos. ds. how many hrs. or min?

8. OCCUPATION

(a) Trade, profession or particular kind of work. Farm laborer
(b) General nature of industry business or establishment in which employed (or employer)

9. BIRTHPLACE

(State or Country) Boxelder Co., Utah

10. NAME OF FATHER

C. P. Nelson

11. BIRTHPLACE OF FATHER

(State or Country) Sweden

12. MAIDEN NAME OF MOTHER

Christen Johnson

13. BIRTHPLACE OF MOTHER

(State or Country) Sweden

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) E. W. Nelson
(Address) Idaho Id.

15.

Filed 191

Blacksage
Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH

July 20 1913
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from

191...., to 191....

that I last saw h..... alive on 191....

and that death occurred on the date stated above, at M.

The CAUSE OF DEATH* was as follows:

Unknown

(Duration) yrs. mos. ds.

Contributory
(Secondary)

(Duration) yrs. mos. ds.

(Signed) L. B. Tallogly, Coroner

July 21, 1913 (Address) Burley, Ida.

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place In the
of death yrs. mos. ds. State yrs. mos. ds.

Where was disease contracted,

If not at place of death?

Former or
usual residence.

19. PLACE OF BURIAL OR REMOVAL DATE OF BURIAL

Idaho July 20, 1913

20. UNDERTAKER

ADDRESS

Bishop Deering Idaho

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Form V. S. No. 5. 12½ M. 7-24-11

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics
File No. 5504
Registered No. _____

1. PLACE OF DEATH. Registration District No. _____
County of Cassia Primary Registration District No. _____
City of Sublett (No. _____, _____ St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME John W. Bowling

If death occurred in a hospital, institution or camp give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX 4. COLOR OR RACE 5. SINGLE, MARRIED, WIDOWED OR DIVORCED.

Male white Single (d.)

6. DATE OF BIRTH

June 7 1888
(Month) (Day) (Year)

7. AGE

25 yrs. 0 mos. 23 ds.

IF LESS than 1 day
how many _____ hrs. or
_____ min?

8. OCCUPATION

(a) Trade, profession or particular kind of work.

Farmer

(b) General nature of industry business or establishment in which employed (or employer)

9. BIRTHPLACE

(State or Country)

Elliott Co. Kentucky

10. NAME OF FATHER

Unknown

11. BIRTHPLACE OF FATHER

(State or Country)

Unknown

12. MAIDEN NAME OF MOTHER

Unknown

13. BIRTHPLACE OF MOTHER

(State or Country)

Unknown

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

James Justice

(Address)

Sublett Ida

15.

Filed _____ 191 _____

J. B. Stockdager
Local Registrar
Jms

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH

July 1 1913
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from

_____ 191 _____, to _____ 191 _____

that I last saw h _____ alive on _____ 191 _____

and that death occurred on the date stated above, at 1 P.M.

The CAUSE OF DEATH* was as follows:

Accidental explosion of dynamite

_____ (Duration) _____ yrs. _____ mos. _____ ds.

Contributory
(Secondary)

_____ (Duration) _____ yrs. _____ mos. _____ ds.

(Signed) L. B. Gallogly, Coroner M. D.

July 3 1913 (Address) Sublett Ida

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place _____ In the _____
of death _____ yrs. _____ mos. _____ ds. State _____ yrs. _____ mos. _____ ds.

Where was disease contracted,
If not at place of death? _____

Former or
usual residence. _____

19. PLACE OF BURIAL OR REMOVAL DATE OF BURIAL

Sublett Ida July 3 1913

20. UNDERTAKER

ADDRESS

L. B. Gallogly Sublett
Ida

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Form V. S. No. 5. 10M. 6-20-11.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH.

Registration District No. 5

County of Gordium

Primary Registration District No. 2018

City of Gordium

(No. _____ St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

William E. King

File No. 5507

Registered No. 14

If death occurred in a hospital, institution or camp give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX

Male

4. COLOR OR RACE

White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED.

Married

6. DATE OF BIRTH

Nov

21

1870

(Month)

(Day)

(Year)

7. AGE

42 yrs. 3 mos. 6 ds.

IF LESS than 1 day
how many _____ hrs. or
_____ min.?

8. OCCUPATION

(a) Trade, profession, or particular kind of work

Limber salesman

(b) General nature of industry, business, or establishment in which employed (or employer)

Ostrander Limber Co

9. BIRTHPLACE

(State or Country)

Chicago Ill.

10. NAME OF FATHER

11. BIRTHPLACE OF FATHER

(State or Country)

12. MAIDEN NAME OF MOTHER

13. BIRTHPLACE OF MOTHER

(State or Country)

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

Wesley F. Miller

(Address)

Gordium

15.

Filed 7/27

1913

J. H. Cronwell

Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

Feb

27

1913

(Month)

(Day)

(Year)

17. I HEREBY CERTIFY, That I attended deceased from

1913

to

1913

that I last saw him alive on 1913

and that death occurred on the date stated above, at M.

The CAUSE OF DEATH* was as follows:

Apoplexy or heart Failure

(Duration) _____ yrs. _____ mos. _____ ds.

Contributory
(Secondary)

(Duration) _____ yrs. _____ mos. _____ ds.

(Signed) J. H. Cronwell

7/27 1913 (Address) Gordium

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL,

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place

In the

of death _____ yrs. _____ mos. _____ ds. State _____ yrs. _____ mos. _____ ds.

Where was Disease contracted,

If not at place of death?

Former or

usual residence.

19. PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

Gordium

Mar 1913

20. UNDERTAKER

ADDRESS

A. E. Thompson

Gordium

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH.

Registration District No. 5County of GoodingPrimary Registration District No. 2018File No. 5508City of Gooding

(No. _____ St.)

Registered No. 13

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

William Hennigshu

If death occurred in a hospital, institution or camp give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX

4. COLOR OR RACE

5. SINGLE, MARRIED, WIDOWED OR DIVORCED.

MaleWhite(Write the word) Single

6. DATE OF BIRTH

unknown 1835
(Month) (Day) (Year)

7. AGE

76 yrs. — mos. — ds.IF LESS than 1 day
how many hrs. or
..... min.?

8. OCCUPATION

(a) Trade, profession, or particular kind of work
(b) General nature of industry business, or establishment in which employed (or employer)None

9. BIRTHPLACE

(State or Country)

England

10. NAME OF FATHER

unknown

11. BIRTHPLACE OF FATHER

(State or Country)

unknown

12. MAIDEN NAME OF MOTHER

unknown

13. BIRTHPLACE OF MOTHER

(State or Country)

unknown

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

L. C. Jones

(Address)

Gooding, Ida.

15.

Filed

April 1 1913J. J. Lamb
Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

Feb. 11 1913
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from

Dec 25 1912, to Feb 11 1913that I last saw him alive on Jan 13 1913and that death occurred on the date stated above, at 6 A. M.

The CAUSE OF DEATH* was as follows:

Chronic Bright's Disease
& Chronic Rheumatism(Duration) 30 yrs. — mos. — ds.

Contributory (Secondary)

None

(Duration) — yrs. — mos. — ds.

(Signed)

J. H. Croswell M. D.
Feb. 11 1913 (Address) Gooding, Ida

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL,

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place In the
of death yrs. mos. ds. State yrs. mos. ds.

Where was Disease contracted,

If not at place of death?

Former or

usual residence.

19. PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

Gooding Cemetery2-13 1913

20. UNDERTAKER

ADDRESS

A. C. ThompsonGoodingWRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Form V. S. No. 5. 10M. 6-20-11.

1. PLACE OF DEATH.

County of LincolnCity of Shoshone

If death occurs away from usual residence, give facts called for under special information.

Registration District No. 5Primary Registration District No. 2016

(No. _____, St.)

State of Idaho
BOARD OF HEALTH
Bureau of Vital StatisticsFile No. 5519Registered No. 1

If death occurred in a hospital, institution or camp give its NAME instead of street and number.

2. FULL NAME

Bernardino Yeusta

PERSONAL AND STATISTICAL PARTICULARS

3. SEX

male

4. COLOR OR RACE 5. SINGLE, MARRIED, WIDOWED OR DIVORCED.

whitesingle
(Write the word.)

6. DATE OF BIRTH

Feb 8 1913Not known

(Month)

(Day)

(Year)

7. AGE

28 years

yrs.

mos.

ds.

IF LESS than 1 day
how many hrs. or
..... min.?

8. OCCUPATION

(a) Trade, profession, or particular kind of work

Shrap Handler

(b) General nature of industry business, or establishment in which employed (or employer)

9. BIRTHPLACE

(State or Country)

Spain

10. NAME OF FATHER

unknown

11. BIRTHPLACE OF FATHER

(State or Country)

Spain

12. MAIDEN NAME OF MOTHER

unknown

13. BIRTHPLACE OF MOTHER

(State or Country)

Spain

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

Domingo Solano

(Address)

15.

Filed

Feb. 9 1913C. F. Zeller

Local Reg

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

Feb.

(Month)

8

(Day)

1913

(Year)

17. I HEREBY CERTIFY, That I attended deceased from

191

to

191

that I last saw h..... alive on..... 191.....

and that death occurred on the date stated above, at..... M.

The CAUSE OF DEATH* was as follows:

Homicide
Killed by shot gun by
A. W. Hastings, self defense
(Duration) yrs. mos. ds.Contributory
(Secondary)

(Duration)

yrs.

mos.

ds.

(Signed)

C. F. Zeller

M. D.

Feb. 9 1913

(Address)

Shoshone, Idaho

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL,

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place

In the

of death..... yrs. mos. ds. State..... yrs. mos. ds.

Where was Disease contracted,

If not at place of death?.....

Former or

usual residence.....

19. PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

Shoshone CemeteryFeb 10 1913

20. UNDERTAKER

(D) Burman

ADDRESS

Shoshone

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Form V. S. No. 5. 10M. 6-20-11.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH.

Registration District No. 6

County of Lincoln

Primary Registration District No. 2016

City of Shoshone

(No. _____, _____ St.)

File No. 5511

Registered No. 10

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME no name Still Born

If death occurred in a hospital, institution or camp give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX

Female

4. COLOR OR RACE 5. SINGLE, MARRIED, WIDOWED OR DIVORCED.

white

000
(Write the word.)

6. DATE OF BIRTH April 11 1913

apx 1 Hour

(Month) (Day) (Year)

7. AGE 1 Hour

_____ yrs. _____ mos. _____ ds.

IF LESS than 1 day
how many _____ hrs. or
_____ min. 00-00

8. OCCUPATION

- (a) Trade, profession, or particular kind of work
(b) General nature of industry business, or establishment in which employed (or employer)

none

9. BIRTHPLACE

(State or Country)

Shoshone

10. NAME OF FATHER

Mr. Newman

11. BIRTHPLACE OF FATHER

(State or Country)

Oregon

12. MAIDEN NAME OF MOTHER

Rachael Ferguson

13. BIRTHPLACE OF MOTHER

(State or Country)

Utah

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

(Address)

Shoshone, Ida

15.

Filed Apr 12 1913

C. F. Zeller
Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

Apr. 11 1913
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from

_____ 191____, to _____ 191____,
that I last saw h _____ alive on _____ 191____,

and that death occurred on the date stated above, at _____ M.

The CAUSE OF DEATH* was as follows:

Premature & Congenital weakness, probably due to fatty degeneration of Placenta
(Duration) _____ yrs. _____ mos. _____ ds.

Contributory
(Secondary)

(Duration) _____ yrs. _____ mos. _____ ds.

(Signed) _____ M. D.

_____ 19____ (Address) _____

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place _____ In the _____
of death _____ yrs. _____ mos. _____ ds. State _____ yrs. _____ mos. _____ ds.
Where was Disease contracted,
If not at place of death? _____
Former or
usual residence. _____

19. PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

Shoshone Cemetery Apr 12 1913

20. UNDERTAKER

ADDRESS

C. F. Zeller Shoshone

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Form V. S. No. 5. 10M. 6-20-11.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH.

Registration District No. 5

County of Lincoln

Primary Registration District No. 2016

City of Shoshone

(No. _____, _____ St.)

File No. 5512

Registered No. 11

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME unknown

If death occurred in a hospital, institution or camp give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX

4. COLOR OR RACE

5. SINGLE, MARRIED, WIDOWED OR DIVORCED.

male

white

single
(Write the word.)

6. DATE OF BIRTH

about 42 years
(Month) (Day) (Year)

7. AGE

42

IF LESS than 1 day
how many _____ hrs. or
_____ min.

8. OCCUPATION

- (a) Trade, profession, or particular kind of work
(b) General nature of industry business, or establishment in which employed (or employer)

unknown

employed as a

labourer

9. BIRTHPLACE

(State or Country)

unknown

10. NAME OF FATHER

unknown

11. BIRTHPLACE OF FATHER

(State or Country)

unknown

12. MAIDEN NAME OF MOTHER

unknown

13. BIRTHPLACE OF MOTHER

(State or Country)

unknown

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) no information

(Address)

15. Accident occurred at

Station O & S R R
Filed Mar. 24, 1913

C. F. Zeller
Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

Mar. 22 1913
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from

191____, to 191____
that I last saw h. _____ alive on 191____,

and that death occurred on the date stated above, at _____ M.

The CAUSE OF DEATH* was as follows:

Crown is injured, accidental death by R. R. train, by means unknown

(Duration) _____ yrs. _____ mos. _____ ds.

Contributory (Secondary)

(Duration) _____ yrs. _____ mos. _____ ds.

(Signed) _____ M. D.

19____ (Address)

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place _____ In the _____
of death _____ yrs. _____ mos. _____ ds. State _____ yrs. _____ mos. _____ ds.

Where was Disease contracted,
If not at place of death? _____
Former or
usual residence _____

19. PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

Shoshone Cemetery

Mar. 24, 1913

20. UNDERTAKER

ADDRESS

O. J. Brown

Shoshone

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Form V. S. No. 5. 10M. 6-20-11.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH. Registration District No. 4
County of Lyon Primary Registration District No. 2
City of Shoshone (No. St.)

File No. 5513
Registered No. 3

If death occurs away from usual residence, give facts called for under special information.

If death occurred in a hospital, institution or camp give its NAME instead of street and number.

2. FULL NAME Henry Bock

PERSONAL AND STATISTICAL PARTICULARS

MEDICAL CERTIFICATE OF DEATH

3. SEX M 4. COLOR OR RACE W 5. SINGLE, MARRIED, WIDOWED OR DIVORCED MARRIED
(Write the word.)

16. DATE OF DEATH Oct 13 1913
(Month) (Day) (Year)

6. DATE OF BIRTH May 2nd 1859
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from 3/29 1913 to 3/29 1913

7. AGE 61 yrs. mos. ds. IF LESS than 1 day how many hrs. or min.

that I last saw him alive on 3/29 1913, and that death occurred on the date stated above, at 2 P. M.

8. OCCUPATION
(a) Trade, profession, or particular kind of work Farmer
(b) General nature of industry business, or establishment in which employed (or employer)

The CAUSE OF DEATH* was as follows:
Accident the result of a run-a-way team of horses & wagon
(Duration) yrs. mos. one ds.

9. BIRTHPLACE (State or Country) Germany

Contributory (Secondary)
(Duration) yrs. mos. ds.

10. NAME OF FATHER Don't know

(Signed) W. H. Bangh M. D.
4/30 1913 (Address) Shoshone Ida

11. BIRTHPLACE OF FATHER (State or Country) Germany

12. MAIDEN NAME OF MOTHER Don't know

13. BIRTHPLACE OF MOTHER (State or Country) Don't know

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Matthias Christensen
(Address) Shoshone Ida

15. Filed 4/1 1913 C. F. Zeller
Local Registrar

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL,

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death yrs. mos. ds. State yrs. mos. ds.
Where was Disease contracted,
If not at place of death?
Former or usual residence

19. PLACE OF BURIAL OR REMOVAL Shoshone DATE OF BURIAL Apr. 2 1913
Wm. Underlaker

20. UNDERTAKER Buried by family ADDRESS Shoshone

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Form V. S. No. 5. 10M. 6-20-11.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH.
County of Lincoln
City of Shoshone

Registration District No. 5
Primary Registration District No. 2016
(No. _____, St.)

File No. 5514
Registered No. 4

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Timothy Garner

If death occurred in a hospital, institution or camp give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

MEDICAL CERTIFICATE OF DEATH

3. SEX male 4. COLOR OR RACE white 5. SINGLE, MARRIED, WIDOWED OR DIVORCED. married
(Write the word.)

16. DATE OF DEATH March 18 1913
(Month) (Day) (Year)

6. DATE OF BIRTH Jan 18 1913
(Month) 2 (Day) 2 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Mar. 17 1913, to Mar. 18 1913
that I last saw him alive on Mar. 18 1913,
and that death occurred on the date stated above, at 4 a. m.
The CAUSE OF DEATH* was as follows:

7. AGE 2 + 2 days
IF LESS than 1 day
how many _____ hrs. or _____ min.?

(Duration) _____ yrs. _____ mos. _____ ds.

8. OCCUPATION none
(a) Trade, profession, or particular kind of work
(b) General nature of industry business, or establishment in which employed (or employer)

Contributory (Secondary) _____
(Duration) _____ yrs. _____ mos. _____ ds.
(Signed) C. F. Zeller M. D.
3/20 1913 (Address) Shoshone

9. BIRTHPLACE Arkansas
(State or Country)

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

10. NAME OF FATHER Timothy Garner

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

11. BIRTHPLACE OF FATHER Arkansas
(State or Country)

At place _____ In the _____
of death _____ yrs. _____ mos. _____ ds. State _____ yrs. _____ mos. _____ ds.
Where was Disease contracted,
If not at place of death? _____
Former or
usual residence _____

12. MAIDEN NAME OF MOTHER Etta Brinkley

13. BIRTHPLACE OF MOTHER Arkansas
(State or Country)

19. PLACE OF BURIAL OR REMOVAL Shoshone Cemetery DATE OF BURIAL Mar. 19 1913

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Etta Garner

20. UNDERTAKER W. B. Brown ADDRESS Shoshone

(Address) walla walla Wash

15. Filed 3/12 1913 C. F. Zeller
Local Registrar

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Form V. S. No. 5. 10M. 6-20-11.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH. Registration District No. _____
County of Canyon Primary Registration District No. _____
City of Romulo precinct (No. _____) St. _____

File No. 5515

Registered No. _____

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

Wm. R. Stevens

If death occurred in a hospital, institution or camp give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX

Male

4. COLOR OR RACE 5. SINGLE, MARRIED, WIDOWED OR DIVORCED

W

(Write the word.)

6. DATE OF BIRTH

3

14

1945

(Month)

(Day)

(Year)

7. AGE

48

yrs.

3

mos.

7

ds.

IF LESS than 1 day how many min. 2 hrs. 6

8. OCCUPATION

(a) Trade, profession or particular kind of work
(b) General nature of industry business or establishment in which employed (or employer)

Tanner

9. BIRTHPLACE

(State or Country)

Ill

10. NAME OF FATHER

James Stevens

11. BIRTHPLACE OF FATHER

(State or Country)

England

12. MAIDEN NAME OF MOTHER

Francis Ober

13. BIRTHPLACE OF MOTHER

(State or Country)

England

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

Wm. R. Stevens

(Address)

Parma

15.

Filed

6/23

1945

R. Plumer

Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

June

21

1913

(Month)

(Day)

(Year)

17. I HEREBY CERTIFY, That I attended deceased from

June 3

1913

to June 21

1913

that I last saw him alive on June 20 1913

and that death occurred on the date stated above, at 1 A. M.

The CAUSE OF DEATH* was as follows:

Broncho-Pneumonia following Measles

(Duration) yrs. mos. 21 ds.

Contributory (Secondary)

Asthma

(Duration) 20 yrs. — mos. ds.

(Signed) Chas. B. Allen M. D.

6-21 1913 (Address) Parma, Ida.

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL OR HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death. yrs. mos. ds. State. yrs. mos. ds.

Where was disease contracted, If not at place of death? Former or usual residence.

19. PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

Parma Idaho

6/23 1913

20. UNDERTAKER

ADDRESS

Flat Backham Co

Parma

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Form V. S. No. 5 20M.1-16-12

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH Registration District No. 1085
County of Twins Falls Primary Registration District No.
City of Twins Falls (No. St.)

File No. 5516

Registered No.

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Infant Abramson

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX M. 4. COLOR OR RACE W. 5. SINGLE, MARRIED, WIDOWED OR DIVORCED. Single

6. DATE OF BIRTH July 1 1913

(Month) (Day) (Year)

7. AGE

..... yrs. mos. 1 ds.

IF LESS than 1 day
how many hrs. or
..... mins.?

8. OCCUPATION

(a) Trade, profession or particular kind of work

(b) General nature of industry, business, or establishment in which employed (or employer)

9. BIRTHPLACE

(State or Country) Idaho

10. NAME OF FATHER Chas. Abramson11. BIRTHPLACE OF FATHER Idaho

(State or Country)

12. MAIDEN NAME OF MOTHER Mylena Bromer13. BIRTHPLACE OF MOTHER Indiana

(State or Country)

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Chas. Abramson

(Address) Twins Falls

15.

Filed July 3 1913

Local Registrar John H. Hughes

Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH July 3 1913

(Month)

(Day)

(Year)

17. I HEREBY CERTIFY, That I attended deceased from July 2 1913, to July 3 1913,

that I last saw him alive on July 2 1913

and that death occurred on the date stated above, at 7 25 A.M.

The CAUSE OF DEATH* was as follows: Shock from

operation for double hernia & cleft palate

(Duration) yrs. mos. ds.

Contributory
(Secondary)

(Duration) yrs. mos. 2 ds.

(Signed) H. Wilson

M. D.

July 3 1913 (Address) Twins Falls, Ida

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death yrs. mos. days. In the State yrs. mos. days.

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL DATE OF BURIAL

Twins Falls July 3 1913

20. UNDERTAKER

ADDRESS P. H. Grosman

Twins Falls

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Form V. S. No. 5 20M.1-16-12

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH.

Registration District No. 1085

County of TWIN FALLS

Primary Registration District No.

File No. 5518

City of

(No. St.)

Registered No.

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

Sarah T. Hamilton

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX

4. COLOR OR RACE

5. SINGLE, MARRIED, WIDOWED OR DIVORCED.

Female White

(While the word.)

6. DATE OF BIRTH

July 5th 1862

(Month)

(Day)

(Year)

7. AGE

51 yrs. 11 mos. 11 ds.

IF LESS than 1 day
how many hrs. or mins.?

8. OCCUPATION

(a) Trade, profession or particular kind of work

Housewife

(b) General nature of industry business, or establishment in which employed (or employer)

9. BIRTHPLACE

(State or Country)

Biggsville Ill.

10. NAME OF FATHER

Isaac McDowell

11. BIRTHPLACE OF FATHER

(State or Country)

Virginia?

12. MAIDEN NAME OF MOTHER

Rhoda Hopkins

13. BIRTHPLACE OF MOTHER

(State or Country)

Ind?

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

S. Hamilton

(Address)

Twin Falls

15.

Filed

July 17 1913

1913

John B. Hughes
Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH

July 16 1913
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from

July 4 1913, to July 16 1913
that I last saw her alive on July 15 1913

and that death occurred on the date stated above, at 7 a.m.

The CAUSE OF DEATH* was as follows:

Paralysis - following auto infection (typhemia).

(Duration) yrs. mos. 12 ds.

Contributory
(Secondary)

(Duration) yrs. mos. ds.

(Signed)

H. Wilson M. D.

July 6 1913 (Address) Twin Falls, Ida.

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death yrs. mos. days. In the State yrs. mos. days.

Where was disease contracted if not at place of death?

Former or usual residence

Personal

19. PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

Colorado Springs

1913

20. UNDERTAKER

ADDRESS

Shrover

Twin Falls

WRITE PLAINLY, WITH UNFADE INK—THIS IS A PERMANENT RECORD. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Form V. S. No. 5 20M.1-16-12

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH.

Registration District No. 1085County of Twinn Falls

Primary Registration District No. _____

City of "

(No. _____ St.)

Registered No. _____

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME John Mathias Hart

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX

4. COLOR OR RACE

5. SINGLE, MARRIED, WIDOWED OR DIVORCED.

MaleWhite

(Write the word.)

6. DATE OF BIRTH

April 11 1847
(Month) (Day) (Year)

7. AGE

66 yrs. 3 mos. 3 ds.IF LESS than 1 day
how many hrs. or
..... mins.?

8. OCCUPATION

(a) Trade, profession or particular kind of work

Contractor

(b) General nature of industry business, or establishment in which employed (or employer)

9. BIRTHPLACE

(State or Country)

Granby, Shefford Co. Quebec, Canada

10. NAME OF FATHER

John Hart

11. BIRTHPLACE OF FATHER

(State or Country)

Ireland ?

12. MAIDEN NAME OF MOTHER

Harriet Battles

13. BIRTHPLACE OF MOTHER

(State or Country)

Ireland

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

Theodore Thomas Hart

(Address)

Twinn Falls Ida.

15.

Filed

7-16 1913John H. Buehler
Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH

July 14 1913
(Month) (Day) (Year)17. I HEREBY CERTIFY, That I attended deceased from July 11 1911, to July 14 1913,that I last saw him alive on July 13 1913, and that death occurred on the date stated above, at 10 P.M.

The CAUSE OF DEATH* was as follows:

Hemorrhage of lungs

(Duration) yrs. mos. ds.

Contributory

Mitral regurgitation

(Secondary)

Aortic regurgitation(Duration) 3 yrs. mos. ds.

(Signed)

Simeau L. Alexander M.D.7/15 1913 (Address) Twinn Falls Ida.

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place

of death yrs. mos. days.

In the

State yrs. mos. days.

Where was disease contracted if not at place of death?

Former or

usual residence.

19. PLACE OF BURIAL OR REMOVAL DATE OF BURIAL

Twinn Falls July 18 1913

20. UNDERTAKER

ADDRESS

Granby Twinn Falls

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Form V. S. No. 5 20M.1-16-12

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics
File No. 5529

1. PLACE OF DEATH Twins Falls Registration District No. 1085
County of Twins Falls Primary Registration District No. _____
City of Twins Falls (No. _____ St.)

Registered No. _____
If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Calib Spain

PERSONAL AND STATISTICAL PARTICULARS

3. SEX Male 4. COLOR OR RACE White 5. SINGLE, MARRIED, WIDOWED OR DIVORCED Widowed

6. DATE OF BIRTH Nov. 12 1925
(Month) (Day) (Year)

7. AGE 87 yrs. 6 mos. 14 ds.
IF LESS than 1 day how many hrs. or mins.?

8. OCCUPATION Farmer
(a) Trade, profession or particular kind of work
(b) General nature of industry business, or establishment in which employed (or employer)

9. BIRTHPLACE Ohio
(State or Country)

10. NAME OF FATHER Edwin Spain

11. BIRTHPLACE OF FATHER West Va.
(State or Country)

12. MAIDEN NAME OF MOTHER Elizabeth Crowder

13. BIRTHPLACE OF MOTHER Ohio
(State or Country)

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Jesse Spain
(Address) Sparks Oregon

15. Filed 6-7 1913 John H. Coughlin
Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH June 6 1913
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from June 1 1913, to June 6 1913, that I last saw him alive on June 6 1913, and that death occurred on the date stated above, at 10 A.M.

The CAUSE OF DEATH* was as follows:

Stroke

(Duration) _____ yrs. _____ mos. _____ ds.

Contributory (Secondary) _____

(Duration) _____ yrs. _____ mos. _____ ds.

(Signed) For Boyd M. D.

June 9 1913 (Address) Twins Falls, Idaho

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death _____ yrs. _____ mos. _____ days. In the State _____ yrs. _____ mos. _____ days.

Where was disease contracted if not at place of death? _____

Former or usual residence _____

19. PLACE OF BURIAL OR REMOVAL Twins Falls DATE OF BURIAL June 9 1913

20. UNDERTAKER J. J. Groseman ADDRESS Twins Falls

Was filed but held for details, 876.

Form V. S. No. 5 20M.1-16-12

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH.

Registration District No.

2085

County of Idaho Falls

Primary Registration District No.

2085

City of Idaho Falls

(No. _____ St.)

File No. 5521

Registered No.

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

Clara Lovett

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX

4. COLOR OR RACE

5. SINGLE, MARRIED, WIDOWED OR DIVORCED.

Female White

(Write the word.)

6. DATE OF BIRTH

Dec 31, 1903
(Month) (Day) (Year)

7. AGE

6 yrs. 6 mos. 15 ds.

IF LESS than 1 day
how many _____ hrs. or
_____ mins.

8. OCCUPATION

(a) Trade, profession or particular kind of work

(b) General nature of industry business, or establishment in which employed (or employer)

9. BIRTHPLACE

(State or Country)

Carroll Co. Arkansas

10. NAME OF FATHER

J. A. Lovett

11. BIRTHPLACE OF FATHER

(State or Country)

Boone Co. Arkansas

12. MAIDEN NAME OF MOTHER

Mary Osborn

13. BIRTHPLACE OF MOTHER

(State or Country)

Missouri

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

J. A. Lovett

(Address)

15.

Filed

July 16 1913

John H. G. G. G.
Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH

July 10, 1913
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from

June 22 1913 to July 14 1913,
that I last saw her alive on July 14 1913

and that death occurred on the date stated above, at 4:20 A.M.

The CAUSE OF DEATH* was as follows:

Acute Paratyphoid fever
following measles

(Duration) _____ yrs. _____ mos. 14 ds.

Contributory (Secondary)

(Duration) _____ yrs. _____ mos. _____ ds.

(Signed)

H. Wilson M. D.

July 10 1913 (Address) Idaho Falls, Ida.

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death _____ yrs. _____ mos. _____ days. In the State _____ yrs. _____ mos. _____ days.

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL DATE OF BURIAL

Idaho Falls July 16 1913

20. UNDERTAKER

J. Krooby Idaho Falls

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Form V. S. No. 5 20M.1-16-12

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH

Registration District No. 1085

County of Twin Falls

Primary Registration District No.

File No.

City of

(No.

St.)

Registered No. 5522

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

Aucos John Churchyard

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX

4. COLOR OR RACE

5. SINGLE, MARRIED, WIDOWED OR DIVORCED.

Male

White

(Write the word)

6. DATE OF BIRTH

May 24-1913

(Month)

(Day)

(Year)

7. AGE

yrs. 1 mos. 7 da.

IF LESS than 1 day
how many hrs. or
mins.?

8. OCCUPATION

- (a) Trade, profession or particular kind of work
(b) General nature of industry business, or establishment in which employed (or employer)

9. BIRTHPLACE

(State or Country)

Twin Falls

10. NAME OF FATHER

Geo. Churchyard

11. BIRTHPLACE OF FATHER

(State or Country)

Hondolun Lac Wis

12. MAIDEN NAME OF MOTHER

Bertha Hayes

13. BIRTHPLACE OF MOTHER

(State or Country)

Fennimore Co. Wis

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

(Address)

Geo Churchyard
Twin Falls Ida

15.

Filed

7-2

191

John H. Hagler

Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

191 (Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from

191, to 191,

that I last saw h. alive on 191,

and that death occurred on the date stated above, at M.

The CAUSE OF DEATH* was as follows:

(Duration) yrs. mos. da.

Contributory
(Secondary)

(Duration) yrs. mos. da.

(Signed) M. D.

19 (Address)

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death. yrs. mos. days. In the State. yrs. mos. days.

Where was disease contracted if not at place of death?

Former or usual residence.

19. PLACE OF BURIAL OR REMOVAL DATE OF BURIAL

Twin Falls

July 2 1913

20. UNDERTAKER

ADDRESS

O J Crosby

Twin Falls

State of Idaho,

County of Twin Falls, ss.

Amelia Batley, being first duly sworn, on oath deposes and says:
That I saw Amos John Churchyard on the night of June 30th., 1913, and
again on the evening of July 1, 1913; that the death occurred on the
last named date at about 5:30 P.M.; the cause of death as same appeared
to me was congestion ^{of lungs} caused by a cold causing choking and strangling;
that the death occurred at the home of the parents of said infant child
in the City of Twin Falls, Idaho at 519 Fourth Avenue West.

Christian Science Healer. Amelia Batley

Subscribed and sworn to before me this 2nd. day of July, 1913.

James W. Porter
Notary Public.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Form V. S. No. 5 20M.1-16-12

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH.

Registration District No. 62County of GatahPrimary Registration District No. 2142File No. 5523City of Genesee

(No. _____, _____ St.)

Registered No. 2

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

Thomas R. Qualey

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX

4. COLOR OR RACE

5. SINGLE, MARRIED, WIDOWED OR DIVORCED.

MaleWhiteMarried
(Write the word.)

6. DATE OF BIRTH

Jan 10
(Month) (Day)1844
(Year)

7. AGE

69 yrs. 7 mos. 4 ds.IF LESS than 1 day
how many _____ hrs. or
_____ mins.

8. OCCUPATION

(a) Trade, profession or particular kind of work

Retired farmer

(b) General nature of industry business, or establishment in which employed (or employer)

9. BIRTHPLACE

(State or Country)

Norway

10. NAME OF FATHER

R. Qualey

11. BIRTHPLACE OF FATHER

(State or Country)

Norway

12. MAIDEN NAME OF MOTHER

Bertha Halvorson

13. BIRTHPLACE OF MOTHER

(State or Country)

Norway

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

F. W. Qualey

(Address)

Genesee

15.

Filed

Aug 151913W. H. Egan
Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH

Aug
(Month)14
(Day)1913
(Year)

17. I HEREBY CERTIFY, That I attended deceased from

Aug 12 1913, to Aug 14 1913that I last saw him alive on Aug 14 1913and that death occurred on the date stated above, at 1230 A

The CAUSE OF DEATH* was as follows:

Cerebral Hemorrhage

(Duration)

yrs. 2 mos. 2 ds.

Contributory (Secondary)

Arterial Sclerosis

(Duration)

yrs. 3 mos. 2 ds.

(Signed)

E. F. Qualey M. D.Aug 19/3 (Address) Genesee Idaho

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place

of death _____ yrs. _____ mos. _____ days.

In the

State _____ yrs. _____ mos. _____ days.

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL DATE OF BURIAL

Ramp 2007 8/161913

20. UNDERTAKER

ADDRESS

J. C. Lovejoy Genesee

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Form V. S. No. 5 20M.1-16-12

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH.

Registration District No. 62

County of Latah

Primary Registration District No. 2142

City of Genesee

(No.)

St.)

Registered No. 5521

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

Mrs. Anna Moley

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX

Female

4. COLOR OR RACE

5. SINGLE, MARRIED, WIDOWED OR DIVORCED.

Married
(Write the word.)

6. DATE OF BIRTH

December 10th 1842
(Month) (Day) (Year)

7. AGE

70 yrs. 8 mos. 2 ds.

IF LESS than 1 day
how many hrs. or
mins.?

8. OCCUPATION

(a) Trade, profession or particular kind of work
(b) General nature of industry, business, or establishment in which employed (or employer)

Housewife

9. BIRTHPLACE

(State or Country)

Norway

10. NAME OF FATHER

Nels Nelson

11. BIRTHPLACE OF FATHER

(State or Country)

Norway

12. MAIDEN NAME OF MOTHER

Olivia Skutumpah

13. BIRTHPLACE OF MOTHER

(State or Country)

Norway

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

F. O. Qualey

(Address)

Genesee Idaho

15.

Filed

Aug 15 1913 W. N. Skum

Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH

Aug 12 1913
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from

Aug 12 1913, to Aug 12 1913
that I last saw him alive on 1913

and that death occurred on the date stated above, at M.

The CAUSE OF DEATH* was as follows:

Chronic Intestinal Hepatitis
Cerebral Hemorrhage

(Duration) yrs. mos. ds.

Contributory Chronic Intestinal Hepatitis
(Secondary)

(Duration) yrs. mos. ds.

(Signed) A. F. Qualey M. D.

Aug 13 1913 (Address) Genesee Idaho

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL OR HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death.....yrs.....mos.....days. In the State.....yrs.....mos.....days.

Where was disease contracted if not at place of death?

Former or usual residence.

19. PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

Genesee Idaho 1913

20. UNDERTAKER

ADDRESS

F. E. Lambert Genesee Idaho

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Form V. S. No. 5 20M.1-16-12

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics
File No. 5525
Registered No. 105

1. PLACE OF DEATH
County of *Latoh*
City of *Moscow*
Registration District No. *61*
Primary Registration District No. *1011*
(No. _____, St.)

If death occurred away from usual residence, give facts called for under special information.

2. FULL NAME *Still Born*

If death occurred in a hospital, institution, or place, give its NAME instead of _____ and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX *Male* 4. COLOR OR RACE *W* 5. SINGLE, MARRIED, WIDOWED OR DIVORCED *Single*
(Write the word.)

6. DATE OF BIRTH *Aug 29 1913*
(Month) (Day) (Year)

7. AGE _____ yrs. _____ mos. _____ ds.
IF LESS than 1 day how many _____ hrs. or _____ mins.

8. OCCUPATION
(a) Trade, profession or particular kind of work
(b) General nature of industry, business, or establishment in which employed (or employer)

9. BIRTHPLACE (State or Country) *Moscow*

10. NAME OF FATHER *Grant Robbins*

11. BIRTHPLACE OF FATHER (State or Country) *Ill.*

12. MAIDEN NAME OF MOTHER *Pauline Maerder*

13. BIRTHPLACE OF MOTHER (State or Country) *Pa.*

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) *Grant Robbins*
(Address) *Moscow*

15. Filed *Aug 29 1913* *JFR* Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH *8 29 1913*
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from *August 26 1913*, to *August 29 1913*, that I last saw him alive on *August 28 1913*, and that death occurred on the date stated above, at *9.9. M.*

The CAUSE OF DEATH* was as follows:

non-visibility

(Duration) _____ yrs. _____ mos. *2 1/2* ds.

Contributory (Secondary)

(Duration) _____ yrs. _____ mos. _____ ds.

(Signed) *Chas. L. Britney* M. D.

8-29-1913 (Address) *Moscow, Idaho*

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death _____ yrs. _____ mos. _____ days. In the State _____ yrs. _____ mos. _____ days.

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL *Moscow* DATE OF BURIAL *Aug 29 1913*

20. UNDERTAKER *none* ADDRESS

Form V. S. No. 5 20M.1-16-12

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH

Registration District No.

County of

Primary Registration District No.

City of

(No.

St.)

File No.

Registered No.

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX

4. COLOR OR RACE

5. SINGLE, MARRIED, WIDOWED OR DIVORCED.

6. DATE OF BIRTH

7. AGE

IF LESS than 1 day
how many hrs. or
..... mins.?

8. OCCUPATION

- (a) Trade, profession or particular kind of work
- (b) General nature of industry business, or establishment in which employed (or employer)

9. BIRTHPLACE

(State or Country)

10. NAME OF FATHER

11. BIRTHPLACE OF FATHER

(State or Country)

12. MAIDEN NAME OF MOTHER

13. BIRTHPLACE OF MOTHER

(State or Country)

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

(Address)

15.

Filed

Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH

17. I HEREBY CERTIFY, That I attended deceased from

that I last saw him alive on

and that death occurred on the date stated above, at A. M.

The CAUSE OF DEATH* was as follows:

Contributory

(Secondary)

(Duration) yrs. mos. ds.

(Signed)

Aug. 14, 1913

(Address)

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death.....yrs.....mos.....days. In the State.....yrs.....mos.....days.

Where was disease contracted if not at place of death?

Former or usual residence.....

19. PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

20. UNDERTAKER

ADDRESS

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Form V. S. No. 5 20M.1-16-12

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH.

Registration District No. 61County of LatahPrimary Registration District No. 2141City of Moscow

(No. _____)

St.)

File No. 5527Registered No. 187

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

Joseph C. Johnston

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX

Male

4. COLOR OR RACE

White5. SINGLE, MARRIED, WID-
OWED OR DIVORCED
married
(Write the word.)

6. DATE OF BIRTH

May 27 1850
(Month) (Day) (Year)

7. AGE

63 yrs. 2 mos. 8 ds.IF LESS than 1 day
how many hrs. or
..... mins.?

8. OCCUPATION

(a) Trade, profession or
particular kind of work
(b) General nature of industry
business, or establishment in
which employed (or employer)Farmer

9. BIRTHPLACE

(State or Country)

Iowa10. NAME OF
FATHERBryan Johnston11. BIRTHPLACE
OF FATHER

(State or Country)

12. MAIDEN NAME
OF MOTHER13. BIRTHPLACE
OF MOTHER

(State or Country)

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

Frederick Johnston

(Address)

Tracy Idaho

15.

Filed

Aug 5 1913S. F. Rar

Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH

Aug 5 1913
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from

May 9 1913, to May 9 1913that I last saw him alive on May 9 1913and that death occurred on the date stated above, at 2 P. M.

The CAUSE OF DEATH* was as follows:

Cancer of Bladder(Duration) One yrs. 0 mos. 0 ds.Contributory
(Secondary)(Duration) 0 yrs. 0 mos. 0 ds.(Signed) J. H. Clarke M. D.19 (Address)

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death yrs. mos. days. In the State yrs. mos. days.

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL DATE OF BURIAL

Bucan Cemetery July 6 1913

20. UNDERTAKER

Geo. Stutz

ADDRESS

Moscow

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Form V. S. No. 5. 10M. 6-20-11.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics
File No. 5528

1. PLACE OF DEATH.

Registration District No. 22

County of Gooding

Primary Registration District No. 2018

City of Wendell

(No. _____, _____ St.).

Registered No. _____

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

If death occurred in a hospital, institution or camp give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX

4. COLOR OR RACE 5. SINGLE, MARRIED, WIDOWED OR DIVORCED.

6. DATE OF BIRTH

7. AGE

IF LESS than 1 day
how many _____ hrs. or
_____ min.

8. OCCUPATION

- (a) Trade, profession or particular kind of work
(b) General nature of industry business or establishment in which employed (or employer)

9. BIRTHPLACE

(State or Country)

10. NAME OF FATHER

11. BIRTHPLACE OF FATHER

(State or Country)

12. MAIDEN NAME OF MOTHER

13. BIRTHPLACE OF MOTHER

(State or Country)

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

(Address)

15.

Filed

July 14 1913

H. E. Parish

Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

17. I HEREBY CERTIFY, That I attended deceased from

July 4 1913, to July 4 1913
that I last saw him alive on July 4 1913,
and that death occurred on the date stated above, at 4:10 PM.

The CAUSE OF DEATH* was as follows:

Pneumonia, 6 mos.

(Duration) _____ yrs. _____ mos. _____ ds.

Contributory
(Secondary)

(Duration) _____ yrs. _____ mos. _____ ds.

(Signed) H. E. Parish M. D.

July 14 1913 (Address) Wendell Idaho

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death _____ yrs. _____ mos. _____ ds. State _____ yrs. _____ mos. _____ ds.

Where was disease contracted.

If not at place of death?

Former or

usual residence.

19. PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

Wendell Idaho

July 3 1913

20. UNDERTAKER

ADDRESS

None

Wendell

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated in full years, months and days. If death occurs away from usual residence, give facts called for under special information. See instructions on back of certificate.

Form V. S. No. 5 20M.1-16-12

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics
File No. 5529

1. PLACE OF DEATH.

Registration District No. 22

County of Gooding

Primary Registration District No. 2018

City of Wendell

(No. St.)

Registered No.

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

Phillip Saize

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX

4. COLOR OR RACE

5. SINGLE, MARRIED, WIDOWED OR DIVORCED.

6. DATE OF BIRTH

7. AGE

IF LESS than 1 day
how many hrs. or
..... mins.

8. OCCUPATION

(a) Trade, profession or particular kind of work
(b) General nature of industry, business, or establishment in which employed (or employer)

9. BIRTHPLACE

(State or Country)

10. NAME OF FATHER

11. BIRTHPLACE OF FATHER

(State or Country)

12. MAIDEN NAME OF MOTHER

13. BIRTHPLACE OF MOTHER

(State or Country)

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

(Address)

15.

Filed

1913

Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH

17. I HEREBY CERTIFY, That I attended deceased from

Jan 15 1913, to July 10 1913

that I last saw him alive on July 1 1913

and that death occurred on the date stated above, at 3:20 P.M.

The CAUSE OF DEATH* was as follows:

Tuberculosis acute

Secondary

(Duration) yrs. mos. ds.

Contributory (Secondary) Nothing

(Duration) yrs. mos. ds.

(Signed) H. B. Lamb, M.D.

July 11 1913 (Address) Wendell, Idaho

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death yrs. mos. days. In the State yrs. mos. days.

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

Wendell Cemetery

20. UNDERTAKER

ADDRESS

None

-SUPPLEMENTARY DEATH CERTIFICATE-

(Please reply on this sheet to
the registrar of Vital Statistics)

Death Certificate No.

Name..... Phillip Saize

Date of Death..... July 10th, 1913.

Cause of Death..... Acute Pulmonary Tuberculosis

Contributory Cause of death..... none

(Sign here)

H. E. Lamb M.D.

WRITE PLAINLY, WITH UNFADE INK—THIS IS A PERMANENT RECORD.
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Form V, S. No. 5. 10M. 6-20-11.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics
File No. 5539

1. PLACE OF DEATH.

Registration District No. 58County of BlainePrimary Registration District No. 2138City of Hill City

(No. _____, St.)

Registered No. _____

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

Mrs. Maggie Trutthurst

If death occurred in a hospital, institution or camp give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX

4. COLOR OR RACE 5. SINGLE, MARRIED, WIDOWED OR DIVORCED.

Female White
Married
(Write the word.)

6. DATE OF BIRTH

Aug 2 1883
(Month) (Day) (Year)

7. AGE

60 yrs. — mos. 23 ds.

IF LESS than 1 day
how many hrs. or
..... min.?

8. OCCUPATION

(a) Trade, profession, or particular kind of work

Housewife

(b) General nature of industry business, or establishment in which employed (or employer)

9. BIRTHPLACE

(State or Country)

Germany

10. NAME OF FATHER

11. BIRTHPLACE OF FATHER

(State or Country)

?

12. MAIDEN NAME OF MOTHER

13. BIRTHPLACE OF MOTHER

(State or Country)

?

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

(Address)

Harry Trutthurst
Hill City

15.

Filed Aug 26 1913
Res. W. H. Higgs
Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

Aug 25 1913
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from

Mar 21 1913 to Aug 25 1913

that I last saw him alive on Aug 4 1913

and that death occurred on the date stated above, at 11 A M.

The CAUSE OF DEATH* was as follows:

Carcinoma of Stomach(Duration) yrs. 4 mos. 4 ds.

Contributory (Secondary)

(Duration) yrs. _____ mos. _____ ds.

(Signed) Del Witt Higgins M. D.
8-25 1913 (Address) Salmon Idaho

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death yrs. mos. ds. State yrs. mos. ds.

Where was Disease contracted, If not at place of death?

Former or usual residence.

19. PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

Carnal Idaho 5-26 1913

20. UNDERTAKER

ADDRESS

Chas Babington Carnal Idaho

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Form V, S. No. 5. 12½ M. 7-24-11

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics
File No. 5531
Registered No. 2

1. PLACE OF DEATH. Registration District No. # 56
County of Lewis Primary Registration District No. 2129
City of Vallamos (No. , St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Joseph M. Ross

If death occurred in a hospital, institution or camp give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX Male 4. COLOR OR RACE White 5. SINGLE, MARRIED, WIDOWED OR DIVORCED. Single (Write the word.)

6. DATE OF BIRTH Jan 31 1888 (Month) (Day) (Year)

7. AGE 55 yrs. 6 mos. 8 ds. IF LESS than 1 day how many hrs. or min?

8. OCCUPATION (a) Trade, profession or particular kind of work Farmer (b) General nature of industry business or establishment in which employed (or employer)

9. BIRTHPLACE (State or Country) Scotland

10. NAME OF FATHER George Ross

11. BIRTHPLACE OF FATHER Scotland (State or Country)

12. MAIDEN NAME OF MOTHER Eliza Morson

13. BIRTHPLACE OF MOTHER Scotland (State or Country)

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE (Informant) E. L. Burck (Address) Vallamos, Ida.

15. Filed Aug 15 1913 L. C. Parrish Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH August 9 1913 (Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from Aug 9 1913, to Aug 9 1913, that I last saw him alive on Aug 9 1913, and that death occurred on the date stated above, at 10 P. M. The CAUSE OF DEATH* was as follows:

Rupture of aneurism in the aorta
not known
(Duration) yrs. mos. ds.
Contributory not known
(Secondary)
(Duration) yrs. mos. ds.
(Signed) E. L. Burck M. D.
Aug 9 1913 (Address) Vallamos, Ida.

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place In the
of death yrs. mos. ds. State yrs. mos. ds.
Where was disease contracted,
If not at place of death?
Former or
usual residence

19. PLACE OF BURIAL OR REMOVAL DATE OF BURIAL
Hillsboro, Or. 191

20. UNDERTAKER ADDRESS
L. D. Leonard Vallamos, Ida.

MARGIN RESERVED FOR BINDING
WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Form V, S. No. 5. 12½ M. 7-24-11

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH. Registration District No. 50
County of Lure Primary Registration District No. 2129
City of Ilo (No. _____, _____ St.)

File No. 5532
Registered No. 4

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME unnamed

If death occurred in a hospital, institution or camp give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX male 4. COLOR OR RACE white 5. SINGLE, MARRIED, WIDOWED OR DIVORCED. single
(Write the word.)

6. DATE OF BIRTH Aug 23 1913
(Month) (Day) (Year)

7. AGE _____ yrs. _____ mos. _____ ds. IF LESS than 1 day
how many _____ hrs. or _____ min?

8. OCCUPATION Infant
(a) Trade, profession or particular kind of work
(b) General nature of industry business or establishment in which employed (or employer)

9. BIRTHPLACE (State or Country) Ilo, Idaho

10. NAME OF FATHER Alvin Bascom Rogers

11. BIRTHPLACE OF FATHER (State or Country) Asheville, N.C.

12. MAIDEN NAME OF MOTHER Enelope Anna Hinrichs

13. BIRTHPLACE OF MOTHER (State or Country) Mokomis, Ill.

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Mrs. P. A. Rogers
(Address) Ilo, Idaho

15. Filed Aug 23 1913 H. C. Parrish
Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH Aug 23 1913
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from Aug 23 1913, to Aug 23 1913
that I last saw him alive on Aug 23 1913
and that death occurred on the date stated above, at 7:10 AM.

The CAUSE OF DEATH* was as follows:
Premature birth
6 m utero

(Duration) _____ yrs. _____ mos. _____ ds.

Contributory (Secondary)

(Duration) _____ yrs. _____ mos. _____ ds.
(Signed) H. C. Parrish M. D.
Aug 23 1913 (Address) Ilo, Idaho

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; (2) whether ACCIDENTAL, SUICIDAL OR HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place _____ In the _____
of death _____ yrs. _____ mos. _____ ds. State _____ yrs. _____ mos. _____ ds.
Where was disease contracted,
If not at place of death? _____
Former or
usual residence _____

19. PLACE OF BURIAL OR REMOVAL DATE OF BURIAL
H. H. & O. F. Cemetery Aug 23 1913

20. UNDERTAKER ADDRESS
H. H. & O. F. Co Ilo, Idaho

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
 B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Form V. S. No. 5. 12½ M. 7-24-11

CERTIFICATE OF DEATH

State of Idaho
 BOARD OF HEALTH
 Bureau of Vital Statistics
 File No. 5533
 Registered No. _____

1. PLACE OF DEATH.

County of *Latah*City of *Postlatch*Registration District No. *65*Primary Registration District No. *21.45*

(No. _____, _____ St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

Edna May Kinsella

If death occurred in a hospital, institution or camp give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX

female

4. COLOR OR RACE

white

5. SINGLE, MARRIED, WIDOWED OR DIVORCED.

single
(Write the word.)

6. DATE OF BIRTH

June 23 1913
 (Month) (Day) (Year)

7. AGE

— yrs. 2 mos. 6 ds.
 IF LESS than 1 day how many _____ hrs. or _____ min?

8. OCCUPATION

(a) Trade, profession or particular kind of work _____
 (b) General nature of industry business or establishment in which employed (or employer) _____

9. BIRTHPLACE

(State or Country)

Postlatch

10. NAME OF FATHER

Nick Kinsella

11. BIRTHPLACE OF FATHER

(State or Country)

N. Y.

12. MAIDEN NAME OF MOTHER

Edith Fallon

13. BIRTHPLACE OF MOTHER

(State or Country)

Canada

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) *Edith Kinsella*(Address) *Postlatch*

15.

Filed *Sept. 1st 1913*
D. J. Thompson
 Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH

Aug 29 1913
 (Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from *Aug 20 1913*, to *Aug 29 1913*

that I last saw her alive on *Aug 26 1913*

and that death occurred on the date stated above, at *2 P. M.*

The CAUSE OF DEATH* was as follows:

Marasmus

_____ (Duration) _____ yrs. _____ mos. _____ ds.

Contributory
 (Secondary)

_____ (Duration) _____ yrs. _____ mos. _____ ds.

(Signed) *Ernest Steier M. D.*

Aug 30 1913 (Address) *Palouse Wash.*

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place _____ In the _____
 of death _____ yrs. _____ mos. _____ ds. State _____ yrs. _____ mos. _____ ds.

Where was disease contracted,

If not at place of death?

Former or

usual residence.

19. PLACE OF BURIAL OR REMOVAL DATE OF BURIAL

Postlatch Cemetery *Sept. 1st 1913*

20. UNDERTAKER ADDRESS

Parents *Postlatch*

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Form V. S. No. 5. 12½ M. 7-24-11

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics
File No. 5534
Registered No. _____

1. PLACE OF DEATH. Registration District No. 65.
County of Latah Primary Registration District No. 2145.
City of Footlatch (No. _____, St.) _____

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Myrtle Audena Johnson

If death occurred in a hospital, institution or camp give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX 4. COLOR OR RACE 5. SINGLE, MARRIED, WIDOWED OR DIVORCED.

Female white (Write the word.)

6. DATE OF BIRTH Oct 4 1909
(Month) (Day) (Year)

7. AGE IF LESS than 1 day
3 yrs. 2 mos. 1 ds. how many hrs. or min?

8. OCCUPATION

- (a) Trade, profession or particular kind of work. ✓
(b) General nature of industry business or establishment in which employed (or employer) ✓

9. BIRTHPLACE

(State or Country)

Footlatch Ida

10. NAME OF FATHER

Isaac Johnson

11. BIRTHPLACE OF FATHER

(State or Country)

Norway

12. MAIDEN NAME OF MOTHER

Johanna Olson

13. BIRTHPLACE OF MOTHER

(State or Country)

Norway

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Mrs. Johanna Johnson
(Address) Footlatch Ida

15.

Filed Aug 5 1913 D. J. W. Thompson
Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH

Aug. 5 1913
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from

July 20 1913, to Aug 5 1913

that I last saw her alive on Aug 5 1913

and that death occurred on the date stated above, at 6 AM

The CAUSE OF DEATH* was as follows:

Acute Endocarditis

(Duration) 2 yrs. _____ mos. _____ ds.

Contributory (Secondary)

Rheumatism

(Duration) 2 yrs. _____ mos. _____ ds.

(Signed) J. W. Thompson M. D.

Aug 6 1913 (Address) Footlatch

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place _____ In the _____
of death yrs. mos. ds. State yrs. mos. ds.

Where was disease contracted,

If not at place of death?

Former or

usual residence.

19. PLACE OF BURIAL OR REMOVAL DATE OF BURIAL

Palouse Wash.Aug 6 1913

20. UNDERTAKER

ADDRESS

E. AndersonPalouse Wash.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Form V. S. No. 5 20M.1-16-12

CERTIFICATE OF DEATH

 State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH.

Registration District No. 65County of LatahPrimary Registration District No. 2145

City of _____

(No. _____, St.)

Registered No. _____

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Fred Bysegger

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX

Male

4. COLOR OR RACE

White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED.

Single
(Write the word.)

6. DATE OF BIRTH

July 17 1884
(Month) (Day) (Year)

7. AGE

29 yrs. — mos. 24 ds.
 IF LESS than 1 day
how many hrs. or
..... mins.?

8. OCCUPATION

(a) Trade, profession or particular kind of work

Farmer

(b) General nature of industry business, or establishment in which employed (or employer)

9. BIRTHPLACE

(State or Country)

Ohio

10. NAME OF FATHER

Fred Bysegger

11. BIRTHPLACE OF FATHER

(State or Country)

Switzerland

12. MAIDEN NAME OF MOTHER

Anna Trapp

13. BIRTHPLACE OF MOTHER

(State or Country)

Switzerland

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

(Address)

John C. Bysegger
Garfield Wash.

15.

Filed Aug. 12 1913
D. J. Thompson
Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH

Aug 10 1913
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended _____ from _____

1913, to 1913,
that I last saw him alive on Aug 10 1913,
and that death occurred on the date stated above, at 8 P.M.

The CAUSE OF DEATH* was as follows:

Drowning by accident -
while bathing in the River.

(Duration) yrs. mos. ds.

Contributory (Secondary)

(Duration) yrs. mos. ds.

(Signed)

McDon M. D.19. (Address) Princeton Ind.

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death yrs. mos. days. In the State yrs. mos. days.

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

Grace of Idaho Aug 12, 1913

20. UNDERTAKER

ADDRESS

E. Anderson Idaho

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Form V. S. No. 5. 12½ M. 7-24-11

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics
File No. 5536
Registered No. _____

1. PLACE OF DEATH. Registration District No. _____
County of My Perce Primary Registration District No. 2074
City of Efford (No. _____, _____ St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Doratha Runkern

If death occurred in a hospital, institution or camp give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX Fi 4. COLOR OR RACE Wh 5. SINGLE, MARRIED, WIDOWED OR DIVORCED.
married
(Write the word.)

6. DATE OF BIRTH May 5 1878
(Month) (Day) (Year)

7. AGE 35 yrs. 2 mos. 1 ds. IF LESS than 1 day
how many.....hrs. or
.....min?

8. OCCUPATION

(a) Trade, profession or particular kind of work.....
(b) General nature of industry business or establishment in which employed (or employer).....

house wife

9. BIRTHPLACE
(State or Country)

Germany

10. NAME OF FATHER Christ Munsterman

11. BIRTHPLACE OF FATHER
(State or Country)

Germany

12. MAIDEN NAME OF MOTHER Dorothea Munsterman

13. BIRTHPLACE OF MOTHER
(State or Country)

Germany

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Wm Munsterman
(Address) Efford

15.

Filed 7-6 1913 E.E. Hatts
Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH July 6 1913
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from 11 a.m 7-5 1913, to 1 a.m 7-6 1913
that I last saw her alive on 7-6 1913
and that death occurred on the date stated above, at 1 a.m.
The CAUSE OF DEATH* was as follows:

Hemorrhage

(Duration) 7 yrs. 15 mos. 15 ds.
Contributory Placenta previa
(Secondary)
(Duration) 7 yrs. 7 mos. 7 ds.
(Signed) E.E. Hatts M. D.
7-6 1913 (Address) Efford

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place _____ In the _____
of death..... yrs..... mos..... ds. State..... yrs..... mos..... ds.
Where was disease contracted,
If not at place of death? _____
Former or
usual residence.....

19. PLACE OF BURIAL OR REMOVAL DATE OF BURIAL

Lutheran Cemetery 7-8 1913

20. UNDERTAKER ADDRESS

H.E. Stoddard Efford

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. PHYSI-
 CIAN'S should be carefully supplied. AGE should be state EXACTLY. Exact state-
 ment of OCCUPATION is very important. See instructions on back of certificate.

Form V. S. No. 5. 10M. 6-20-11.

CERTIFICATE OF DEATH

State of Idaho
 BOARD OF HEALTH
 Bureau of Vital Statistics
 File No. 5537

1. PLACE OF DEATH.

Registration District No. 35County of ElmorePrimary Registration District No. 2021City of Elmore

(No. _____, St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

Frank M. Lucas

Registered No. _____

If death occurred in a hospital, institution or camp give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX

male4. COLOR OR RACE 5. SINGLE, MARRIED, WID-
OWED OR DIVORCED.whitesingle
(Write the word.)

6. DATE OF BIRTH

_____ 1 _____
 (Month) (Day) (Year)

7. AGE

about28 yrs. _____ mos. _____ ds.

IF LESS than 1 day
 how many _____ hrs. or
 _____ min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work
 (b) General nature of industry business or establishment in which employed (or employer)

laborer in bridge gang

9. BIRTHPLACE

(State or Country)

Virginia

10. NAME OF FATHER

11. BIRTHPLACE OF FATHER

(State or Country)

dont know

12. MAIDEN NAME OF MOTHER

Mrs. Kate Lucas

13. BIRTHPLACE OF MOTHER

(State or Country)

dont know

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

H. H. Eaton, brother

(Address)

W. H. Home, Ida.

15.

Filed

Aug 23 d 1913J. W. Davis
Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

August 23 1913
 (Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from

23 d 1913, to 191that I last saw him alive on 191and that death occurred on the date stated above, at 4 a.m.

The CAUSE OF DEATH* was as follows:

Accidental, by being run over by engine #1117, while apparently asleep on the track

Instant (Duration) _____ yrs. _____ mos. _____ ds.

Contributory (Secondary)

Cardiac on his own part

(Duration) _____ yrs. _____ mos. _____ ds.

(Signed)

H. H. Eaton, brotherAug 23 1913 (Address) W. H. Home, Ida.

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death _____ yrs. _____ mos. _____ ds. In the State _____ yrs. _____ mos. _____ ds.

Where was disease contracted?

If not at place of death?

Former or

usual residence

19. PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

Christiansburg, Va.191

20. UNDERTAKER

ADDRESS

H. D. WilburW. H. Home

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Form V. S. No. 5. 12½ M. 7-24-11

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics
File No. 5538
Registered No.

1. PLACE OF DEATH. Registration District No. 39.
County of Twin Falls. Primary Registration District No. 2087
City of Buhl (No. , St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Edward Morris Lankes

If death occurred in a hospital, institution or camp give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX male 4. COLOR OR RACE white 5. SINGLE, MARRIED, WIDOWED OR DIVORCED. single (Write the word.)

6. DATE OF BIRTH Nov 3 1913 (Month) (Day) (Year)

7. AGE yrs. 9 mos. 2 ds. IF LESS than 1 day how many hrs. or min?

8. OCCUPATION (a) Trade, profession or particular kind of work none (b) General nature of industry business or establishment in which employed (or employer)

9. BIRTHPLACE (State or Country) Buhl

10. NAME OF FATHER Fred Lankes

11. BIRTHPLACE OF FATHER Ind. (State or Country)

12. MAIDEN NAME OF MOTHER Lella Paulsen

13. BIRTHPLACE OF MOTHER Mich (State or Country)

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE (Informant) Fred Lankes (Address) Buhl

15. Filed 8-6 1913 J. Murphy Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH Aug 5 1913 (Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from Aug 2 1913, to Aug 5 1913 that I last saw him alive on Aug 5 1913 and that death occurred on the date stated above, at 99. M.

The CAUSE OF DEATH* was as follows: Enterocolitis

(Duration) yrs. mos. 7 ds.

Contributory (Secondary)

(Duration) yrs. mos. ds. (Signed) Chas. Weeber M. D. Aug 5 1913 (Address) Buhl Ida.

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place In the of death yrs. mos. ds. State yrs. mos. ds. Where was disease contracted, If not at place of death? Former or usual residence.

19. PLACE OF BURIAL OR REMOVAL Buhl DATE OF BURIAL 8-6 1913

20. UNDERTAKER H.B. Evans ADDRESS Buhl

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Form V. S. No. 5 20M.1-16-12

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH. Registration District No. 17
County of Bohmer Primary Registration District No. 1053
City of Corn & Alun (No. _____ St.)

File No. 5540
Registered No. 301

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME James Morgan

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX male 4. COLOR OR RACE white 5. SINGLE, MARRIED, WIDOWED OR DIVORCED. married
(Write the word.)

6. DATE OF BIRTH 1885
(Month) (Day) (Year)

7. AGE 28 yrs. mos. ds. IF LESS than 1 day how many hrs. or mins.

8. OCCUPATION
(a) Trade, profession or particular kind of work Logger
(b) General nature of industry business, or establishment in which employed (or employer).

9. BIRTHPLACE
(State or Country) Nebraska

10. NAME OF FATHER Geo Morgan

11. BIRTHPLACE OF FATHER
(State or Country) Ill

12. MAIDEN NAME OF MOTHER Elizabeth Wright

13. BIRTHPLACE OF MOTHER
(State or Country) Ind

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Neurologist
(Address) Corn & Alun

15. Filed 8/10 1913 S. S. Schuman
Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH June 7th 1913
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from June 3rd 1913, to June 7th 1913, that I last saw him alive on June 6th 1913, and that death occurred on the date stated above, at 7 P. M.
The CAUSE OF DEATH* was as follows:

Septicemia
Septic Septicemia (F)
(Duration) 3 yrs. mos. ds.
Contributory chronic septemia
(Secondary)
(Duration) 3 yrs. mos. ds.
(Signed) Geo B. B. B. M. D.
19 (Address) Corn & Alun Id

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death. yrs. mos. days. In the State. yrs. mos. days.

Where was disease contracted if not at place of death?

Former or usual residence.

19. PLACE OF BURIAL OR REMOVAL Funerary DATE OF BURIAL June 9 1913
20. UNDERTAKER S. S. Schuman ADDRESS Corn & Alun

-SUPPLEMENTARY DEATH CERTIFICATE-

(Please reply on this sheet, to
the registrar of Vital Statistics)

Death Certificate No.

Name.....James Morgan.....

Date of Death.....June 7th, 1913.....

Cause of Death.....Septic Cholecystitis.....

Contributory Cause of death.....General Septicemia.....

(Sign here)

Ind Bunby

M.D.

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Form V. S. No. 5 20M.1-16-12

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH. Registration District No. 12
County of Idaho Primary Registration District No. 1503
City of Rathdrum (No. _____ St.)

File No. 5541
Registered No. 302

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

Gilbert Miller

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX male 4. COLOR OR RACE white 5. SINGLE, MARRIED, WIDOWED OR DIVORCED. single
(Write the word.)

6. DATE OF BIRTH 1879
(Month) (Day) (Year)

7. AGE 34 yrs. 0 mos. 0 ds. IF LESS than 1 day how many 0 hrs. or 0 mins.

8. OCCUPATION

(a) Trade, profession or particular kind of work
(b) General nature of industry business, or establishment in which employed (or employer)

9. BIRTHPLACE

(State or Country)

Ohio

10. NAME OF FATHER

Matthew Miller

11. BIRTHPLACE OF FATHER

(State or Country)

New Jersey

12. MAIDEN NAME OF MOTHER

Clara Spencer

13. BIRTHPLACE OF MOTHER

(State or Country)

Ohio

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

G. E. Miller

(Address)



15.

Filed

8/10

913

J. S. Spencer
Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH

June 13th

(Month)

(Day)

1913

(Year)

17. I HEREBY CERTIFY, That I attended deceased from March 30 1913, to June 13 1913, that I last saw him alive on June 12 1913, and that death occurred on the date stated above, at 10⁰⁰ P.M.

The CAUSE OF DEATH* was as follows:

Pulmonary Tuberculosis - (Probably has had Tuberculosis for 2 or 3 yrs. only knew him from March 30-1913)

(Duration) yrs. 2 mos. 13 ds.

Contributory (Secondary)

(Duration) yrs. 0 mos. 0 ds.

(Signed)

W. H. Holden M. D.

June 12, 1913 (Address) Leonard Allen, Idaho

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death. yrs. 0 mos. 0 days. In the State. yrs. 0 mos. 0 days.

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

Home cem

June 18 1913

20. UNDERTAKER

ADDRESS

Spencer

E. W. A

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Form V. S. No. 5 20M.1-16-12

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH. Registration District No. 12
County of Kootenai Primary Registration District No. 1003
City of Curlew (No. _____, St.)

File No. 5513
Registered No. 304

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

Robert Esala

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX male 4. COLOR OR RACE white 5. SINGLE, MARRIED, WIDOWED OR DIVORCED. married
(Write the word.)

6. DATE OF BIRTH

12 85
(Month) (Day) (Year)

7. AGE

28 yrs. _____ mos. _____ ds.

IF LESS than 1 day
how many _____ hrs. or
_____ mins.?

8. OCCUPATION

(a) Trade, profession or particular kind of work

Houseman

(b) General nature of industry business, or establishment in which employed (or employer)

9. BIRTHPLACE

(State or Country)

Idaho

10. NAME OF FATHER

11. BIRTHPLACE OF FATHER

(State or Country)

12. MAIDEN NAME OF MOTHER

13. BIRTHPLACE OF MOTHER

(State or Country)

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

(Address)

Wagon Utah

15.

Filed

8/101910

S. A. Drumm
Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH

June 3 1913
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from May 24 1913, to June 3 1913,
that I last saw him alive on June 3 1913,
and that death occurred on the date stated above, at 10 A.M.

The CAUSE OF DEATH* was as follows:

Pneumonia (lobar)(Duration) _____ yrs. _____ mos. 5 ds.Contributory
(Secondary)

(Duration) _____ yrs. _____ mos. _____ ds.

(Signed)

June 6 1913 (Address) Curlew Idaho M. D.

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death _____ yrs. _____ mos. _____ days. In the State _____ yrs. _____ mos. _____ days.

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

Wagon Utah 1913

20. UNDERTAKER

ADDRESS

S. J. Drumm Curlew

-SUPPLEMENTARY DEATH CERTIFICATE-

(Please reply on this sheet to
the registrar of Vital Statistics)

Death Certificate No. _____

Name _____ Robert Gayle _____

Date of Death _____ June 3, 1913 _____

Cause of Death _____ Lobar Pneumonia _____

Contributory Cause of death _____

(Sign here) J. C. Bryan

M.D.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

1. **PLACE OF DEATH.** County of Kootenai Registration District No. 1003
 City of Coeur d'Alene (No. _____, _____ St.)

BOARD OF HEALTH
 Bureau of Vital Statistics

File No. 5541
 Registered No. 305

If death occurred in a hospital, institution or camp give its NAME instead of street and number.

If death occurs away from usual residence, give facts called for under special information.

2. **FULL NAME** Mrs. Shelby Roberts

PERSONAL AND STATISTICAL PARTICULARS

3. **SEX** Female 4. **COLOR OR RACE** White 5. **SINGLE, MARRIED, WIDOWED OR DIVORCED.** Married
 (Write the word.)

6. **DATE OF BIRTH** Feb. 26 1880
 (Month) (Day) (Year)

7. **AGE** 25 yrs. 3 mos. 8 ds. IF LESS than 1 day
 how many _____ hrs. or _____ min?

8. **OCCUPATION**
 (a) Trade, profession or particular kind of work House wife
 (b) General nature of industry business or establishment in which employed (or employer)

9. **BIRTHPLACE** (State or Country) Minnesota

10. **NAME OF FATHER** John Groves

11. **BIRTHPLACE OF FATHER** (State or Country) Penn.

12. **MAIDEN NAME OF MOTHER** Elizabeth Hobbs

13. **BIRTHPLACE OF MOTHER** (State or Country) New York.

14. **THE ABOVE IS TRUE TO THE BEST OF MY KNOW**
 (Informant) Leonard Ruelle
 (Address) _____

15. **Filed** 8/10 1913 D. D. Brown
 Local Regi

MEDICAL CERTIFICATE OF DEATH.

16. **DATE OF DEATH** June 3 1913
 (Month) (Day) (Year)

17. **I HEREBY CERTIFY**, That I attended deceased from May 24 1913, to June 2 1913
 that I last saw him alive on June 2 1913
 and that death occurred on the date stated above, at 11:30 A.M.

The **CAUSE OF DEATH*** was as follows:
Obstruction of bowels
Caused by foreign body being left in abdomen by former operators
 (Duration) _____ yrs. _____ mos. _____ ds.

Contributory (Secondary) _____
 (Duration) _____ yrs. _____ mos. _____ ds.
 (Signed) P. H. Seaton M. D.
June 4 1913 (Address) Coeur d'Alene Id.

*State the **DISEASE CAUSING DEATH**; or in deaths from **VIOLENT CAUSES**, state (1) **MEANS OF INJURY**; (2) whether **ACCIDENTAL, SUICIDAL OR HOMICIDAL**.

18. **LENGTH OF RESIDENCE** (For Hospitals, Institutions, Transients or Recent Residents.)

At place _____ In the _____
 of death _____ yrs. _____ mos. _____ ds. State _____ yrs. _____ mos. _____ ds.
 Where was disease contracted, _____
 If not at place of death? _____
 Former or _____
 usual residence _____

19. **PLACE OF BURIAL OR REMOVAL** Catholic Cem. **DATE OF BURIAL** 6-6 1913

20. **UNDERTAKER** Cassedy & Nelson **ADDRESS** 209 2nd

WRITING PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Form V. S. No. 5. 12½M.7-24-11

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics
File No. **5545**
Registered No. **306**

1. PLACE OF DEATH. Registration District No. **14**
County of **Boone** Primary Registration District No. **7051**
City of **Rathdrum** (No. **30** St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

Joseph Lapineau

If death occurred in a hospital, institution or camp give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX **male** 4. COLOR OR RACE **white** 5. SINGLE, MARRIED, WIDOWED OR DIVORCED. **widower**
(Write the word.)

6. DATE OF BIRTH _____
(Month) (Day) (Year)

7. AGE **about 60** yrs. mos. ds. IF LESS than 1 day how many hrs. or min?

8. OCCUPATION

(a) Trade, profession or particular kind of work. **laborer**
(b) General nature of industry business or establishment in which employed (or employer)

9. BIRTHPLACE
(State or Country)

10. NAME OF FATHER

11. BIRTHPLACE OF FATHER
(State or Country)

12. MAIDEN NAME OF MOTHER

13. BIRTHPLACE OF MOTHER
(State or Country)

England

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) **Mrs. Elsie Smith**

(Address) **Rathdrum, Ida.**

15.

Filed **8/10** 191**3**

J. A. Shuman
Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH **July 4th** 191**3**
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from **July 2** 191**3**, to **July 4** 191**3**, that I last saw him alive on **July 2** 191**3**, and that death occurred on the date stated above, at **10.4 M.**

The CAUSE OF DEATH* was as follows:

Acute Pneumonia (lobar)

(Duration) _____ yrs. mos. ds. 7
Contributory **Old Injury to brain**
(Secondary)

(Duration) **1** yrs. mos. ds.
(Signed) **Frank Henry** M. D.
7/4 191**3** (Address) **Rathdrum, Ida.**

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place In the
of death _____ yrs. mos. ds. State _____ yrs. mos. ds.
Where was disease contracted,
If not at place of death? _____
Former or
usual residence _____

19. PLACE OF BURIAL OR REMOVAL **Rathdrum** DATE OF BURIAL **7-8-1913**

20. UNDERTAKER **Rabo** ADDRESS **Rathdrum**

-SUPPLEMENTARY DEATH CERTIFICATE-

(Please reply on this sheet to
the registrar of Vital Statistics)

Death Certificate No.

Name..... ~~Joseph Papincan~~ Papineau

Date of Death..... July 4, 1913.

Cause of Death..... Heart (Cor) pneumonia

Contributory Cause of death.....

(Sign here) Frank Henry M.D.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Form V. S. No. 5 20M.1-16-12

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH.

Registration District No. 12

County of Rudley

Primary Registration District No. 2049

City of Rudley(No. Turn of Rudley - St.)

File No. 5546

Registered No. 307

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Mrs. G. Goldley

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX

4. COLOR OR RACE

5. SINGLE, MARRIED, WID-
OWED OR DIVORCED.Female White Widowed
(Write the word.)

6. DATE OF BIRTH

Oct 18 1
(Month) (Day) (Year)

7. AGE

68 yrs. mos. ds.IF LESS than 1 day
how many hrs. or
..... mins.?

8. OCCUPATION

(a) Trade, profession or
particular kind of work(b) General nature of industry
business, or establishment in
which employed (or employer)Housewife

9. BIRTHPLACE

(State or Country)

Oregon10. NAME OF
FATHERWm. Thippa11. BIRTHPLACE
OF FATHER

(State or Country)

Id.12. MAIDEN NAME
OF MOTHERSarah Boone13. BIRTHPLACE
OF MOTHER

(State or Country)

Mo

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

Mrs. E. C. Widaman

(Address)

Rudley, Ida.

15.

Filed

8/10

1913

J. S. Schuman

Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH

July 3 1913
(Month) (Day) (Year)17. I HEREBY CERTIFY, That I attended deceased ~~from~~
in Apr. 1913, to 1913that I last saw her alive on May 15 1913
and that death occurred on the date stated above, at 9:15 P.M.

The CAUSE OF DEATH* was as follows:

Senile Debility(Duration) about 4 yrs. mos. ds.Contributory Small cell Lungs & worry(Secondary) past two or three years

(Duration) yrs. mos. ds.

(Signed) C. E. Nightingale M. D.July 4 1913 (Address) Rose Lane Id.

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions,
Transients or Recent Residents.)At place of death 4 yrs. mos. days. In the 4 yrs. mos. days. State.Where was disease contracted
if not at place of death?Former or
usual residenceOakdale, Mo.

19. PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

Spokane, WnJuly 4 1913

20. UNDERTAKER

ADDRESS

Smith & CoSpokane, Wn

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Form V. S. No. 5. 12½M.7-24-11

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics
File No. 5547
Registered No. 308

1. PLACE OF DEATH.

County of Bonanza
City of Sp. Lake

Registration District No. 12Primary Registration District No. 2051

(No. _____, St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

William S. Amad

If death occurred in a hospital, institution or camp give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX

Male

4. COLOR OR RACE

White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED.

Single
(Write the word.)

6. DATE OF BIRTH

2??

(Month)

(Day)

(Year)

7. AGE

about 47?IF LESS than 1 day
how many _____ hrs. or
_____ min?

8. OCCUPATION

- (a) Trade, profession or particular kind of work.
(b) General nature of industry business or establishment in which employed (or employer)

Drum, jack

9. BIRTHPLACE

(State or Country)

10. NAME OF FATHER

11. BIRTHPLACE OF FATHER

(State or Country)

12. MAIDEN NAME OF MOTHER

13. BIRTHPLACE OF MOTHER

(State or Country)

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

(Address)

15.

Filed

8/101913

Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH

July191913

(Month)

(Day)

(Year)

17. I HEREBY CERTIFY, That I attended deceased from

July 12 1913, to July 19 1913that I last saw him alive on July 19 1913and that death occurred on the date stated above, at 6 P.M.

The CAUSE OF DEATH* was as follows

Appendicitis with gangrene & rupture of appendix(Duration) _____ yrs. _____ mos. 10 ds.Contributory
(Secondary)

(Duration) _____ yrs. _____ mos. _____ ds.

(Signed)

7-24 1913 (Address) Sp. Lake

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place _____ In the _____
of death _____ yrs. _____ mos. _____ ds. State _____ yrs. _____ mos. _____ ds.

Where was disease contracted,

If not at place of death? _____

Former or
usual residence. _____

19. PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

Sp. LakeJuly 20 1913

20. UNDERTAKER

ADDRESS

KloppBarbours

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Form V. S. No. 5 20M.1-16-12

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH.

Registration District No. 12County of ButterfieldPrimary Registration District No. 1003City of Sheels Gulch(No. 1003 St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

Blara W. DunkleFile No. 5548Registered No. 309

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX

2

4. COLOR OR RACE

W.

5. SINGLE, MARRIED, WIDOWED OR DIVORCED.

married
(Write the word.)

6. DATE OF BIRTH

Sept. 20 1852
(Month) (Day) (Year)

7. AGE

60 yrs. 3 mos. 10 ds.IF LESS than 1 day
how many hrs. or
..... mins.?

8. OCCUPATION

(a) Trade, profession or particular kind of work

Housewife

(b) General nature of industry business, or establishment in which employed (or employer)

9. BIRTHPLACE

(State or Country)

Penn

10. NAME OF FATHER

Levi White

11. BIRTHPLACE OF FATHER

(State or Country)

Penn

12. MAIDEN NAME OF MOTHER

Hannah Deball

13. BIRTHPLACE OF MOTHER

(State or Country)

Penn

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

(Address)

L. J. Dunkle
Cataldo Id.

15.

Filed

8/101913J. D. Newman

Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH

June 8 1913
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from

1913, to 1913,that I last saw h..... alive on 1913,and that death occurred on the date stated above, at M.

The CAUSE OF DEATH* was as follows:

No M.D.

(Duration) yrs. mos. ds.

Contributory
(Secondary)

(Duration) yrs. mos. ds.

(Signed)

June 1913

(Address)

M. D.

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death yrs. mos. days. In the State yrs. mos. days.

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

Kingston Idaho June 11 1913

20. UNDERTAKER

ADDRESS

W. W. WallaceWallace Id.

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Form V. S. No. 5 20M.1-16-12

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH.

Registration District No. 12

County of Kootenai

Primary Registration District No. 1008

City of Colt

(No. St.)

File No. 5549

Registered No. 310

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Crabb

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX F.

4. COLOR OR RACE W.

5. SINGLE, MARRIED, WIDOWED OR DIVORCED. Single
(Write the word.)

6. DATE OF BIRTH July 13 1913
(Month) (Day) (Year)

7. AGE 17 yrs. 17 mos. 17 ds.

IF LESS than 1 day
how many hrs. or
 mins.

8. OCCUPATION

- (a) Trade, profession or particular kind of work
(b) General nature of industry business, or establishment in which employed (or employer)

9. BIRTHPLACE Colt Idaho
(State or Country)

10. NAME OF FATHER Stephen Crabb

11. BIRTHPLACE OF FATHER Idaho
(State or Country)

12. MAIDEN NAME OF MOTHER Sarah Crabb

13. BIRTHPLACE OF MOTHER Idaho
(State or Country)

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

(Address)

15. 8/10

Filed July 31 1913

Local Registrar W. A. Newman

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH July 30 1913
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from July 13 1913 to July 30 1913
that I last saw her alive on July 30 1913
and that death occurred on the date stated above, at 10 P.M.

The CAUSE OF DEATH* was as follows:

Whooping cough, child born prematurely at seven months.

(Duration) yrs. mos. ds.

Contributory (Secondary)

(Duration) yrs. mos. ds.

(Signed) W. A. Newman M.D.

July 31 1913 (Address) Colt Idaho

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death yrs. mos. days. In the State yrs. mos. days.

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL Colt

DATE OF BURIAL 7-31-1913

20. UNDERTAKER

ADDRESS Colt

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Form V. S. No. 5. 12½ M. 7-24-11

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics
File No. 5551
Registered No. 319

1. PLACE OF DEATH. Registration District No. 2118 12
County of Blaine Primary Registration District No. 2118
City of Franklin (No. _____, _____ St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Annie Abraham

If death occurred in a hospital, institution or camp give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX Female 4. COLOR OR RACE Indian 5. SINGLE, MARRIED, WIDOWED OR DIVORCED. Single
(Write the word.)

6. DATE OF BIRTH

Oct — 1907
(Month) (Day) (Year)

7. AGE

5 yrs. 9 mos. — ds.

IF LESS than 1 day
how many hrs. or
..... min?

8. OCCUPATION

(a) Trade, profession or particular kind of work.

None

(b) General nature of industry business or establishment in which employed (or employer)

9. BIRTHPLACE

(State or Country)

Reservation

10. NAME OF FATHER

Leo Abraham

11. BIRTHPLACE OF FATHER

(State or Country)

Reservation

12. MAIDEN NAME OF MOTHER

Mary Louisa Cha. op. Lin

13. BIRTHPLACE OF MOTHER

(State or Country)

Reservation

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Leo Abraham

(Address) Franklin, Idaho

15.

Filed

8/10

1917

A. D. Bruggen

Geo. J. Kessler
Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH

July 13 1917
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from
..... 191....., to..... 191.....

that I last saw h..... alive on..... 191.....

and that death occurred on the date stated above, at..... M.

The CAUSE OF DEATH* was as follows:

Not known from description
probably cardiac Apical
Myocarditis

..... (Duration) yrs. mos. ds.

Contributory

(Secondary)

..... (Duration) yrs. mos. ds.

(Signed) M. D.

..... 19..... (Address)

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place In the
of death..... yrs..... mos..... ds. State..... yrs..... mos..... ds.

Where was disease contracted,

If not at place of death?.....

Former or

usual residence.....

19. PLACE OF BURIAL OR REMOVAL DATE OF BURIAL

July 15 1917

20. UNDERTAKER

ADDRESS

None

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Form V. S. No. 5 20M.1-16-12

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH.

Registration District No. *17*County of *Idaho*Primary Registration District No. *1003*City of *C. I. O.*

(No. _____, St.)

File No. *5551*Registered No. *376*

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

Emerson Howard

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX

male

4. COLOR OR RACE

white

5. SINGLE, MARRIED, WIDOWED OR DIVORCED.

married
(Write the word.)

6. DATE OF BIRTH

(Month)

(Day)

(Year)

1867

7. AGE

49 yrs.

mos.

ds.

IF LESS than 1 day
how many hrs. or
..... mins.?

8. OCCUPATION

(a) Trade, profession or particular kind of work

fruit grower

(b) General nature of industry, business, or establishment in which employed (or employer)

9. BIRTHPLACE

(State or Country)

Id

10. NAME OF FATHER

Philip Howard

11. BIRTHPLACE OF FATHER

(State or Country)

12. MAIDEN NAME OF MOTHER

James

13. BIRTHPLACE OF MOTHER

(State or Country)

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

Wife

(Address)

1214 Sherman St

15.

Filed

8/10

1913

St. Lawrence
Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH

July 24

(Month)

24

(Day)

1913

(Year)

17. I HEREBY CERTIFY, That I attended deceased from

July 1912, to *July 24* 1913that I last saw him alive on *July 24* 1913and that death occurred on the date stated above, at *7 P.* M.

The CAUSE OF DEATH* was as follows:

Apoplexy

(Duration)

yrs.

mos.

2 ds.

Contributory

(Secondary)

Nephritis

(Duration)

yrs.

mos.

ds.

(Signed)

July 25, 1913

(Address)

Over the Sea

M. D.

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place

of death

yrs.

mos.

days.

In the

State

yrs.

mos.

days.

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

*Idaho Id**1913*

UNDERTAKER

S. J. Linn

ADDRESS

C. W. A.

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFAADING INK—THIS IS A PERMANENT RECORD.
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Form V. S. No. 5 20M.1-16-12

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. **PLACE OF DEATH** _____ Registration District No. _____
County of Boole Primary Registration District No. 1003
City of Coeur d'Alene (No. _____ St.) Registered No. 5555
If death occurs away from usual residence, give facts called for under special information. 2. **FULL NAME** Sarah Harriet Glasspool If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. **SEX** Female 4. **COLOR OR RACE** White 5. **SINGLE, MARRIED, WIDOWED OR DIVORCED.** Married
(Write the word.)

6. **DATE OF BIRTH** Sept 27 1885
(Month) (Day) (Year)

7. **AGE** 27 yrs 9 mos 9 ds. IF LESS than 1 day how many hrs. or mins.?

8. **OCCUPATION**
(a) Trade, profession or particular kind of work Housewife
(b) General nature of industry, business, or establishment in which employed (or employer) _____

9. **BIRTHPLACE** Mo.
(State or Country)

10. **NAME OF FATHER** Chas Billlesstone

11. **BIRTHPLACE OF FATHER** England
(State or Country)

12. **MAIDEN NAME OF MOTHER** Emma Rickels

13. **BIRTHPLACE OF MOTHER** Indiana
(State or Country)

14. **THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE**
(Informant) Wm M Glasspool
(Address) 6 view d alene Idaho

15. Filed 8/10 1913 Adhemar
Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. **DATE OF DEATH** July 6 1913
(Month) (Day) (Year)

17. **I HEREBY CERTIFY**, That I attended deceased from June 24 1913 to July 5 1913, that I last saw her alive on July 5 1913 and that death occurred on the date stated above, at _____ M.

The CAUSE OF DEATH* was as follows:
Pneumonia
(lobar)

(Duration) _____ yrs. _____ mos. _____ ds.

Contributory (Secondary) _____
(Duration) _____ yrs. _____ mos. _____ ds.

(Signed) Max A. Grandy, M. D.
19 _____ (Address) Co d Alene Idaho.

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. **LENGTH OF RESIDENCE** (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death _____ yrs. _____ mos. _____ days. In the State _____ yrs. _____ mos. _____ days.

Where was disease contracted if not at place of death? _____

Former or usual residence _____

19. **PLACE OF BURIAL OR REMOVAL** Forest Cem. **DATE OF BURIAL** July 8 1913

20. **UNDERTAKER** Cassidy & Nelson **ADDRESS** Coeur d'Alene

-SUPPLEMENTARY DEATH CERTIFICATE-

(Please reply on this sheet to
the registrar of Vital Statistics)

Death Certificate No.

Name..... Sarah Harriett Glasspool

Date of Death..... July 6, 1913

Cause of Death..... *Lobar pneumonia*

Contributory Cause of death.....

(Sign here) *Max A. D. Menden* M.D.

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Form V. S. No. 5 20M.1-16-12

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH.

Registration District No. _____

County of Blaine

Primary Registration District No. 1003

City of Elmer

(No. _____, _____ St.)

File No. 5557

Registered No. 213

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Bengta Erickson

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX

Female

4. COLOR OR RACE

White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED.

Widowed
(Write the word.)

6. DATE OF BIRTH

(Month)

(Day)

(Year)

1830

7. AGE

83

yrs.

mos.

ds.

IF LESS than 1 day
how many _____ hrs. or
_____ mins.

8. OCCUPATION

(a) Trade, profession or particular kind of work

(b) General nature of industry business, or establishment in which employed (or employer)

9. BIRTHPLACE

(State or Country)

Sweden

10. NAME OF FATHER

Erick Erickson

11. BIRTHPLACE OF FATHER

(State or Country)

Sweden

12. MAIDEN NAME OF MOTHER

Bengta Erickson

13. BIRTHPLACE OF MOTHER

(State or Country)

Sweden

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

Geo. Ell

(Address)

615 Lake Side

15.

Filed

8/10

1913

St. Lawrence

Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH

(Month)

(Day)

1913

17. I HEREBY CERTIFY, That I attended deceased from

July 29 1913, to July 30 1913

that I last saw her alive on July 29 1913

and that death occurred on the date stated above, at 7:30 PM

The CAUSE OF DEATH* was as follows:

Cardiac Insufficiency

(Duration)

yrs.

mos.

ds.

Contributory (Secondary)

Senility

(Duration)

yrs.

mos.

ds.

(Signed)

July 30 1913

(Address)

Geo. B. B. B. M. D. Crenshaw City

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death

_____ yrs. _____ mos. _____ days.

In the State

_____ yrs. _____ mos. _____ days.

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

Funeral Home

Aug 1 1913

20. UNDERTAKER

ADDRESS

St. Lawrence

Elmer

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Form V. S. No. 5 20M.1-16-12

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH. Registration District No. *12*
County of *Kootenai* Primary Registration District No. *1003*
City of *Conrad* (No. _____ St.)

File No. *5558*
Registered No. *312*

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME *John Davis*

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX *Male* 4. COLOR OR RACE *White* 5. SINGLE, MARRIED, WIDOWED OR DIVORCED. *Married*
(Write the word.)

6. DATE OF BIRTH _____
(Month) (Day) (Year) *1871*

7. AGE *42* yrs. _____ mos. _____ ds.
IF LESS than 1 day how many _____ hrs. or _____ mins.?

8. OCCUPATION *Farmer*
(a) Trade, profession or particular kind of work
(b) General nature of industry business, or establishment in which employed (or employer)

9. BIRTHPLACE *Iowa*
(State or Country)

10. NAME OF FATHER *Davis*

11. BIRTHPLACE OF FATHER *✓*
(State or Country)

12. MAIDEN NAME OF MOTHER *✓*

13. BIRTHPLACE OF MOTHER *✓*
(State or Country)

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) *A. R. Miller*
(Address) *Conrad*

15. Filed *8/10* 1913 *S. S. Newman*
Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH *7* *31* 191*3*
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from 191*1*, to *4/1* 191*3*, that I last saw him alive on *4/1* 191*3*, and that death occurred on the date stated above, at _____ M.

The CAUSE OF DEATH* was as follows:
Pulmonary Tuberculosis

(Duration) *3* yrs. _____ mos. _____ ds.
Contributory (Secondary) _____
(Duration) _____ yrs. _____ mos. _____ ds.
(Signed) *John Hunt* M. D.
19 (Address) *Conrad*

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death _____ yrs. _____ mos. _____ days. In the State _____ yrs. _____ mos. _____ days.
Where was disease contracted if not at place of death? _____
Former or usual residence _____

19. PLACE OF BURIAL OR REMOVAL *Forest Cem.* DATE OF BURIAL *Aug 2* 191*3*

20. UNDERTAKER *Cassidy & Nelson* ADDRESS *Conrad*

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Form V. S. No. 5 20M.1-16-12

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH.

Registration District No.

County of *Kootenai*

Primary Registration District No. *1003*

City of *Conrad Allen*

(No. *2*, *Suburban* St.)

File No. *5559*

Registered No. *311*

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

W. Sudman

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX

male

4. COLOR OR RACE

white

5. SINGLE, MARRIED, WIDOWED OR DIVORCED.

single
(Write the word.)

6. DATE OF BIRTH

1913
(Month) (Day) (Year)

7. AGE

— yrs. *—* mos. *—* ds.

IF LESS than 1 day
how many *—* hrs. or
— mins?

8. OCCUPATION

(a) Trade, profession or particular kind of work

(b) General nature of industry business, or establishment in which employed (or employer)

9. BIRTHPLACE

(State or Country)

Conrad Allen

10. NAME OF FATHER

W. Sudman

11. BIRTHPLACE OF FATHER

(State or Country)

Kansas

12. MAIDEN NAME OF MOTHER

Caroline W. Sudman

13. BIRTHPLACE OF MOTHER

(State or Country)

Idaho

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

(Address)

15.

Filed

8/10

1913

W. Sudman
Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH

July *7* *1913*
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from

1913, to *July* *7* *1913*

that I last saw him alive on *July* *7* *1913*

and that death occurred on the date stated above, at *2 P.M.*

The CAUSE OF DEATH* was as follows:

Maternal delivery

(Duration) *—* yrs. *—* mos. *—* ds.

Contributory
(Secondary)

(Duration) *—* yrs. *—* mos. *—* ds.

(Signed)

7/7 *1913* (Address) *Conrad Allen* *Idaho* M. D.

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death *—* yrs. *—* mos. *—* days. In the State *—* yrs. *—* mos. *—* days.

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

St. Thomas

July 8 *1913*

20. UNDERTAKER

ADDRESS

W. Sudman

Conrad Allen

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Form V. S. No. 5. 10M. 6-20-11.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics
File No. 5560

1. PLACE OF DEATH.
County of Canyon
City of Emmett

Registration District No. 2010
Primary Registration District No. 1010
(No. _____, St.)

Registered No. _____
If death occurred in a hospital, institution or camp give its NAME instead of street and number.

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

Edward De Walt

PERSONAL AND STATISTICAL PARTICULARS

3. SEX 4. COLOR OR RACE 5. SINGLE, MARRIED, WIDOWED OR DIVORCED.

Male White Married
(Write the word.)

6. DATE OF BIRTH

Mar 17 1849
(Month) (Day) (Year)

7. AGE

67 yrs. 5 mos. 5 ds.
IF LESS than 1 day how many hrs. or min.?

8. OCCUPATION

(a) Trade, profession, or particular kind of work
(b) General nature of industry business, or establishment in which employed (or employer)
Carpenter

9. BIRTHPLACE

(State or Country) Penn

10. NAME OF FATHER

Don't know

11. BIRTHPLACE OF FATHER

(State or Country) Don't know

12. MAIDEN NAME OF MOTHER

Don't know

13. BIRTHPLACE OF MOTHER

(State or Country) Don't know

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Mrs Maud Darland

(Address) Emmett Ida

15.

Filed 8-25-1913 J. L. Reynolds
Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

Aug 22 1913
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That ~~I attended~~ deceased from

191 to 191
that I last saw h alive on 191

and that death occurred on the date stated above, at 9:30 P.M.

The CAUSE OF DEATH* was as follows:

Suicide
gun shot wound

(Duration) yrs. mos. ds.

Contributory (Secondary)

(Duration) yrs. mos. ds.

(Signed) F. L. Robinson Cover M.D.

19 (Address)

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL,

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place In the
of death. yrs. mos. ds. State. yrs. mos. ds.

Where was Disease contracted,
If not at place of death?

Former or
usual residence.

19. PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

Emmett Cemetery

Aug 25 1913

20. UNDERTAKER

ADDRESS

C. D. Buckner

Emmett

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Form V. S. No. 5. 10M. 6-20-11.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH.

Registration District No. 2010

County of Canyon

Primary Registration District No. 1011

City of Emmett

(No. _____ St.)

File No. 5561

Registered No. _____

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

William R. Cartwright

If death occurred in a hospital, institution or camp give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX

male

4. COLOR OR RACE 5. SINGLE, MARRIED, WIDOWED OR DIVORCED.

white

married

(Write the word.)

6. DATE OF BIRTH

Sept 15 1853
(Month) (Day) (Year)

7. AGE

59 yrs. 10 mos. 16 ds.

IF LESS than 1 day
how many hrs. or
..... min.?

8. OCCUPATION

(a) Trade, profession, or particular kind of work

Banker

(b) General nature of industry business, or establishment in which employed (or employer)

9. BIRTHPLACE

(State or Country)

California

10. NAME OF FATHER

John Cartwright

11. BIRTHPLACE OF FATHER

(State or Country)

Don't Know

12. MAIDEN NAME OF MOTHER

" "

13. BIRTHPLACE OF MOTHER

(State or Country)

" "

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

Lauren Dean

(Address)

Emmett Idaho

15.

Filed 8-5-13 1913

J. D. Reynolds
Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

August 1 1913
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from

1913, to July 31 1913

that I last saw him alive on July 31 1913,

and that death occurred on the date stated above, at 3 9 A. M.

The CAUSE OF DEATH* was as follows:

Chronic Nephritis

Seven
(Duration) yrs. mos. ds.

Contributory (Secondary)

(Duration) yrs. mos. ds.

(Signed) P. C. Bucknum D.

Aug 1 1913 (Address) Emmett

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place In the
of death yrs. mos. ds. State yrs. mos. ds.

Where was Disease contracted,
If not at place of death?

Former or
usual residence.

19. PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

Boise Idaho

Aug 2 1913

20. UNDERTAKER

ADDRESS

C. D. Bucknum

Emmett

MARGIN RESERVED FOR BINDING
WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Form V. S. No. 5 20M.1-16-12

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH

Registration District No. 28

County of Shoshone

Primary Registration District No. 1011

City of Wallace

(No. _____, _____ St.)

File No. 5562

Registered No. 51

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

Robert Linn

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX

male

4. COLOR OR RACE

white

5. SINGLE, MARRIED, WIDOWED OR DIVORCED.

single
(Write the word.)

6. DATE OF BIRTH

_____ 1 _____
(Month) (Day) (Year)

7. AGE

28 yrs. — mos. — ds.

IF LESS than 1 day
how many hrs. or
..... mins.?

8. OCCUPATION

(a) Trade, profession or particular kind of work

Laborer

(b) General nature of industry business, or establishment in which employed (or employer)

9. BIRTHPLACE

(State or Country)

Finland

10. NAME OF FATHER

unknown

11. BIRTHPLACE OF FATHER

(State or Country)

12. MAIDEN NAME OF MOTHER

13. BIRTHPLACE OF MOTHER

(State or Country)

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

(Address)

William Wright & Son

15.

Filed

July 2 1913

H. L. Linn
Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

Jul 1 1913
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from

_____ 191____, to _____ 191____,
that I last saw him alive on _____ 191____,

and that death occurred on the date stated above, at 2 P.M.

The CAUSE OF DEATH* was as follows:

Drowned while
on a raft on north
fork Coeur d'Alene River

(Duration) yrs. mos. ds.

Contributory
(Secondary)

None

(Duration) yrs. mos. ds.

(Signed) H. L. Linn, M.D.

Jul 2 1913 (Address) Wallace Idaho

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death yrs. mos. days. In the State yrs. mos. days.

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

Evansville July 3 1913

20. UNDERTAKER

ADDRESS

Bruce H. Worster Wallace Idaho

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Form V. S. No. 5 20M.1-16-12

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics
File No. **5563**
Registered No. **53**

1. PLACE OF DEATH Registration District No. **10 28**
County of **Shoshone** Primary Registration District No. **1011**
City of **Wallace** (No. **Providence Hospital** St.)
If death occurs away from usual residence, give facts called for under special information. 2. FULL NAME **Alfred Andrieux**

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX **male** 4. COLOR OR RACE **white** 5. SINGLE, MARRIED, WIDOWED OR DIVORCED **divorced**
(Write the word.)

6. DATE OF BIRTH

(Month) (Day) (Year)

7. AGE

55 yrs. mos. ds.

IF LESS than 1 day
how many hrs. or mins.?

8. OCCUPATION

(a) Trade, profession or particular kind of work **miner**
(b) General nature of industry, business, or establishment in which employed (or employer)

9. BIRTHPLACE

(State or Country)

France

10. NAME OF FATHER

Andrieux

11. BIRTHPLACE OF FATHER

(State or Country)

France

12. MAIDEN NAME OF MOTHER

Mathieu

13. BIRTHPLACE OF MOTHER

(State or Country)

France

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

Joseph Huber

(Address)

Wallace (Idaho)

15.

Filed

July 7191**3****H. Leo Simpson**

Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH

July 5 191**3**
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from **April** 191**3** to **July 5** 191**3**
that I last saw him alive on **July 4** 191**3**
and that death occurred on the date stated above, at **89** M.

The CAUSE OF DEATH* was as follows:

Auto intoxication

(Duration) yrs. mos. ds.
Contributory **fracture first lumbar vertebra**
(Secondary)

(Duration) yrs. mos. ds.
(Signed) **H. Leo Simpson, M. D.**

July 6, 1913 (Address) **Wallace**

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death. yrs. mos. days. In the State. yrs. mos. days.

Where was disease contracted if not at place of death?

Former or usual residence **Larson, Idaho**

19. PLACE OF BURIAL OR REMOVAL DATE OF BURIAL

Wallace **July 7** 191**3**

20. UNDERTAKER

H. Thompson **Wallace Id.**

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Form V. S. No. 5 20M.1-16-12

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH.

Registration District No. 28County of ShoshonePrimary Registration District No. 1011-City of Wallace

(No. _____, St.)

File No. 5564Registered No. 53

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Vera Starwood

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX

Female

4. COLOR OR RACE

white

5. SINGLE, MARRIED, WIDOWED OR DIVORCED.

married
(Write the word.)

6. DATE OF BIRTH

(Month)

(Day)

(Year)

7. AGE

22 yrs. — mos. — ds.IF LESS than 1 day
how many hrs. or
..... min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work

Housewife

(b) General nature of industry, business, or establishment in which employed (or employer)

9. BIRTHPLACE

(State or Country)

Montana

10. NAME OF FATHER

Elmer C. Cochran

11. BIRTHPLACE OF FATHER

(State or Country)

Idaho

12. MAIDEN NAME OF MOTHER

Willie Cassel

13. BIRTHPLACE OF MOTHER

(State or Country)

Virginia

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

Willie J. Cochran

(Address)

Mullan Id.

15.

Filed

July 16, 1913

Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH

Jul 14
(Month)14
(Day)1913
(Year)

17. I HEREBY CERTIFY, That I attended deceased from

Jul 10 1913, to Jul 14 1913,
that I last saw him alive on Jul 14 1913.and that death occurred on the date stated above, at 9 P. M.

The CAUSE OF DEATH* was as follows:

Chronic Tuberculosis
Pulmonitis(Duration) 5 yrs. 10 mos. — ds.Contributory
(Secondary)None

(Duration) _____ yrs. _____ mos. — ds.

(Signed)

Dr. Mowery, M. D.

(Address)

Wallace, Ida.

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL OR HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death yrs. mos. days. In the State yrs. mos. days.

Where was disease contracted if not at place of death?

Former or usual residence.

19. PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

MullanJuly 17, 1913

20. UNDERTAKER

ADDRESS

Wards Undertaking Co., Wallace

Form V. S. No. 5 20M.1-16-12

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH.

Registration District No. 28County of ShoshonePrimary Registration District No. 1011File No. 5565City of Wallace

(No. _____, _____ St.)

Registered No. 34

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Hermis Driscoll

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX

4. COLOR OR RACE

5. SINGLE, MARRIED, WIDOWED OR DIVORCED

malewhitesingle
(Write the word.)

6. DATE OF BIRTH

(Month)

(Day)

(Year)

7. AGE

61 yrs. — mos. — ds.IF LESS than 1 day
how many _____ hrs. or
_____ mins.?

8. OCCUPATION

(a) Trade, profession or particular kind of work
(b) General nature of industry business, or establishment in which employed (or employer)engineer

9. BIRTHPLACE

(State or Country)

New York

10. NAME OF FATHER

unknown

11. BIRTHPLACE OF FATHER

(State or Country)

12. MAIDEN NAME OF MOTHER

..

13. BIRTHPLACE OF MOTHER

(State or Country)

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

(Address)

John P. Sheehy
Wallace, Idaho

15.

Filed

July 17, 1913

1913

St. Leo Zumbly
Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH

(Month)

(Day)

1913
(Year)

17. I HEREBY CERTIFY, That I attended deceased from

Jul. 1, 1913, to Jul. 16, 1913,
that I last saw him alive on Jul. 15, 1913and that death occurred on the date stated above, at 5 a.m.

The CAUSE OF DEATH* was as follows:

Carcinoma of liver

(Duration)

several mos.

ds.

Contributory
(Secondary)none

(Duration)

yrs. mos. ds.

(Signed)

Dr. Mowbray
July 16, 1913 (Address) Wallace, Idaho

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death

yrs. mos. days.

In the State

yrs. mos. days.

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

Wallace, IdahoJuly 17, 1913

20. UNDERTAKER

ADDRESS

Ward's Undertaking Co.Wallace

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Form V. S. No. 5 20M.1-16-12

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH

Registration District No. 28County of ShoshonePrimary Registration District No. 1011City of Wallace,(No. 214 High Street, Wallace, St.)File No. 5566Registered No. 53

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Stewart Fuller

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX

male

4. COLOR OR RACE

white

5. SINGLE, MARRIED, WID-
OWED OR DIVORCED.

married

(Write the word.)

6. DATE OF BIRTH

June 9th 1838
(Month) (Day) (Year)

7. AGE

75 yrs. 1 mos. 8 ds.IF LESS than 1 day
how many hrs. or
..... mins.?

8. OCCUPATION

(a) Trade, profession or
particular kind of work

Merchant

(b) General nature of industry
business, or establishment in
which employed (or employer)

9. BIRTHPLACE

(State or Country)

New York

10. NAME OF
FATHER

Eligahlet Fuller

11. BIRTHPLACE
OF FATHER

(State or Country)

New York

12. MAIDEN NAME
OF MOTHER

Louise Williams

13. BIRTHPLACE
OF MOTHER

(State or Country)

New York

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

(Address)

Wallace, Idaho.

15.

Filed

July 18,1913Dr. Leo Dwyer
Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH

7 16 1913
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from

191 to 191that I last saw him alive on July 15th 191and that death occurred on the date stated above, at 9 P.M.

The CAUSE OF DEATH* was as follows:

Carcinoma of the Prostate

(Duration) yrs. mos. ds.

Contributory Advanced age, Hypertension
(Secondary)

(Duration) yrs. mos. ds.

(Signed)

Dr. L. Dwyer

M. D.

7/17 1913 (Address) Wallace, Idaho.

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions,
Transients or Recent Residents.)

At place of death yrs. mos. days. In the State yrs. mos. days.

Where was disease contracted
if not at place of death?Former or
usual residence19. PLACE OF BURIAL OR REMOVAL
Wallace, IdahoDATE OF BURIAL
7/18 1913

20. UNDERTAKER

ADDRESS

Dr. L. DwyerWallace,

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Form V. S. No. 5 20M.1-16-12

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. **PLACE OF DEATH.**

Registration District No. 18

County of Shoshone

Primary Registration District No. 1011

City of Wallace

(No. _____ St.)

If death occurs away from usual residence, give facts called for under special information.

2. **FULL NAME** John Penihan

File No. 5567

Registered No. 56

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. **SEX** Female 4. **COLOR OR RACE** white 5. **SINGLE, MARRIED, WIDOWED OR DIVORCED.** single
(Write the word.)

6. **DATE OF BIRTH**

(Month) (Day) (Year)

7. **AGE** 70 yrs. ____ mos. ____ ds.
IF LESS than 1 day how many ____ hrs. or ____ mins.

8. **OCCUPATION**
(a) Trade, profession or particular kind of work miner
(b) General nature of industry business, or establishment in which employed (or employer)

9. **BIRTHPLACE**
(State or Country) Ireland

10. **NAME OF FATHER** unknown

11. **BIRTHPLACE OF FATHER**
(State or Country)

12. **MAIDEN NAME OF MOTHER**

13. **BIRTHPLACE OF MOTHER**
(State or Country)

14. **THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE**
(Informant) John P. Shoshone
(Address) Wallace Idaho

15. Filed July 17 1913 J. L. Simpson
Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. **DATE OF DEATH**
Jul 14 1913
(Month) (Day) (Year)

17. **I HEREBY CERTIFY**, That I attended deceased from Jul 10 1913 to Jul 14 1913 that I last saw him alive on Jul 14 1913 and that death occurred on the date stated above, at 8 A.M.
The **CAUSE OF DEATH*** was as follows:
Chronic Alcoholism

(Duration) ____ yrs. ____ mos. ____ ds.
Contributory (Secondary) Alcoholism
(Duration) ____ yrs. ____ mos. ____ ds.
(Signed) Dr. M. D. Mowbray
Jul 16 1913 (Address) Wallace, Ida

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. **LENGTH OF RESIDENCE** (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death ____ yrs. ____ mos. ____ days. In the State ____ yrs. ____ mos. ____ days.
Where was disease contracted if not at place of death?
Former or usual residence.

19. **PLACE OF BURIAL OR REMOVAL** Miner **DATE OF BURIAL** July 17 1913

20. **UNDERTAKER** Bruck & Norton **ADDRESS** Wallace

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Form V. S. No. 5 20M.1-16-12

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH

Registration District No. 28

County of *Shoshone*

Primary Registration District No. 1011

City of *Wallace*(No. *Osbourn Idaho* St.)

File No. 5568

Registered No. 57

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

James M. Laren

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX

Male

4. COLOR OR RACE

White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED.

Single
(Write the word.)

6. DATE OF BIRTH

(Month)

(Day)

(Year)

7. AGE

26 yrs. — mos. — ds.IF LESS than 1 day
how many hrs. or
..... mins.?

8. OCCUPATION

(a) Trade, profession or particular kind of work

(b) General nature of industry, business, or establishment in which employed (or employer)

Lineman
Electric Power Service

9. BIRTHPLACE

(State or Country)

Scotland

10. NAME OF FATHER

not known

11. BIRTHPLACE OF FATHER

(State or Country)

"

12. MAIDEN NAME OF MOTHER

"

13. BIRTHPLACE OF MOTHER

(State or Country)

"

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

(Address)

Box 1777 Spokane Id

15.

Filed

July 20

1913

G. Leo Zimdy

Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

July 15th 1913
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from

— 191—, to — 191—,
that I last saw him alive on *Jul 15* 1913and that death occurred on the date stated above, at *3:45 P.M.*

The CAUSE OF DEATH* was as follows:

Electrocuted while working on the power line
(Duration) *inst.* ds.

Contributory (Secondary)

none

(Signed)

*Chas. R. Mowery M.D.*19 (Address) *Wallace, Idaho*

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death yrs. mos. days. In the State yrs. mos. days.

Where was disease contracted if not at place of death?

Former or usual residence.

19. PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

Wallace Idaho July 20 1913

20. UNDERTAKER

ADDRESS

Bruce G. Worsell Wallace Id

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Form V. S. No. 5 20M.1-16-12

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH.

Registration District No. 28County of ShoshonePrimary Registration District No. 1011City of Wallace(No. Hope Hospital St.)File No. 5569Registered No. 58

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Frank Eugene McClellan,

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX

male

4. COLOR OR RACE

white

5. SINGLE, MARRIED, WID-
OWED OR DIVORCED.
married
(Write the word.)

6. DATE OF BIRTH

2 19 1867
(Month) (Day) (Year)

7. AGE

46 yrs. 5 mos. 6 ds.

IF LESS than 1 day
how many hrs. or
..... mins.

8. OCCUPATION

(a) Trade, profession or

particular kind of work Clerk

(b) General nature of industry
business, or establishment in
which employed (or employer)

9. BIRTHPLACE

(State or Country)

Maine

10. NAME OF FATHER

Charles

11. BIRTHPLACE OF FATHER

(State or Country)

Maine

12. MAIDEN NAME OF MOTHER

Elizabeth M. A. Clellan

13. BIRTHPLACE OF MOTHER

(State or Country)

Maine

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Leo A. McClellan(Address) Wallace, Idaho.

15.

Filed July 21, 1913Local Registrar S. R. L. Lough

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH

7 19 1913
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from

April 21 1913, to July 19th 1913

that I last saw him alive on July 19th 1913

and that death occurred on the date stated above, at 11:40 A.M.

The CAUSE OF DEATH* was as follows:

Chronic Pulmonary tuberculosis

(Duration) several yrs. mos. ds.

Contributory
(Secondary)

(Duration) several yrs. mos. ds.

Signed)

7/21 1913 (Address) Wallace, Idaho

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place Hope Hospital In the
of death 7 yrs. 12 mos. 12 days. State yrs. mos. days.

Where was disease contracted
if not at place of death? from travel

Former or
usual residence Wallace, Idaho.

19. PLACE OF BURIAL OR REMOVAL DATE OF BURIAL

Wallace, Idaho 7/21 1913

20. UNDERTAKER

Wm. E. Wautel

ADDRESS
Wallace

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Form V. S. No. 5 20M.1-16-12

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics
File No. 5570

1. PLACE OF DEATH

Registration District No.

County of

Primary Registration District No.

City of

(No.

St.)

Registered No.

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX

4. COLOR OR RACE

5. SINGLE, MARRIED, WIDOWED OR DIVORCED.

6. DATE OF BIRTH

7. AGE

IF LESS than 1 day
how many hrs. or
..... mins.?

8. OCCUPATION

(a) Trade, profession or particular kind of work

(b) General nature of industry business, or establishment in which employed (or employer)

9. BIRTHPLACE

(State or Country)

10. NAME OF FATHER

11. BIRTHPLACE OF FATHER

(State or Country)

12. MAIDEN NAME OF MOTHER

13. BIRTHPLACE OF MOTHER

(State or Country)

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

(Address)

15.

Filed

1913

Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

17. I HEREBY CERTIFY, That I attended deceased from

June 16, 1913 to July 9, 1913

that I last saw him alive on July 9, 1913

and that death occurred on the date stated above, at 2 P.M.

The CAUSE OF DEATH* was as follows:

(Duration) 3 yrs. mos. ds.

Contributory Arteriosclerosis (Secondary)

(Duration) 2 yrs. mos. ds.

(Signed) O. B. Bloom M. D.

7/9 1913 (Address) Eagle

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death yrs. mos. days. In the State yrs. mos. days.

Where was disease contracted if not at place of death?

Former or usual residence Eagle, Idaho.

19. PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

Boise, Harris Hill 7/11 1913

20. UNDERTAKER

ADDRESS

Schreiber & Siderfaden Boise

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Form V. S. No. 5. 10M. 6-20-11.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics
File No. 5571

1. PLACE OF DEATH
County of Minidoka
City of Idaho

Registration District No.
Primary Registration District No.
(No., St.)

Registered No.
If death occurred in a hospital, institution or camp give its NAME instead of street and number.

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

James L Thomas

PERSONAL AND STATISTICAL PARTICULARS

3. SEX 4. COLOR OR RACE 5. SINGLE, MARRIED, WIDOWED OR DIVORCED.

Male White Married

6. DATE OF BIRTH

June 2 1894
(Month) (Day) (Year)

7. AGE

29 yrs. 2 mos. 10 ds.
IF LESS than 1 day
how many hrs. or
min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work
(b) General nature of industry business or establishment in which employed (or employer)

Farmer

9. BIRTHPLACE
(State or Country)

Missouri

10. NAME OF FATHER

Mat Thomas

11. BIRTHPLACE OF FATHER
(State or Country)

Missouri

12. MAIDEN NAME OF MOTHER

Amanda Johnson

13. BIRTHPLACE OF MOTHER
(State or Country)

Missouri

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Rosa C. Kungesser
(Address) Minidoka Idaho

15.

Filed Aug 14 1913 Ch Scott
Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

Aug 13 1913
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from 191 to 191
no Physician called
that I last saw h. alive on 191

and that death occurred on the date stated above, at M.

The CAUSE OF DEATH* was as follows:

Heart failure from
lung tuberculosis

(Duration) 6 yrs. mos. ds.

Contributory
(Secondary)

(Duration) yrs. mos. ds.

(Signed) Ch Scott M. D.
Aug 14 1913 (Address) Rupert Idaho

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death yrs. mos. ds. State yrs. mos. ds.
Where was disease contracted.
If not at place of death?
Former or usual residence.

19. PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

Cebu Missouri 1913

20. UNDERTAKER

ADDRESS

W. A. Goodman Rupert Idaho

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Form V. S. No. 5. 10M. 6-20-11.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics
File No. 5572

1. PLACE OF DEATH. Registration District No. _____
County of Shoshone Primary Registration District No. _____
City of Rupert (No. _____ St.)

Registered No. _____

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

Peter F Swarngen

If death occurred in a hospital, institution or camp give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX 4. COLOR OR RACE 5. SINGLE, MARRIED, WIDOWED OR DIVORCED.

MaleWhiteMarried

6. DATE OF BIRTH

Jan251884

(Month)

(Day)

(Year)

7. AGE

29 yrs.6 mos.7 ds.

IF LESS than 1 day
how many hrs. or
min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work
(b) General nature of industry business or establishment in which employed (or employer)

Farmer

9. BIRTHPLACE

(State or Country)

Missouri

10. NAME OF FATHER

O. G. Swarngen

11. BIRTHPLACE OF FATHER

(State or Country)

Virginia

12. MAIDEN NAME OF MOTHER

Mary A. Will

13. BIRTHPLACE OF MOTHER

(State or Country)

Missouri

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

John Swarngen

(Address)

Rupert Idaho

15.

Filed

Aug 161913J. H. Scott

Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

Aug21913

(Month)

(Day)

(Year)

17. I HEREBY CERTIFY, That I attended deceased from

Aug 2 - 1913, to Aug 2 - 1913that I last saw him alive on Aug 2 - 1913and that death occurred on the date stated above, at 7:30 p.m.

The CAUSE OF DEATH* was as follows:

Rheumatism of Heart

(Duration) yrs. mos. ds.

Contributory (Secondary)

(Duration) yrs. mos. ds.

(Signed) J. H. Scott M. D.Aug 14 1913 (Address)

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted,

If not at place of death?

Former or

usual residence.

19. PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

Pomona MoAug 7 - 1913

20. UNDERTAKER

ADDRESS

W. G. GoodmanRupert

MARGIN RESERVED FOR BINDING
WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Form V. S. No. 5. 10M. 6-20-11.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics
File No. 5573

1. PLACE OF DEATH. Registration District No. _____
County of Blaine Primary Registration District No. _____
City of Rupert (No. _____, St.) _____

Registered No. _____
If death occurred in a hospital, institution or camp give its NAME instead of street and number.

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Elta M Bond

PERSONAL AND STATISTICAL PARTICULARS

3. SEX Female 4. COLOR OR RACE White 5. SINGLE, MARRIED, WIDOWED OR DIVORCED. Married

6. DATE OF BIRTH July 16 1861
(Month) (Day) (Year)

7. AGE 52 yrs. 28 mos. days ds. IF LESS than 1 day how many hrs. or min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work House Wife
(b) General nature of industry business or establishment in which employed (or employer)

9. BIRTHPLACE (State or Country) Oregon

10. NAME OF FATHER Hosa Davidson

11. BIRTHPLACE OF FATHER (State or Country) Illinois

12. MAIDEN NAME OF MOTHER Olmyra Cramer

13. BIRTHPLACE OF MOTHER (State or Country) Illinois

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Mrs Olmyra Cramer
(Address) Rupert Idaho

15. Filed Aug 16 1913 J. H. Scott
Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH Aug 14 1913
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from June 1911, to Aug 14 1913,
that I last saw him alive on July 1913,
and that death occurred on the date stated above, at 9 p M.

The CAUSE OF DEATH* was as follows:
Pulmonary Tuberculosis

(Duration) 6 yrs. ? mos. ? ds.

Contributory (Secondary)

(Duration) ? yrs. ? mos. ? ds.

(Signed) J. H. Scott M. D.
Aug 16 1913 (Address) Rupert Idaho

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death. _____ yrs. _____ mos. _____ ds. In the State. _____ yrs. _____ mos. _____ ds.
Where was disease contracted, _____
If not at place of death? _____
Former or usual residence. _____

19. PLACE OF BURIAL OR REMOVAL DATE OF BURIAL
Rupert Cemetery Aug 17 1913

20. UNDERTAKER ADDRESS
W. G. Goodman Rupert

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Form V. S. No. 5. 12½ M. 7-24-11

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics
File No. 5571
Registered No. 1

1. PLACE OF DEATH. Registration District No. 43
County of Owyhee Primary Registration District No. 2120
City of Silver (No. _____ St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

Richard Poelnd

If death occurred in a hospital, institution or camp give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX Male 4. COLOR OR RACE White 5. SINGLE, MARRIED, WIDOWED OR DIVORCED. Single
(Write the word.)

6. DATE OF BIRTH About the year 1831
(Month) (Day) (Year)

7. AGE 82 yrs. — mos. — ds. IF LESS than 1 day how many... hrs. or min?

8. OCCUPATION
(a) Trade, profession or particular kind of work Wood-sawing &c
(b) General nature of industry business or establishment in which employed (or employer) Chicken Business
(Had a chicken farm near Silver City)

9. BIRTHPLACE (State or Country) Michigan, Adrian

10. NAME OF FATHER unknown

11. BIRTHPLACE OF FATHER (State or Country) unknown (Michigan)

12. MAIDEN NAME OF MOTHER unknown

13. BIRTHPLACE OF MOTHER (State or Country) unknown (Michigan?)

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) E. C. Adams
(Address) Silver City Idaho

15. Filed August 4 1913 W. H. Schuyler, M.D.
Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH August 1 1913
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from August 1 1913, to August 1 1913 that I last saw him alive on August 1 1913 and that death occurred on the date stated above, at 10 P. M.

The CAUSE OF DEATH* was as follows:

Apoplexy (death followed in a few minutes after rupture of cerebral vessels). In apparent good health prior to attack. (Duration) — yrs. — mos. — ds.

Contributory none unless old age (Secondary)
(Duration) — yrs. — mos. — ds.

(Signed) W. H. Schuyler, M. D.
Aug. 2 1913 (Address) Silver City, Idaho

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place In the
of death... yrs... mos... ds. State... yrs... mos... ds.
Where was disease contracted,
If not at place of death?
Former or usual residence.

19. PLACE OF BURIAL OR REMOVAL DATE OF BURIAL
By Mt P. Cemetery Aug 3rd 1913

20. UNDERTAKER ADDRESS
John Grete Silver City

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Form V. S. No. 5 20M.1-16-12

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH.

Registration District No. 25County of ShoshonePrimary Registration District No. 2105City of Kellogg(No. St.)File No. 5575Registered No.

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

Sarah Alice Holmes

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX

F.

4. COLOR OR RACE

White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED

widowed
(Write the word)

6. DATE OF BIRTH

Nov.
(Month)14
(Day)1849
(Year)

7. AGE

73 yrs. 7 mos. 29 ds.

IF LESS than 1 day
how many hrs. or
..... mins.?

8. OCCUPATION

(a) Trade, profession or particular kind of work

Housewife

(b) General nature of industry business, or establishment in which employed (or employer)

9. BIRTHPLACE

(State or Country)

Wisconsin

10. NAME OF FATHER

Samuel Richardson

11. BIRTHPLACE OF FATHER

(State or Country)

Scotland

12. MAIDEN NAME OF MOTHER

Lucy Hart

13. BIRTHPLACE OF MOTHER

(State or Country)

England

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

Mrs. D. J. McNally

(Address)

15.

Filed

July 161913D. Charles L. Pittman
Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH

July
(Month)13
(Day)1913
(Year)

17. I HEREBY CERTIFY, That I attended deceased from

7/6th 1913 to 7/13th 1913that I last saw him alive on 7/13th 1913and that death occurred on the date stated above, at 12 A. M.

The CAUSE OF DEATH* was as follows:

Apoplexy

(Duration) yrs. mos. ds.

Contributory

(Secondary)

(Duration) yrs. mos. ds.

(Signed)

J. R. Mason M. D.

19

(Address)

Kellogg Idaho

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death

..... yrs. mos. days.

In the

State yrs. mos. days.

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL

Kellogg Idaho
E. B. Thornhill

DATE OF BURIAL

July 15 1913

20. UNDERTAKER

ADDRESS

Kellogg

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Form V. S. No. 5 20M.1-16-12

CERTIFICATE OF DEATH

 State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH.

Registration District No. 25County of ShoshonePrimary Registration District No. 2105City of Kellogg(No. 2105)

St.)

Registered No. _____

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Josephine Veduck

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX ♀4. COLOR OR RACE White5. SINGLE, MARRIED, WIDOWED OR DIVORCED. Single

(Write the word.)

6. DATE OF BIRTH June 16 1913

(Month)

(Day)

(Year)

7. AGE _____

yrs. 16 mos. _____ ds.
 IF LESS than 1 day
how many hrs. or
..... mins.?

8. OCCUPATION

(a) Trade, profession or particular kind of work _____

(b) General nature of industry, business, or establishment in which employed (or employer) _____

9. BIRTHPLACE Idaho

(State or Country)

10. NAME OF FATHER John Veduck11. BIRTHPLACE OF FATHER Austria

(State or Country)

12. MAIDEN NAME OF MOTHER Josephine Glass13. BIRTHPLACE OF MOTHER Austria

(State or Country)

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) John Vidrick

(Address) _____

15. _____

Filed July 7 1913 D. A. L. Dittus

Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH July 2 1913

(Month)

(Day)

(Year)

17. I HEREBY CERTIFY, That I attended deceased from _____

1913, to _____1913,

that I last saw h. _____ alive on _____

1913,

and that death occurred on the date stated above, at _____ M.

The CAUSE OF DEATH* was as follows:

No Doctor

(Duration) _____ yrs. _____ mos. _____ ds.

Contributory _____

(Secondary) _____

(Duration) _____ yrs. _____ mos. _____ ds.

(Signed) _____

M. D.

19 _____ (Address) _____

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death _____ yrs. _____ mos. _____ days. In the State _____ yrs. _____ mos. _____ days.

Where was disease contracted if not at place of death? _____

Former or usual residence _____

19. PLACE OF BURIAL OR REMOVAL Greenwood-KelloggDATE OF BURIAL July 4 191320. UNDERTAKER E. B. ShunkieADDRESS Kellogg, Idaho

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Form V. S. No. 5. 12½ M. 7-24-11

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH.
County of Cassia
City of Burley

Registration District No.
Primary Registration District No.
(No., St.)

File No. 5577
Registered No.

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Archie Estelle Webb

If death occurred in a hospital, institution or camp give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX Female 4. COLOR OR RACE white 5. SINGLE, MARRIED, WIDOWED OR DIVORCED. Single

6. DATE OF BIRTH April 26 1890
(Month) (Day) (Year)

7. AGE 23 yrs. 2 mos. 21 ds.
IF LESS than 1 day how many hrs. or min?

8. OCCUPATION
(a) Trade, profession or particular kind of work. At home
(b) General nature of industry business or establishment in which employed (or employer)

9. BIRTHPLACE
(State or Country) Tennessee

10. NAME OF FATHER J. T. Webb

11. BIRTHPLACE OF FATHER
(State or Country) Tennessee

12. MAIDEN NAME OF MOTHER Ardella Bartlett

13. BIRTHPLACE OF MOTHER
(State or Country) Tennessee

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) J. T. Webb
(Address) Burley Idaho

15. Filed 191

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH July 17 1913
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from July 17 1913, to July 17 1913 that I last saw her alive on July 17 1913 and that death occurred on the date stated above, at 7 A.M.

The CAUSE OF DEATH* was as follows:
Chronic Intestinal & Hepatitis

(Duration) Unknown mos. ds.
Contributory Chronic Poisoning
(Secondary)
(Duration) yrs. mos. 6 hrs. ds.
(Signed) J. C. Patterson M. D.
July 15 1913 (Address) Burley Ida.

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place In the
of death yrs. mos. ds. State yrs. mos. ds.
Where was disease contracted,
If not at place of death?
Former or
usual residence.....

19. PLACE OF BURIAL OR REMOVAL Burley Ida. DATE OF BURIAL July 18 1913

20. UNDERTAKER J. B. Gallagher ADDRESS Burley Ida.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Form V. S. No. 5. 10M. 6-20-11.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH. Registration District No. _____
County of Canyon Primary Registration District No. _____
City of Mayfa (No. _____) Registered No. _____
If death occurs away from usual residence, give facts called for under special information. 2. FULL NAME Lela May Maxwell (If death occurred in a hospital, institution or camp give its NAME instead of street and number.)

PERSONAL AND STATISTICAL PARTICULARS

3. SEX Female 4. COLOR OR RACE white 5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.)
6. DATE OF BIRTH Aug 2 1913
(Month) (Day) (Year)

7. AGE _____ yrs. _____ mos. 4 ds. IF LESS than 1 day how many _____ hrs. or _____ min.?

8. OCCUPATION

- (a) Trade, profession, or particular kind of work
(b) General nature of industry, business, or establishment in which employed (or employer)

None

9. BIRTHPLACE

(State or Country)

Idaho

10. NAME OF FATHER

T. R. Maxwell

11. BIRTHPLACE OF FATHER

(State or Country)

N. C.

12. MAIDEN NAME OF MOTHER

Gladys Freeman

13. BIRTHPLACE OF MOTHER

(State or Country)

Montana

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

(Address)

T. R. Maxwell

Mayfa Idaho

15.

Filed

Aug 7 1913

P. D. Calonge

Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

Aug 6 1913
(Month) (Day) (Year)

17. I HEREBY CERTIFY, that I attended deceased from Birth 8/2 1913, to Death 8/6 1913.

that I last saw her alive on Aug 5 1913,

and that death occurred on the date stated above, at 7:30 AM.

The CAUSE OF DEATH* was as follows:

Meningioma due to Bifid Spine ruptured spontaneously

(Duration) ✓ yrs. ✓ mos. 4 ds.

Contributory (Secondary)

(Duration) ✓ yrs. ✓ mos. ✓ ds.

(Signed)

P. D. Calonge

M. D.

Aug 7 1913 (Address) Mayfa Idaho

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place ✓ yrs. ✓ mos. ✓ ds. In the ✓ State ✓ yrs. ✓ mos. ✓ ds.

Where was Disease contracted,

If not at place of death?

Former or

usual residence.

19. PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

Shohlerlawn Cem

Aug 7 1913

20. UNDERTAKER

ADDRESS

F. H. Robinson

Mayfa Idaho

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Form V. S. No. 5. 12½ M. 7-24-11

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics
File No. 5579
Registered No.

1. PLACE OF DEATH. Registration District No.
County of Latah Primary Registration District No. 2127
City of Julietta (No. St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Edwin David Gummalt

If death occurred in a hospital, institution or camp give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX 4. COLOR OR RACE 5. SINGLE, MARRIED, WIDOWED OR DIVORCED.
male white married.
(Write the word.)

6. DATE OF BIRTH June 21 1869.
(Month) (Day) (Year)

7. AGE 43 yrs. 11 mos. 24 ds. IF LESS than 1 day how many hrs. or min?

8. OCCUPATION Farmer
(a) Trade, profession or particular kind of work.
(b) General nature of industry business or establishment in which employed (or employer)

9. BIRTHPLACE Oregon
(State or Country)

10. NAME OF FATHER

11. BIRTHPLACE OF FATHER Missouri
(State or Country)

12. MAIDEN NAME OF MOTHER

13. BIRTHPLACE OF MOTHER Ills.
(State or Country)

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)
(Address)

15. Filed June 15 1913 S. A. Roe Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH June 15 1913.
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from 191 to 191

that I last saw him alive on 191

and that death occurred on the date stated above, at M.

The CAUSE OF DEATH* was as follows:

Probably Heart Disease.
Died without medical attendance

(Duration) yrs. mos. ds.

Contributory (Secondary)

(Duration) yrs. mos. ds.

(Signed) S. A. Roe M. D.

June 15 1913 (Address) Julietta, Ida.

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place In the
of death yrs. mos. ds. State yrs. mos. ds.

Where was disease contracted,

If not at place of death?

Former or usual residence.

19. PLACE OF BURIAL OR REMOVAL DATE OF BURIAL

Moscow, Ida. 191

20. UNDERTAKER ADDRESS

J. C. Grosechase Julietta, Ida.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Form V. S. No. 5. 12½ M. 7-24-11

CERTIFICATE

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics
File No. 5580

1. PLACE OF DEATH. Registration District No.
County of Primary Registration District No.
City of (No., St.)

Registered No.

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

Francis Joseph Fox

If death occurred in a hospital, institution or camp give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX *m* 4. COLOR OR RACE *w* 5. SINGLE, MARRIED, WIDOWED OR DIVORCED. *married*
(Write the word.)

6. DATE OF BIRTH *February 4 1886*
(Month) (Day) (Year)

7. AGE *77 yrs. 5 mos. 13 ds.* IF LESS than 1 day how many hrs. or min?

8. OCCUPATION

(a) Trade, profession or particular kind of work.
(b) General nature of industry, business or establishment in which employed (or employer).

farming

9. BIRTHPLACE

(State or Country)

Germany

10. NAME OF FATHER

Joseph Fox

11. BIRTHPLACE OF FATHER

(State or Country)

Germany

12. MAIDEN NAME OF MOTHER

Don't know

13. BIRTHPLACE OF MOTHER

(State or Country)

Germany

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

(Address)

J. J. Fox

15.

Filed

7/18

1913

S. A. Roe

Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH

July 17 1913
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from

191....., to..... 191.....

that I last saw h..... alive on..... 191.....

and that death occurred on the date stated above, at..... M.

The CAUSE OF DEATH* was as follows:

Died suddenly without the attendance of physician

..... (Duration) yrs. mos. ds.

Contributory
(Secondary)

..... (Duration) yrs. mos. ds.

(Signed) *S. A. Roe* M. D.

..... 19..... (Address)

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place In the
of death yrs. mos. ds. State yrs. mos. ds.

Where was disease contracted,

If not at place of death?

Former or

usual residence.

19. PLACE OF BURIAL OR REMOVAL DATE OF BURIAL

Julietta, Ida, 191.....

20. UNDERTAKER

ADDRESS

J. B. Cronston

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Form V. S. No. 5. 10M. 6-20-11.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH.

Registration District No. 71County of BlainePrimary Registration District No. 7022City of Belleme

(No. _____ St.)

File No. 5581Registered No. 29

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

Mary E. Mc Atee

If death occurred in a hospital, institution or camp give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX

Female

4. COLOR OR RACE

White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED.

Married
(Write the word.)

6. DATE OF BIRTH

June
(Month)16
(Day)1846
(Year)

7. AGE

67 yrs.17 mos.ds.IF LESS than 1 day
how many _____ hrs. or
_____ min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work

Housewife

(b) General nature of industry business or establishment in which employed (or employer)

9. BIRTHPLACE

(State or Country)

Kentucky

10. NAME OF FATHER

11. BIRTHPLACE OF FATHER

(State or Country)

12. MAIDEN NAME OF MOTHER

13. BIRTHPLACE OF MOTHER

(State or Country)

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

J. C. Noel

(Address)

Belleme

15.

Filed

July 15 1913Robert W. Wright
Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

July
(Month)3
(Day)1913
(Year)

17. I HEREBY CERTIFY, That I attended deceased from

June 28 1913, to July 5 1913that I last saw her alive on July 3 1913,and that death occurred on the date stated above, at 3 P. M.

The CAUSE OF DEATH* was as follows:

Serious Illness(Duration) _____ yrs. _____ mos. 12 ds.Contributory
(Secondary)

(Duration) _____ yrs. _____ mos. _____ ds.

(Signed)

John T. Harris

M. D.

July 5 1913(Address) Belleme

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death _____ yrs. _____ mos. _____ ds. State _____ yrs. _____ mos. _____ ds.

Where was disease contracted,

If not at place of death? _____

Former or

usual residence _____

19. PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

Belleme IdaJuly 5 1913

20. UNDERTAKER

ADDRESS

W. HarrisBelleme

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Form V. S. No. 5. 10M. 6-20-11.

CERTIFICATE OF DEATH

1. PLACE OF DEATH.

County of BlaineCity of Arco

If death occurs away from usual residence, give facts called for under special information.

Registration District No. 21Primary Registration District No. 2024

(No. _____ St.)

Bureau of Vital Statistics

File No. 5582Registered No. 30

If death occurred in a hospital, institution or camp give its NAME instead of street and number.

2. FULL NAME

Phyllis Vernon Watterlin

PERSONAL AND STATISTICAL PARTICULARS

3. SEX

F

4. COLOR OR RACE

W.

5. SINGLE, MARRIED, WIDOWED OR DIVORCED.

single
(Write the word.)

6. DATE OF BIRTH

May 23 1901
(Month) (Day) (Year)

7. AGE

12 yrs. 1 mos. 12 ds.
IF LESS than 1 day
how many hrs. or
..... min.?

8. OCCUPATION

- (a) Trade, profession or particular kind of work
(b) General nature of industry business or establishment in which employed (or employer)

School girl

9. BIRTHPLACE

(State or Country)

Utah

10. NAME OF FATHER

Fred Watterlin

11. BIRTHPLACE OF FATHER

(State or Country)

Utah

12. MAIDEN NAME OF MOTHER

Hilda Lemander

13. BIRTHPLACE OF MOTHER

(State or Country)

Germany

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Fred Watterlin(Address) Arco, Ida.

15.

Filed July 15 1913Robert H. Knight
Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

July 3 1913
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from

June 23 1913, to July 3 1913that I last saw h. alive on July 3 1913and that death occurred on the date stated above, at 3 P. M.

The CAUSE OF DEATH* was as follows:

Septic Peritonitis following perforating appendicitis.
Operation on June 24 -
(Duration) yrs. mos. 12 ds.Contributory
(Secondary)

(Duration) yrs. mos. ds.

(Signed) D. W. Mathaei M. D.July 3 1913 (Address) Arco Ida.

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death yrs. mos. ds. State yrs. mos. ds.

Where was disease contracted,

If not at place of death?

Former or

usual residence.

19. PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

Arco, Ida. July 5 1913

20. UNDERTAKER

ADDRESS

Arco, Ida. Mrs. Oliver

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
N. B.—Every item of information should be carefully supplied. AGE should be state EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Form V. S. No. 5. 10M. 6-20-11.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics
File No. 5583
Registered No. 31

1. PLACE OF DEATH.

Registration District No. 71County of BlainePrimary Registration District No. 7022City of Hailey

(No. _____, St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

George Warnicke

If death occurred in a hospital, institution or camp give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX

Male

4. COLOR OR RACE

Wht

5. SINGLE, MARRIED, WIDOWED OR DIVORCED.

(Write the word.)

6. DATE OF BIRTH

Rep- 11 1906
(Month) (Day) (Year)

7. AGE

6-yrs. 10 mos. 16 ds.

IF LESS than 1 day
how many _____ hrs. or
_____ min.

8. OCCUPATION

(a) Trade, profession or

particular kind of work

(b) General nature of industry

business or establishment in

which employed (or employer)

9. BIRTHPLACE

(State or Country)

Hailey

10. NAME OF FATHER

John Henry Warnicke

11. BIRTHPLACE OF FATHER

(State or Country)

Germany -

12. MAIDEN NAME OF MOTHER

Nellie Cooper

13. BIRTHPLACE OF MOTHER

(State or Country)

Missouri

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

John H. Warnicke

(Address)

Muldoon Ida

15.

Filed

Aug 1 1913Robert H. Wright

Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

July 28 1913
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from

191____, to 191____

that I last saw h_____ alive on 191____,

and that death occurred on the date stated above, at 1 a-M.

The CAUSE OF DEATH* was as follows:

Accident -

(Duration) _____ yrs. _____ mos. _____ ds.

Contributory
(Secondary)

(Duration) _____ yrs. _____ mos. _____ ds.

(Signed) Robert H. Wright M. D.19 _____ (Address) Hailey Ida

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place _____ In the
of death _____ yrs. _____ mos. _____ ds. State _____ yrs. _____ mos. _____ ds.

Where was disease contracted.

If not at place of death?

Former or

usual residence.

19. PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

Hailey IdaJuly 3 1913

20. UNDERTAKER

ADDRESS

R. D. HarrisHailey

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. N. B.—Every item of information should be carefully supplied. AGE should be state EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Form V. S. No. 5. 10M. 6-20-11.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH.

Registration District No. 71

County of Blaine

Primary Registration District No. 7022

City of Hailey

(No. _____)

St.)

File No. 5581

Registered No. 32

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

James McIntosh

If death occurred in a hospital, institution or camp give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX

Male

4. COLOR OR RACE 5. SINGLE, MARRIED, WIDOWED OR DIVORCED.

White

Single
(Write the word.)

6. DATE OF BIRTH

(Month)

(Day)

(Year)

7. AGE

65

yrs.

mos.

ds.

IF LESS than 1 day
how many hrs. or
min.

8. OCCUPATION

(a) Trade, profession or
particular kind of work

Miner

(b) General nature of industry
business or establishment in
which employed (or employer)

9. BIRTHPLACE

(State or Country)

Canada

10. NAME OF
FATHER

Dougal Mc Intosh

11. BIRTHPLACE
OF FATHER

(State or Country)

12. MAIDEN NAME
OF MOTHER13. BIRTHPLACE
OF MOTHER

(State or Country)

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

Robert Mc Donald

(Address)

Hailey, Idaho

15.

Filed

191

Robert H. Wright
Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

July

(Month)

18

(Day)

1913

(Year)

17. I HEREBY CERTIFY, That I attended deceased from

July 10th 1913, to July 18th 1913that I last saw him alive on July 18th 1913,

and that death occurred on the date stated above, at 6 P. M.

The CAUSE OF DEATH* was as follows:

Cerebral Fever

(Duration) 21 yrs. mos. ds.

Contributory
(Secondary)

Starvation

(Duration) yrs. mos. ds.

(Signed) J. H. H. H. H. H. M. D.

July 18, 1913 (Address) Hailey, Idaho

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death yrs. mos. ds. State yrs. mos. ds.

Where was disease contracted,

If not at place of death?

Former or

usual residence

19. PLACE OF BURIAL OR REMOVAL

Hailey Ida

DATE OF BURIAL

July 20 1913

20. UNDERTAKER

R. D. Harris

ADDRESS

Hailey Ida

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. N. B.—Every item of information should be carefully supplied. AGE should be state EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Form V. S. No. 5. 10M. 6-20-11.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics
File No. 5585
Registered No. 33

1. PLACE OF DEATH.

Registration District No. 21

County of Blaine

Primary Registration District No. 7022

City of

(No. St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

Thomas Christopher Doer

If death occurred in a hospital, institution or camp give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX

Male

4. COLOR OR RACE

White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED.

(Write the word.)

Married

6. DATE OF BIRTH

March 10

(Month)

(Day)

1862 (Year)

7. AGE

51

yrs.

4

mos.

ds.

IF LESS than 1 day
how many hrs. or
min.

8. OCCUPATION

(a) Trade, profession or particular kind of work

Farmer

(b) General nature of industry business or establishment in which employed (or employer)

9. BIRTHPLACE

(State or Country)

Ireland

10. NAME OF FATHER

John Doer

11. BIRTHPLACE OF FATHER

(State or Country)

Ireland

12. MAIDEN NAME OF MOTHER

Catherine York

13. BIRTHPLACE OF MOTHER

(State or Country)

Ireland

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

Mrs Deack

(Address)

Stanton, Idaho

15.

Filed

191

Robert L. Wright

Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

July

(Month)

10

(Day)

1913 (Year)

17. I HEREBY CERTIFY, That I attended deceased from

July 9 1913, to July 10 1913

that I last saw him alive on July 10 1913,

and that death occurred on the date stated above, at 6:30 A.M.

The CAUSE OF DEATH* was as follows:

Acute Peritonitis

(Duration) yrs. mos. ds.

Contributory (Secondary)

Men of bowel

(Duration) yrs. mos. ds.

(Signed) J. J. Daal M. D.

July 11 1913 (Address) Hailey

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and 2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death yrs. mos. ds. State yrs. mos. ds.

Where was disease contracted.

If not at place of death?

Former or usual residence.

19. PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

Bellevue

July 12 1913

20. UNDERTAKER

R. D. Harris

ADDRESS

Hailey

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Form V. S. No. 5 20M.1-16-12

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH.

Registration District No. 44

County of Owyhee

Primary Registration District No. 2121

City of Hot Spring

(No. _____ St.)

File No. 5586

Registered No. 2

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Julian Corta

If death occurred in a hospital, institution or camp, give its name instead of street and number

PERSONAL AND STATISTICAL PARTICULARS

3. SEX

Male

4. COLOR OR RACE

Spanish

5. SINGLE, MARRIED, WIDOWED OR DIVORCED.

Single (Write the word.)

6. DATE OF BIRTH

March 19 1913
(Month) (Day) (Year)

7. AGE

0 yrs. 3 mos. 15 ds.

IF LESS than 1 day
how many _____ hrs. or
_____ mins.?

8. OCCUPATION

(a) Trade, profession or particular kind of work
(b) General nature of industry, business, or establishment in which employed (or employer)

9. BIRTHPLACE

(State or Country)

Hot Spring Idaho

10. NAME OF FATHER

Joe Corta

11. BIRTHPLACE OF FATHER

(State or Country)

Spain

12. MAIDEN NAME OF MOTHER

Don't know in English

13. BIRTHPLACE OF MOTHER

(State or Country)

Spain

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

(Address)

J. Corta
Hot Spring Idaho

15.

Filed

July 10 1913

J. C. Bartlett
Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH

July 4th 1913
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased

1913, to June 26 1913

that I last saw him alive on June 26 1913

and that death occurred on the date stated above, at 8 P. M.

The CAUSE OF DEATH* was as follows:

Branchopneumonia

(Duration) ✓ yrs. ✓ mos. 4

Contributory
(Secondary)

(Duration) _____ yrs. _____ mos.

(Signed)

July 1913 (Address) Peru Idaho

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death _____ yrs. _____ mos. _____ days. In the State _____ yrs. _____ mos. _____ days.

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

Hot Spring Cemetery

July 5 1913

20. UNDERTAKER

ADDRESS

None

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Form V. S. No. 5 20M.1-16-12

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH. Registration District No. 44
County of Owyhee Primary Registration District No. 2121
City of Bruneau (No. _____ St.)

File No. 5587
Registered No. 1

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Lillie Jones

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX Female 4. COLOR OR RACE White 5. SINGLE, MARRIED, WIDOWED OR DIVORCED. Single
(Write the word.)

6. DATE OF BIRTH March 20 1913
(Month) (Day) (Year)

7. AGE 0 yrs. 3 mos. 11 ds.
IF LESS than 1 day how many hrs. or mins.?

8. OCCUPATION
(a) Trade, profession or particular kind of work
(b) General nature of industry business, or establishment in which employed (or employer)

9. BIRTHPLACE Idaho
(State or Country)

10. NAME OF FATHER C. H. Jones

11. BIRTHPLACE OF FATHER Texas
(State or Country)

12. MAIDEN NAME OF MOTHER Nettie M. Mahan

13. BIRTHPLACE OF MOTHER Oregon
(State or Country)

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) J. C. Bartlett
(Address) Bruneau

15. Filed July 1 1913 J. C. Bartlett
Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH July 1st 1913
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from July 1 1913 to July 1 1913
that I last saw her alive on June 25 1913
and that death occurred on the date stated above, at 59 M.
The CAUSE OF DEATH* was as follows:

Secondary Pneumonia

(Duration) yrs. mos. ds.
Contributory Insufficient nutriment
(Secondary)

(Duration) yrs. mos. ds.
(Signed) J. C. Bartlett M. D.
71 1913 (Address) Bruneau

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death. yrs. mos. days. In the State. yrs. mos. days.

Where was disease contracted if not at place of death?
Former or usual residence.

19. PLACE OF BURIAL OR REMOVAL Bruneau Cemetery DATE OF BURIAL July 2 1913
20. UNDERTAKER None ADDRESS _____

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Form V. S. No. 5. 12½ M. 7-24-11

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH. Registration District No. 48
County of Idaho Primary Registration District No. 2128
City of Hammanah (No. _____ St.)

File No. 5-5588
Registered No. 5

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Leta Elders

If death occurred in a hospital, institution or camp give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX female 4. COLOR OR RACE white 5. SINGLE, MARRIED, WIDOWED OR DIVORCED. married
(Write the word.)
6. DATE OF BIRTH Sept-17 1883
(Month) (Day) (Year)

7. AGE 29 yrs. 10 mos. 23 ds. IF LESS than 1 day how many _____ hrs. or _____ min?

8. OCCUPATION
(a) Trade, profession or particular kind of work Housekeeper
(b) General nature of industry business or establishment in which employed (or employer)

9. BIRTHPLACE Kentucky
(State or Country)

10. NAME OF FATHER John M. Guire

11. BIRTHPLACE OF FATHER Don't know
(State or Country)

12. MAIDEN NAME OF MOTHER Jessie Hatten

13. BIRTHPLACE OF MOTHER Kentucky
(State or Country)

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Eugene Elders
(Address) Hammanah Idaho

15. Filed Aug 2 1913 E Taylor MD
Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH July 27 1913
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from July 20 1913, to July 27 1913
that I last saw her alive on July 27 1913
and that death occurred on the date stated above, at 5 P.M.
The CAUSE OF DEATH* was as follows:

Blood Poison

(Duration) _____ yrs. _____ mos. 19 ds.
Contributory Salivation
(Secondary)

(Duration) _____ yrs. _____ mos. 19 ds.
(Signed) E Taylor M. D.
July 20 1913. (Address) Kamiah

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place _____ In the _____
of death _____ yrs. _____ mos. _____ ds. State _____ yrs. _____ mos. _____ ds.
Where was disease contracted, _____
If not at place of death? _____
Former or _____
usual residence. _____

19. PLACE OF BURIAL OR REMOVAL 100 ft cemetery DATE OF BURIAL July 29 1913
20. UNDERTAKER E Johnson ADDRESS Kamiah

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Form V. S. No. 5. 12½ M. 7-24-11

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics
File No. 5589
Registered No. 4

1. PLACE OF DEATH. Registration District No. 49
County of Lewiston Primary Registration District No. 2128
City of Hammar (No. _____, _____ St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

Reginald

Johnson

If death occurred in a hospital, institution or camp give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX male 4. COLOR OR RACE Indian 5. SINGLE, MARRIED, WIDOWED OR DIVORCED. single
(Write the words)

6. DATE OF BIRTH July 8 1913
(Month) (Day) (Year)

7. AGE 8 yrs. 8 mos. 8 ds.
IF LESS than 1 day how many _____ hrs. or _____ min?

8. OCCUPATION

(a) Trade, profession or particular kind of work
(b) General nature of industry business or establishment in which employed (or employer)

9. BIRTHPLACE (State or Country) Hammar Idaho

10. NAME OF FATHER Robert Johnson

11. BIRTHPLACE OF FATHER (State or Country) Idaho

12. MAIDEN NAME OF MOTHER Rosa Tenley

13. BIRTHPLACE OF MOTHER (State or Country) Idaho

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Rosa Johnson
(Address) Hammar Idaho

15. Filed July 23 1913 W. Taylor M.D.
Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH 7 / 15 1913
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from July 8th 1913, to July 15th 1913
that I last saw him alive on 7/15th 1913
and that death occurred on the date stated above, at 7:30 M.

The CAUSE OF DEATH* was as follows:

Capillary Bronchitis

(Duration) _____ yrs. _____ mos. 8 days ds.

Contributory (Secondary)

(Duration) _____ yrs. _____ mos. _____ ds.

(Signed) W. T. Taylor M. D.
7/16 1913 (Address) Hammar Idaho

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place In the
of death _____ yrs. _____ mos. _____ ds. State _____ yrs. _____ mos. _____ ds.
Where was disease contracted,
If not at place of death?
Former or
usual residence _____

19. PLACE OF BURIAL OR REMOVAL DATE OF BURIAL

Family Plot Hammar July 16 1913

20. UNDERTAKER ADDRESS
W. Taylor Hammar

Form V. S. No. 5 20M.1-16-12

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH

Registration District No.

2

County of

Ada

Primary Registration District No.

1004

City of

Boise

(No. 824, E. Damrock St.)

File No. 5590

Registered No. 162

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

Joseph Doerr

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX

M

4. COLOR OR RACE

W

5. SINGLE, MARRIED, WIDOWED OR DIVORCED.

Single
(Write the word.)

6. DATE OF BIRTH

July

9

1913

(Month)

(Day)

(Year)

7. AGE

yrs. mos. ds.

IF LESS than 1 day
how many hrs. or mins.?

8. OCCUPATION

(a) Trade, profession or particular kind of work

(b) General nature of industry, business, or establishment in which employed (or employer)

9. BIRTHPLACE

(State or Country)

Boise

10. NAME OF FATHER

John G. Doerr

11. BIRTHPLACE OF FATHER

(State or Country)

Id

12. MAIDEN NAME OF MOTHER

Mary J. Mueller

13. BIRTHPLACE OF MOTHER

(State or Country)

Id

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

John G. Doerr

(Address)

Boise

15.

Filed

7-10

1913

M. Parker

Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH

July

9

1913

(Month)

(Day)

(Year)

17. I HEREBY CERTIFY, That I attended deceased from

July 9 1913, to July 9 1913,

that I last saw him alive on July 9 1913

and that death occurred on the date stated above, at 8 P.M.

The CAUSE OF DEATH* was as follows:

Pneumonia

(Duration) yrs. mos. ds.

Contributory

(Secondary)

(Duration) yrs. mos. ds.

(Signed)

July 9 1913 (Address) Boise

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death yrs. mos. days. In the State yrs. mos. days.

Where was disease contracted if not at place of death?

Former or usual residence.

19. PLACE OF BURIAL OR REMOVAL DATE OF BURIAL

St. John's Cemetery 7/10 1913

20. UNDERTAKER

ADDRESS

Schubert & Sons, Boise

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Form V. S. No. 5 20M.1-16-12

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH

Registration District No. 2

County of Ada

Primary Registration District No. 1004

City of Boise

(No. St. Alphonsus Hospital)

File No. 5591

Registered No. 163

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Hubbard Brown

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX

Male

4. COLOR OR RACE

white american

5. SINGLE, MARRIED, WIDOWED OR DIVORCED.

single
(Write the word.)

6. DATE OF BIRTH

not obtainable

(Month)

(Day)

(Year)

7. AGE

76 yrs. 00 mos. 00 ds.

IF LESS than 1 day
how many hrs. or
..... mins.?

8. OCCUPATION

(a) Trade, profession or particular kind of work

Civil War Veteran

(b) General nature of industry, business, or establishment in which employed (or employer)

9. BIRTHPLACE

(State or Country)

not obtainable

10. NAME OF FATHER

11. BIRTHPLACE OF FATHER

(State or Country)

12. MAIDEN NAME OF MOTHER

13. BIRTHPLACE OF MOTHER

(State or Country)

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) E. G. Burnet

(Address) Soldiers Home

15.

Filed 7-19 1913 M. S. Parker

Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

7 19 1913
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from

July 1912, to July 19 1913

that I last saw him alive on July 18 1913

and that death occurred on the date stated above, at 6 A M.

The CAUSE OF DEATH* was as follows:

Exhaustion

(Duration) 00 mos. 00 ds.

Contributory

(Secondary)

(Duration) 00 yrs. 00 mos. 00 ds.

(Signed) Frederick J. Bladder M. D.

7/9 1913 (Address) Bladder

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death.....yrs.....mos.....days. In the State.....yrs.....mos.....days.

Where was disease contracted if not at place of death?

Former or usual residence Boise Soldiers Home

19. PLACE OF BURIAL OR REMOVAL DATE OF BURIAL

Morris Hill July 20 1913

20. UNDERTAKER

ADDRESS

Fry & Summers Boise

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Form V. S. No. 5 20M.1-16-12

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH.

Registration District No. 2

County of AdaPrimary Registration District No. 1004File No. 5592City of Boise(No. 223 Thatcher St.)Registered No. 164

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

Thomas Henry Manning
If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX

Male

4. COLOR OR RACE

White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED.

Married
(Write the word.)

6. DATE OF BIRTH

Dec 5 1848
(Month) (Day) (Year)

7. AGE

64 yrs. 7 mos. 16 ds.IF LESS than 1 day
how many hrs. or mins.?

8. OCCUPATION

(a) Trade, profession or particular kind of work

(b) General nature of industry, business, or establishment in which employed (or employer)

Assayer

9. BIRTHPLACE

(State or Country)

Quebec, Canada

10. NAME OF FATHER

Henry Manning

11. BIRTHPLACE OF FATHER

(State or Country)

Canada

12. MAIDEN NAME OF MOTHER

Not Obtainable

13. BIRTHPLACE OF MOTHER

(State or Country)

Not Obtainable

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Mr. T. H. Manning(Address) Boise, Idaho.

15.

Filed 7-21 1913 W. B. Parker
Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH

July 21 1913
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from

July 20 1913, to July 20 1913,that I last saw him alive on July 19 1913,and that death occurred on the date stated above, at M.

The CAUSE OF DEATH* was as follows:

Bright's disease

(Duration) yrs. mos. ds.

Contributory

(Secondary)

(Duration) yrs. mos. ds.

(Signed) T. H. Manning M. D.

19 (Address)

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death yrs. mos. days. In the State yrs. mos. days.

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL DATE OF BURIAL

Morris Hill Cemetery 7/22 1913

20. UNDERTAKER

ADDRESS

Schreiber & Vidensky, Boise, Ida

Collister

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Form V. S. No. 5 20M.1-16-12

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH.

Registration District No. 2

County of Ada

Primary Registration District No. 1004

File No. 5593

City of Boise

(No. 112, E. Barnack St.)

Registered No. 165

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

Ruth Margaret Shannon

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX F. 4. COLOR OR RACE W. 5. SINGLE, MARRIED, WIDOWED OR DIVORCED. Single

(Write the word.)

6. DATE OF BIRTH

May 22nd 1908

(Month)

(Day)

(Year)

7. AGE

5 yrs. 1 mos. 29 ds.

IF LESS than 1 day
how many hrs. or
mins.?

8. OCCUPATION

(a) Trade, profession or particular kind of work

none

(b) General nature of industry, business, or establishment in which employed (or employer)

9. BIRTHPLACE

(State or Country)

Ada County Idaho

10. NAME OF FATHER

Jess Shannon

11. BIRTHPLACE OF FATHER

(State or Country)

Kansas

12. MAIDEN NAME OF MOTHER

Leah A. Powell

13. BIRTHPLACE OF MOTHER

(State or Country)

Iowa

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

(Address)

Jess Shannon
Perkins Ida

15.

Filed 7 - 22 1913

M.S. Parker

Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH

July 20th 1913

(Month)

(Day)

(Year)

17. I HEREBY CERTIFY, That I attended deceased from July 19 1913, to July 20 1913, that I last saw her alive on July 20 1913, and that death occurred on the date stated above, at 8 P.M.

The CAUSE OF DEATH* was as follows:

Peritonitis Acute

(Duration) — yrs. — mos. 13 ds.

Contributory
(Secondary)

(Duration) — yrs. — mos. — ds.

(Signed)

W. B. Turkey M. D.

July 21 1913 (Address) Boise Ida

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death 2 yrs. 2 mos. 2 days. In the State 2 yrs. 2 mos. 2 days.

Where was disease contracted if not at place of death?

Former or usual residence

Perkins Idaho

19. PLACE OF BURIAL OR REMOVAL DATE OF BURIAL

Marion Hill Cemetery 7/22 1913

20. UNDERTAKER

ADDRESS

Schreiber & Sidergaden Boise

MARGIN RESERVED FOR BINDING
WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Form V. S. No. 5 20M.1-16-12

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH.

Registration District No. 2

County of Ada

Primary Registration District No. 1004

City of Boise

(No. St. Luke's Hospital, St.)

File No. 5591

Registered No. 166

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

Villa Potest

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX

4. COLOR OR RACE

5. SINGLE, MARRIED, WIDOWED OR DIVORCED.

Female White

Married
(Write the word.)

6. DATE OF BIRTH

June 1 1899
(Month) (Day) (Year)

7. AGE

49 yrs. 1 mos. 20 ds.

IF LESS than 1 day
how many hrs. or
..... mins.

8. OCCUPATION

(a) Trade, profession or particular kind of work

(b) General nature of industry business, or establishment in which employed (or employer)

Housewife

9. BIRTHPLACE

(State or Country) Ohio

10. NAME OF FATHER

Henry Bluebaker

11. BIRTHPLACE OF FATHER

(State or Country) Not obtainable

12. MAIDEN NAME OF MOTHER

Not obtainable

13. BIRTHPLACE OF MOTHER

(State or Country) Not obtainable

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

L. J. Potest

(Address)

Richfield Idaho

15.

Filed

7-24

1913

M. S. Parker

Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH

July 21 1913
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from July 17th 1913, to July 21st 1913, that I last saw her alive on July 21 1913, and that death occurred on the date stated above, at 10 A.M.

The CAUSE OF DEATH* was as follows:

Thrombosis of Superior Mesenteric
Vein following cystitis

(Duration) yrs. mos. ds.

Contributory Interoid time of illness
(Secondary)

(Duration) yrs. mos. ds.

(Signed) Geo. R. Summers M. D.
July 25 1913 (Address) Boise Idaho

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death yrs. mos. days. In the State yrs. mos. days.

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

Morris Hill Cemetery July 21 1913

20. UNDERTAKER

ADDRESS

Geo. Summers Boise Id

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Form V. S. No. 5 20M.1-16-12

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH.

Registration District No. 2

County of Ada

Primary Registration District No. 1004

City of Boise

(No. 1908, N. 14 St.)

File No. 5595

Registered No. 167

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

Rhoda E. Gibson

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX

F

4. COLOR OR RACE

W.

5. SINGLE, MARRIED, WIDOWED OR DIVORCED.

Widow
(Write the word.)

6. DATE OF BIRTH

June 21st 1832
(Month) 27 (Day) 1913 (Year)

7. AGE

81 yrs. 2 mos. 6 ds.

IF LESS than 1 day
how many hrs. or
..... mins.?

8. OCCUPATION

(a) Trade, profession or particular kind of work

(b) General nature of industry business, or establishment in which employed (or employer)

Retired, Invalid

9. BIRTHPLACE

(State or Country)

Tennessee

10. NAME OF FATHER

John Patton

11. BIRTHPLACE OF FATHER

(State or Country)

Alabama

12. MAIDEN NAME OF MOTHER

Rhoda E. Yates

13. BIRTHPLACE OF MOTHER

(State or Country)

Alabama

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

F. D. Wagner

(Address)

Boise, Ida.

15.

Filed 7-27 1913

M. B. Parker
Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH

July 27th 1913
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from

July 28th 1913, to July 27th 1913,

that I last saw him alive on July 26th 1913,

and that death occurred on the date stated above, at M.

The CAUSE OF DEATH* was as follows:

General giving away due to old age.

(Duration) yrs. mos. ds.

Contributory

(Secondary)

(Duration) yrs. mos. ds.

(Signed)

Rollin S. Gregory M. D.

19. (Address) 204 S. Main Block, Boise

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death yrs. mos. days. In the State yrs. mos. days.

Where was disease contracted if not at place of death?

Former or usual residence

Dayton, Wash

19. PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

Dayton, Wash

7/27 1913

20. UNDERTAKER

ADDRESS

Schreiber & Vidinofaden Boise, Ida

Form V. S. No. 5 20M.1-16-12

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH.

Registration District No. 2County of AdaPrimary Registration District No. 1004City of Boise(No. 109 Jefferson St.)File No. 5596Registered No. 168

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Leo Smith late

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX

4. COLOR OR RACE

5. SINGLE, MARRIED, WIDOWED OR DIVORCED.

Female Whitemarried
(Write the word.)

6. DATE OF BIRTH

May 29 1867
(Month) (Day) (Year)

7. AGE

46 yrs. 1 mos. 27 ds.IF LESS than 1 day
how many hrs. or
..... mins.?

8. OCCUPATION

(a) Trade, profession or particular kind of work

(b) General nature of industry, business, or establishment in which employed (or employer)

Housewife

9. BIRTHPLACE

(State or Country)

Kentucky

10. NAME OF FATHER

Joseph M. Smith

11. BIRTHPLACE OF FATHER

(State or Country)

Kentucky

12. MAIDEN NAME OF MOTHER

Miss Ella Davis

13. BIRTHPLACE OF MOTHER

(State or Country)

Missouri

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

E. L. late

(Address)

Boise

15.

Filed 7-27 1913

Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH

7 26 1913
(Month) (Day) (Year)17. I HEREBY CERTIFY, That I attended deceased from about July 10 1913, to July 26 1913, that I last saw her alive on 7-26 1913, and that death occurred on the date stated above, at 4 P. M.

The CAUSE OF DEATH* was as follows:

Surgical prolapse of rectum
perforated by valvula
osteoalony
(Duration) yrs. mos. 3 ds.Contributory
(Secondary)

(Duration) yrs. mos. ds.

(Signed) Stewart & Boray M. D.19. (Address) Boise

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death yrs. mos. days. In the State yrs. mos. days.

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

Morris Hill July 27 1913

20. UNDERTAKER

ADDRESS

Jay & Summers Boise

Form V. S. No. 5 20M.1-16-12

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH.

Registration District No. 7City of AdaPrimary Registration District No. 1004City of Boise(No. 112, E. Bamock St.)File No. 5597Registered No. 169

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

Floyd A. McConnell

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX

Male

4. COLOR OR RACE

White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED.

Single
(Write the word.)

6. DATE OF BIRTH

Sept 29 1893
(Month) (Day) (Year)

7. AGE

19 yrs. 10 mos. 1 ds.IF LESS than 1 day
how many hrs. or
mins.?

8. OCCUPATION

(a) Trade, profession or particular kind of work

Student

(b) General nature of industry business, or establishment in which employed (or employer)

9. BIRTHPLACE

(State or Country)

Ada County Idaho

10. NAME OF FATHER

Elmer A. McConnell

11. BIRTHPLACE OF FATHER

(State or Country)

Wayne Co. Iowa

12. MAIDEN NAME OF MOTHER

Abbie F. Toller

13. BIRTHPLACE OF MOTHER

(State or Country)

Kansas

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

Olin F. McConnell

(Address)

Boise Idaho

15.

Filed

7-22-1913

Local Registrar

Dr. Stewart

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH

July 28 1913
(Month) (Day) (Year)17. I HEREBY CERTIFY, That I attended deceased from July 17 1913 to July 28 1913that I last saw him alive on July 28 1913
and that death occurred on the date stated above, at 8 P. M.

The CAUSE OF DEATH* was as follows:

Tubercular Meningitis

(Duration) yrs. mos. ds.

Contributory
(Secondary)

(Duration) yrs. mos. ds.

(Signed)

7/29/13 (Address) Boise

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death St. Luke's Hospital
In the State Idaho
yrs. mos. days. State yrs. mos. days.

Where was disease contracted if not at place of death?

Former or usual residence Boise Idaho

19. PLACE OF BURIAL OR REMOVAL DATE OF BURIAL

Masonic Cemetery 7/30 1913

20. UNDERTAKER ADDRESS

Schreiber & Sidenfaden Boise, Idaho

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Form V. S. No. 5 20M.1-16-12

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH.

Registration District No. 2

County of Ada

Primary Registration District No. 1004

City of Boise

(No. 622 Front St.)

File No. 5598

Registered No. 170

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Fong Chung

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX M 4. COLOR OR RACE Yellow 5. SINGLE, MARRIED, WIDOWED OR DIVORCED. Single
(Write the word.)

6. DATE OF BIRTH _____
(Month) (Day) (Year)

7. AGE 40 yrs. mos. ds. IF LESS than 1 day how many hrs. or mins.?

8. OCCUPATION
(a) Trade, profession or particular kind of work Cook
(b) General nature of industry, business, or establishment in which employed (or employer)

9. BIRTHPLACE China
(State or Country)

10. NAME OF FATHER

11. BIRTHPLACE OF FATHER China
(State or Country)

12. MAIDEN NAME OF MOTHER

13. BIRTHPLACE OF MOTHER China
(State or Country)

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Fong Gee
(Address) Boise

15. Filed 7-30-1913 M. D. Baker Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH July 25 1913.
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from July 21 1913, to July 25 1913, that I last saw him alive on July 25 1913, and that death occurred on the date stated above, at 7:30 P. M.

The CAUSE OF DEATH was as follows:
Hemorrhage & Peritonitis
Caused by pistol shot wound.
(Duration) yrs. mos. ds.

Contributory (Secondary)
(Duration) yrs. mos. ds.
(Signed) Stuart B. Baker M. D.
19 (Address) Boise

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
St. Luke's Hospital
At place of death. yrs. mos. days. In the State. yrs. mos. days.

Where was disease contracted if not at place of death?
Former or usual residence 622 Front St. slaps

19. PLACE OF BURIAL OR REMOVAL Hong Kong China DATE OF BURIAL 7/30 1913

20. UNDERTAKER Schreiber & Sidenfaden ADDRESS Boise

Dr. Back

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Form V. S. No. 5 20M.1-16-12

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH.

Registration District No. 2County of adaPrimary Registration District No. 1004File No. 5594City of Boise(No. 1304, N. 16th St.)Registered No. 171

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

Bessie Belle Franklin
If death occurred in a hospital, institution, or nursing home, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX

Female

4. COLOR OR RACE

white

5. SINGLE, MARRIED, WIDOWED OR DIVORCED.

married
(Write the word.)

6. DATE OF BIRTH

February 27 1879
(Month) (Day) (Year)

7. AGE

34 yrs. 5 mos. 2 ds.IF LESS than 1 day
how many hrs. or
..... mins.?

8. OCCUPATION

(a) Trade, profession or particular kind of work

House Wife

(b) General nature of industry, business, or establishment in which employed (or employer)

9. BIRTHPLACE

(State or Country)

Kansas

10. NAME OF FATHER

W. R. Franklin

11. BIRTHPLACE OF FATHER

(State or Country)

Virginia

12. MAIDEN NAME OF MOTHER

Mrs. C. Underwood

13. BIRTHPLACE OF MOTHER

(State or Country)

Virginia

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

J. Lee Buck

(Address)

Boise

15.

Filed 7 - 30 1913 M. S. Parker

Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH

July 29 1913
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from

June 26 1913, to July 29 1913that I last saw her alive on July 29 1913and that death occurred on the date stated above, at 10 A.M.

The CAUSE OF DEATH* was as follows:

Puerperal infection, complicated with phlegmasia alba dolens(Duration) yrs. 2 mos. — ds.

Contributory (Secondary)

Pulmonary tuberculosis(Duration) about 2 yrs. — mos. — ds.

(Signed)

M. S. Parker M. D.7 - 30 1913 (Address) Boise, Idaho

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death Staphouse yrs. — mos. — days. In the State Idaho yrs. — mos. — days.

Where was disease contracted if not at place of death?

Former or usual residence

Boise Idaho

19. PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

Atchison Kans 7/30 1913

20. UNDERTAKER

ADDRESS

Schreiber & Videnfaden Boise, Idaho

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Form V. S. No. 5 20M.1-16-12

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH.

Registration District No.

Primary Registration District No.

(No. 504, S. 14" St.)

File No.

Registered No.

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

PERSONAL AND STATISTICAL PARTICULARS

3. SEX

4. COLOR OR RACE

5. SINGLE, MARRIED, WIDOWED OR DIVORCED.

(Write the word.)

6. DATE OF BIRTH

7. AGE

IF LESS than 1 day
how many hrs. or
..... mins.?

8. OCCUPATION

(a) Trade, profession or particular kind of work
(b) General nature of industry business, or establishment in which employed (or employer)

9. BIRTHPLACE

(State or Country)

10. NAME OF FATHER

11. BIRTHPLACE OF FATHER

(State or Country)

12. MAIDEN NAME OF MOTHER

13. BIRTHPLACE OF MOTHER

(State or Country)

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

(Address)

15.

Filed 7-30-1913

1913

M. S. Parker
Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH

17. I HEREBY CERTIFY, That I attended deceased from

that I last saw her alive on

and that death occurred on the date stated above, at P. M.

The CAUSE OF DEATH* was as follows:

Contributory
(Secondary)

(Signed)

(Address)

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death yrs. mos. days. In the State yrs. mos. days.

Where was disease contracted if not at place of death?

Former or usual residence.

19. PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

20. UNDERTAKER

ADDRESS

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Form V. S. No. 5 20M.1-16-12

CERTIFICATE OF DEATH

1. PLACE OF DEATH

Registration District No.

County of Ada

Primary Registration District No.

City of Boise(No. 21, 7 Boise St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

John P. TrumanState
BOARD OF
Bureau of Vital StatisticsFile No. 5601Registered No. 173

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX

4. COLOR OR RACE

5. SINGLE, MARRIED, WID-
OWED OR DIVORCED.Male WhiteMarried
(Write the word.)

6. DATE OF BIRTH

Aug 14 1833
(Month) (Day) (Year)

7. AGE

79 yrs. 11 mos. — ds.IF LESS than 1 day
how many hrs. or
..... mins.

8. OCCUPATION

(a) Trade, profession or
particular kind of work(b) General nature of industry
business, or establishment in
which employed (or employer)Retired Farmer

9. BIRTHPLACE

(State or Country)

New York10. NAME OF
FATHERJ. P. Truman11. BIRTHPLACE
OF FATHER

(State or Country)

Not obtainable12. MAIDEN NAME
OF MOTHERNot obtainable13. BIRTHPLACE
OF MOTHER

(State or Country)

Not obtainable

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

John P. Truman

(Address)

Boise Idaho R.F. 10.3

15.

Filed 7 - 15 1911W. S. Parker

Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

7 14 1913
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from

2 1913, to 7 - 14 1913,that I last saw him alive on 7 - 14 1913,and that death occurred on the date stated above, at 2:45 P.M.

The CAUSE OF DEATH* was as follows:

Senility(Duration) 2 yrs. — mos. — ds.Contributory
(Secondary)(Duration) — yrs. — mos. — ds.(Signed) L. B. Brown M. D.

19 (Address)

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death yrs. mos. days. In the State yrs. mos. days.

Where was disease contracted
if not at place of death?Former or
usual residence

19. PLACE OF BURIAL OR REMOVAL DATE OF BURIAL

Dry Creek Cemetery July 15 1913

20. UNDERTAKER

ADDRESS

J. W. Summers Boise Idaho

Form V. S. No. 5. 12½ M. 7-24-11

CERTIFICATE OF DEATH

1. PLACE OF DEATH.
County of Clearwater
City of Cavendish

Registration District No. 90
Primary Registration District No. 2168
(No. _____, _____ St.)

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics
File No. 5602
Registered No. 29

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Benjamin F. Brutchfield

If death occurred in a hospital, institution or camp give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX male 4. COLOR OR RACE White 5. SINGLE, MARRIED, WIDOWED OR DIVORCED. married
(Write the word.)

6. DATE OF BIRTH July 21 1890
(Month) (Day) (Year)

7. AGE 43 yrs. 4 mos. 7 ds. IF LESS than 1 day how many _____ hrs. or _____ min?

8. OCCUPATION
(a) Trade, profession or particular kind of work. Farmer
(b) General nature of industry business or establishment in which employed (or employer)

9. BIRTHPLACE
(State or Country) Iowa

10. NAME OF FATHER John Brutchfield

11. BIRTHPLACE OF FATHER
(State or Country) England

12. MAIDEN NAME OF MOTHER Perene Faloday

13. BIRTHPLACE OF MOTHER
(State or Country) Michigan

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Mrs. Brutchfield
(Address) Cavendish Idaho

15. Filed Jan 1 1913 W. E. Stoddard
Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH Jan. 28 1913
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from Jan 19 1913, to Jan 28 1913
that I last saw him alive on Jan 28 1913
and that death occurred on the date stated above, at 7:10 P.M.
The CAUSE OF DEATH* was as follows:

Paralysis
(Benign)
(Duration) _____ yrs. _____ mos. 9 ds.
Contributory (Secondary) Diabetes

(Signed) W. B. Stone M. D.
Jan 19 1913 (Address) Leland Idaho

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place _____ In the _____
of death _____ yrs. _____ mos. _____ ds. State _____ yrs. _____ mos. _____ ds.
Where was disease contracted,
If not at place of death?
Former or
usual residence _____

19. PLACE OF BURIAL OR REMOVAL DATE OF BURIAL

Pine Grove Jan. 30 1913
20. UNDERTAKER ADDRESS
W. E. Stoddard Leland

by A. H. Smith & Son

-SUPPLEMENTARY DEATH CERTIFICATE-

(Please reply on this sheet to
the registrar of Vital Statistics)

Death Certificate No.

Name..... Benjimin F. Crutchfield

Date of Death..... Jan. 28, 1913.

Cause of Death..... Hemiplegia

Contributory Cause of death..... apoplexy

(Sign here) J. W. Stoneburner M.D.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Form V. S. No. 5. 12½ M. 7-24-11

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics
File No. 5691
Registered No. 31

1. PLACE OF DEATH.
County of Clearwater
City of Orofino

Registration District No. 90
Primary Registration District No. 2168
(No. _____, _____ St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

Nile Trejo

If death occurred in a hospital, institution or camp give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX Male 4. COLOR OR RACE White 5. SINGLE, MARRIED, WIDOWED OR DIVORCED. unknown
(Write the word.)

6. DATE OF BIRTH _____ 1849?
(Month) (Day) (Year)

7. AGE 64 yrs. _____ mos. _____ ds. IF LESS than 1 day
how many _____ hrs. or _____ min?

8. OCCUPATION
(a) Trade, profession or particular kind of work Laborer
(b) General nature of industry business or establishment in which employed (or employer) _____

9. BIRTHPLACE
(State or Country) ✓

10. NAME OF FATHER ✓

11. BIRTHPLACE OF FATHER ✓
(State or Country)

12. MAIDEN NAME OF MOTHER ✓

13. BIRTHPLACE OF MOTHER ✓
(State or Country)

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Jno M. Givens
(Address) Orofino, Ida

15. Filed Aug 1 1913 M. Trejo
Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH July 15th 1913
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from June 28 1913, to July 15 1913
that I last saw him alive on July 15 1913
and that death occurred on the date stated above, at 7:30 P.M.
The CAUSE OF DEATH* was as follows:

Paraplegia.

(Duration) 1 yrs. _____ mos. _____ ds.
Contributory (Secondary) Insanity.

(Duration) 6 yrs. _____ mos. _____ ds.
(Signed) John M. Givens M. D.
July 15 1913 (Address) Orofino Idaho

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death _____ yrs. _____ mos. 17 ds. In the State 6 yrs. _____ mos. _____ ds.
Where was disease contracted,
If not at place of death?
Former or usual residence _____

19. PLACE OF BURIAL OR REMOVAL DATE OF BURIAL
N. Idaho Sanitarium Cemetery July 17 1913

20. UNDERTAKER ADDRESS

J. C. Ackerman Orofino, Ida

MARGIN RESERVE

WRITE PLAINLY, WITH UNFADING INK—Every item of information should be carefully supplied. Do not state CAUSE OF DEATH in plain terms, so that the cause of OCCUPATION is very important. See instructions on back of record.

N. B.—Every item of information should be carefully supplied. Do not state CAUSE OF DEATH in plain terms, so that the cause of OCCUPATION is very important. See instructions on back of record.

Form V. S. No. 100-7-24-11
1. PLACE OF DEATH
County of Water
City of Idaho

CERTIFICATE OF DEATH
Registration District No. 90
Primary Registration District No. 2168
(No. , St.)

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics
File No. 5605
Registered No. 31

If death occurred from unusual or violent causes called for information.

2. FULL NAME

Alexander Heltzel

If death occurred in a hospital, institution or camp give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

4. COLOR OR RACE W 5. SINGLE, MARRIED, WIDOWED OR DIVORCED. Widow
(Write the word.)

DATE OF BIRTH

July 1 1849
(Month) (Day) (Year)

7. AGE

64 yrs. 19 mos. 19 ds. IF LESS than 1 day
how many hrs. or min?

8. OCCUPATION

(a) Trade, profession or particular kind of work. Farmer
(b) General nature of industry business or establishment in which employed (or employer)

9. BIRTHPLACE

(State or Country) Penn

10. NAME OF FATHER

Samuel Heltzel

11. BIRTHPLACE OF FATHER

(State or Country) ✓

12. MAIDEN NAME OF MOTHER

✓

13. BIRTHPLACE OF MOTHER

(State or Country) ✓

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Owen Lehman
(Address) Lenore Idaho Rd

15.

Filed 27-25-3 191 J M Lively
Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH

July-19- 1913
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from June 18 1913, to July 19 1913 that I last saw him alive on July 19 1913 and that death occurred on the date stated above, at 12 P.M.

The CAUSE OF DEATH* was as follows:

Typhoid fever

(Duration) 1 yrs. 1 mos. ds.

Contributory (Secondary)

(Duration) yrs. mos. ds.

(Signed) J M Lively M. D.
7/25-1913 (Address)

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place In the
of death yrs. mos. ds. State yrs. mos. ds.
Where was disease contracted,
If not at place of death?
Former or
usual residence.

19. PLACE OF BURIAL OR REMOVAL DATE OF BURIAL

Laplan Idaho July 20 1913

20. UNDERTAKER

ADDRESS

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Form V. S. No. 5 20M.1-16-12

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH.

Registration District No. 15.

County of *Salt Lake*

Primary Registration District No. 2066

City of *Patterson*

(No. _____ St.)

File No. 5605

Registered No. _____

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

Elizabeth Johnson

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX

4. COLOR OR RACE

5. SINGLE, MARRIED, WIDOWED OR DIVORCED.

Female *White* *Married*

6. DATE OF BIRTH

May *29* *1829*
(Month) (Day) (Year)

7. AGE

84 yrs. *1* mos. *13* ds.IF LESS than 1 day
how many _____ hrs. or
_____ mins.

8. OCCUPATION

(a) Trade, profession or particular kind of work

(b) General nature of industry business, or establishment in which employed (or employer)

House Wife

9. BIRTHPLACE

(State or Country)

Sweden

10. NAME OF FATHER

Richard

11. BIRTHPLACE OF FATHER

(State or Country)

not known

12. MAIDEN NAME OF MOTHER

not known

13. BIRTHPLACE OF MOTHER

(State or Country)

not known

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

(Address)

M. Symberg
Patterson, Idaho

15.

Filed

July 12 191*3*191*3**J. J. Thompson*
Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH

7 *12* *1913*
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from

July 6 191*3*, to *July 12* 191*3*,that I last saw her alive on *July 11* 191*3*,and that death occurred on the date stated above, at *4 P.M.*

The CAUSE OF DEATH* was as follows:

Endocarditis(Duration) _____ yrs. _____ mos. *6* ds.Contributory
(Secondary)*old age*

(Duration) _____ yrs. _____ mos. _____ ds.

(Signed)

J. S. Le Poir M. D.
19 (Address) *Patterson, Idaho*

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death _____ yrs. _____ mos. _____ days. In the State _____ yrs. _____ mos. _____ days.

Where was disease contracted if not at place of death?

Former or usual residence _____

19. PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

Patterson, Idaho *July 13* 191*3*

20. UNDERTAKER

ADDRESS

E. Anderson *Palouse*

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Form V. S. No. 5 20M.1-16-12

CERTIFICATE OF DEATH

 State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH

Registration District No. 50

County of Lewis

Primary Registration District No. 2129

City of Leo

(No. , St.)

File No. 5609

Registered No. 1

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Clara Maud Buttery

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX

Female

4. COLOR OR RACE

White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED.

Married
(Write the word.)

6. DATE OF BIRTH

July

29

1877
(Month) (Day) (Year)

7. AGE

36 yrs. 1 mos. 9 ds.

 IF LESS than 1 day
how many hrs. or
mins.?

8. OCCUPATION

(a) Trade, profession or particular kind of work

House wife

(b) General nature of industry business, or establishment in which employed (or employer)

9. BIRTHPLACE

(State or Country)

Michigan

10. NAME OF FATHER

J. N. Buncer

11. BIRTHPLACE OF FATHER

(State or Country)

Massachusetts

12. MAIDEN NAME OF MOTHER

Rebecca Peterout

13. BIRTHPLACE OF MOTHER

(State or Country)

Michigan

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

James Buttery

(Address)

Leo, Idaho

15.

Filed

July 29

1913

H. C. Parrish
Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

July

28

1913
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from

mch. 31 1913, to July 26 1913,

that I last saw her alive on July 26 1913,

and that death occurred on the date stated above, at 2:30 AM.

The CAUSE OF DEATH* was as follows:

Mitral Regurgitation

(Duration) 10 yrs. mos. ds.

Contributory
(Secondary)

(Duration) yrs. mos. ds.

(Signed) H. C. Parrish M. D.

7-28 1913 (Address) Leo Idaho

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death yrs. mos. days. In the State yrs. mos. days.

Where was disease contracted if not at place of death?

Former or usual residence.

19. PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

Leo Cemetery

July 28 1913

20. UNDERTAKER

ADDRESS

Leo Idaho

Leo Idaho

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Form V. S. No. 5. 12½ M. 7-24-11

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics
File No. 5612
Registered No. 33

1. PLACE OF DEATH
County of Benewah
City of Lamar
Registration District No. 24
Primary Registration District No. 2293
(No. _____ St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

Thelma Parry

If death occurred in a hospital, institution or camp give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX Female 4. COLOR OR RACE W. 5. SINGLE, MARRIED, WIDOWED OR DIVORCED. Single
(Write the word.)

6. DATE OF BIRTH Aug 39 1912
(Month) (Day) (Year)

7. AGE 10 yrs. 18 mos. 18 ds.
IF LESS than 1 day how many _____ hrs. or _____ min?

8. OCCUPATION

(a) Trade, profession or particular kind of work. Baby
(b) General nature of industry business or establishment in which employed (or employer)

9. BIRTHPLACE

(State or Country) Lamar

10. NAME OF FATHER

Clarence Parry

11. BIRTHPLACE OF FATHER

(State or Country) Idaho

12. MAIDEN NAME OF MOTHER

Norma Burr

13. BIRTHPLACE OF MOTHER

(State or Country) Lamar

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Julia B. Parry

(Address) Lamar, Idaho

15.

Filed July 19 1913

Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH

July 18 1913
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from

July 16 1913, to July 18 1913

that I last saw her alive on July 18 1913

and that death occurred on the date stated above, at 8 P. M.

The CAUSE OF DEATH* was as follows:

Enteric colitis and Pneumonia

4 (Duration) X yrs. X mos. 3 ds.

Contributory (Secondary)

(Duration) _____ yrs. _____ mos. _____ ds.

(Signed) A. D. Cooley M. D.

July 19 1913 (Address) Benewah

State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death _____ yrs. _____ mos. _____ ds. In the State _____ yrs. _____ mos. _____ ds.

Where was disease contracted,

If not at place of death? _____

Former or

usual residence _____

19. PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

Lamar July 20 1913

20. UNDERTAKER

ADDRESS

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Form V. S. No. 5. 12½ M. 7-24-11

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics
File No. 5613
Registered No. 34

1. PLACE OF DEATH Registration District No. 24
County of Bear Lake Primary Registration District No. 2092
City of Paris (No. , St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Sarah Ellen Shepherd

If death occurred in a hospital, institution or camp give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX Female 4. COLOR OR RACE W. 5. SINGLE, MARRIED, WIDOWED OR DIVORCED. Married (Write the word.)

6. DATE OF BIRTH July 25 1913
(Month) (Day) (Year)

7. AGE 48 yrs. 3 mos. 20 ds. IF LESS than 1 day how many hrs. or min?

8. OCCUPATION

(a) Trade, profession or particular kind of work.
(b) General nature of industry business or establishment in which employed (or employer)

Housewife

9. BIRTHPLACE

(State or Country)

Utah

10. NAME OF FATHER

John J. Humphreys

11. BIRTHPLACE OF FATHER

(State or Country)

England

12. MAIDEN NAME OF MOTHER

Anna Lee

13. BIRTHPLACE OF MOTHER

(State or Country)

Don't know

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

S. E. Shepherd

(Address)

Paris Idaho

15.

Filed July 26 1913 Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH July 25 1913
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from July 25 1913, to July 25 1913, that I last saw her alive on July 25 1913 and that death occurred on the date stated above, at 10:30 AM.

The CAUSE OF DEATH* was as follows:

Myocardial degeneration
Hepatitis

(Duration) yrs. mos. ds.

Contributory (Secondary)

(Duration) 70 years. yrs. mos. ds.

(Signed) A. C. Cooley M. D.

725 1913 (Address) Paris, Idaho

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place In the of death yrs. mos. ds. State yrs. mos. ds.

Where was disease contracted,

If not at place of death?

Former or

usual residence.

19. PLACE OF BURIAL OR REMOVAL DATE OF BURIAL

Paris July 27 1913

20. UNDERTAKER

ADDRESS

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Form V. S. No. 5. 12½M.7-24-11

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics
File No. 5611
Registered No. 1

1. PLACE OF DEATH. Registration District No. 96
County of Nez Perce Primary Registration District No. 1009
City of Lewiston (No. _____, _____ St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Iva Mildred Sherry

If death occurred in a hospital, institution or camp give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX Female 4. COLOR OR RACE white 5. SINGLE, MARRIED, WIDOWED OR DIVORCED. married
(Write the word.)

6. DATE OF BIRTH January 22 1883
(Month) (Day) (Year)

7. AGE 30 yrs. 5 mos. 8 ds. IF LESS than 1 day how many _____ hrs. or _____ min?

8. OCCUPATION

- (a) Trade, profession or particular kind of work. Housewife
(b) General nature of industry business or establishment in which employed (or employer)

9. BIRTHPLACE

(State or Country) Wisconsin10. NAME OF FATHER J. E. Knight

11. BIRTHPLACE OF FATHER

(State or Country) Canada12. MAIDEN NAME OF MOTHER L. A. Lamphier

13. BIRTHPLACE OF MOTHER

(State or Country) Canada

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) J. W. Mullins(Address) Lewiston Ida.

15.

Filed Aug 10 1913L. Perkins

Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH

July 1 1913
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from June 13 1913, to July 1 1913

that I last saw her alive on July 1 1913

and that death occurred on the date stated above, at 7 P. M.

The CAUSE OF DEATH* was as follows:

Nephritis
(Chronic tubercular)

(Duration) _____ yrs. _____ mos. 27 ds.

Contributory (Secondary)

Tuberculosis

(Duration) _____ yrs. _____ mos. _____ ds.

(Signed)

R. J. Alcorn M. D.

July 1 1913 (Address) Lewiston Ida

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place _____ In the _____
of death _____ yrs. _____ mos. _____ ds. State _____ yrs. _____ mos. _____ ds.

Where was disease contracted,

If not at place of death?

Former or

usual residence.

19. PLACE OF BURIAL OR REMOVAL DATE OF BURIAL

Asotia Hall1913

20. UNDERTAKER

ADDRESS

H. R. Muchant Asotia Hall

-SUPPLEMENTARY DEATH CERTIFICATE-

(Please reply on this sheet to
the registrar of Vital Statistics)

Death Certificate No.

Name Ina Mildred Sherry,

Date of Death July 1st, 1913

Cause of Death Tubercular nephritis (chronic)

Contributory Cause of death

(Sign here) *W. C. [Signature]* M.D.

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Form V. S. No. 5 20M.1-16-12

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH.

Registration District No.

96

County of

Latah

Primary Registration District No.

1009

City of

Lewiston

(No. 825,

9th Ave

St.)

File No.

5615

Registered No.

2

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

Emilie L Davis

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX

45

4. COLOR OR RACE

W

5. SINGLE, MARRIED, WID-
OWED OR DIVORCED.

(Write the word.)

6. DATE OF BIRTH

Oct

12

1912

(Month)

(Day)

(Year)

7. AGE

— yrs. 8 mos. 19 ds.

IF LESS than 1 day
how many hrs. or
..... mins.?

8. OCCUPATION

(a) Trade, profession or
particular kind of work

None

(b) General nature of industry
business, or establishment in
which employed (or employer)

9. BIRTHPLACE

(State or Country)

Lewiston

10. NAME OF
FATHER

E. W. Davis

11. BIRTHPLACE
OF FATHER

(State or Country)

Texas

12. MAIDEN NAME
OF MOTHER

Jessie E Johnson

13. BIRTHPLACE
OF MOTHER

(State or Country)

Mo.

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

E. W. Davis

(Address)

Lewiston Idaho

15.

Filed

Aug 10

1913

R. C. Becken

Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH

July

1

1913

(Month)

(Day)

(Year)

17. I HEREBY CERTIFY, That I attended deceased from

6/14

1913

to 7/1

1913

that I last saw her alive on 7/1 1913

and that death occurred on the date stated above, at 3 P. M.

The CAUSE OF DEATH* was as follows:

Erysipelas

(Duration) yrs. mos. 16 ds.

Contributory
(Secondary)

(Duration) yrs. mos. ds.

(Signed) E. F. Pinner M. D.

19 (Address)

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death yrs. mos. days. In the State yrs. mos. days.

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

Lewiston

July 22 1913

20. UNDERTAKER

ADDRESS

E. W. Pinner Lewiston

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Form V. S. No. 5 20M.1-16-12

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

File No. 5619

Registered No. 3

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

1. PLACE OF DEATH

Registration District No. 96

County of

Primary Registration District No. 1009

City of

(No. 814, 8th St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

PERSONAL AND STATISTICAL PARTICULARS

3. SEX

4. COLOR OR RACE

5. SINGLE, MARRIED, WIDOWED OR DIVORCED.

(Write the word.)

6. DATE OF BIRTH

7. AGE

IF LESS than 1 day
how many hrs. or mins.

8. OCCUPATION

(a) Trade, profession or particular kind of work

(b) General nature of industry business, or establishment in which employed (or employer)

9. BIRTHPLACE

(State or Country)

10. NAME OF FATHER

11. BIRTHPLACE OF FATHER

(State or Country)

12. MAIDEN NAME OF MOTHER

13. BIRTHPLACE OF MOTHER

(State or Country)

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

(Address)

15.

Filed

1913

Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH

(Month)

(Day)

1913

17. I HEREBY CERTIFY, That I attended deceased from

June 10 1913, to July 2nd 1913,

that I last saw him alive on July 1st 1913,

and that death occurred on the date stated above, at 5:00 P.M.

The CAUSE OF DEATH* was as follows:

Dysentery

(Duration)

yrs. 7 mos. ds.

Contributory (Secondary)

(Duration)

yrs. 2 mos. 9 ds.

(Signed)

C. S. Sams

M. D.

7/2 1913 (Address) Lewiston

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place

of death

Where was disease contracted if not at place of death?

Former or usual residence

In the

State

19. PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

Lewiston Idaho

July 3rd 1913

20. UNDERTAKER

ADDRESS

C. S. Sams

Lewiston

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Form V. S. No. 5 20M.1-16-12

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics
File No. 5617
Registered No. 4

1. PLACE OF DEATH. Registration District No. 96
County of Logan Primary Registration District No. 1009
City of Lewiston (No. _____, St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Fortunate Ina chard

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX M 4. COLOR OR RACE W 5. SINGLE, MARRIED, WIDOWED OR DIVORCED. Single
(Write the word.)

6. DATE OF BIRTH June 15 1864
(Month) (Day) (Year)

7. AGE 48 yrs. 0 mos. 16 ds.
IF LESS than 1 day how many hrs. or mins.?

8. OCCUPATION Priest
(a) Trade, profession or particular kind of work
(b) General nature of industry business, or establishment in which employed (or employer)

9. BIRTHPLACE France
(State or Country)

10. NAME OF FATHER Not known

11. BIRTHPLACE OF FATHER

12. MAIDEN NAME OF MOTHER

13. BIRTHPLACE OF MOTHER

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Sister M. Borgia
(Address) Lewiston

15. Filed Aug 10 1913 R. G. Verhies
Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH July 4 1913
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from June 28 1913, to July 4 1913, that I last saw him alive on July 3 1913, and that death occurred on the date stated above, at 6 P.M.

The CAUSE OF DEATH* was as follows:
Artic suppuratation with cardiac aneurysm

(Duration) 3 yrs. 0 mos. 0 ds.
Contributory Marasmus
(Secondary)

(Signed) J. H. Arthur M. D.
July 1913 (Address) Lewiston

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death.....yrs.....mos.....days. In the State.....yrs.....mos.....days.

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL Lutonwood DATE OF BURIAL 1913

20. UNDERTAKER C. Vassar ADDRESS Lewiston

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Form V. S. No. 5 20M.1-16-12

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH.

Registration District No. 96

County of Boise

Primary Registration District No. 1009

City of Boise

(No. 121, Prospectors St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

Mr. L. C. Alexander

File No. 5618

Registered No. 3

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX

M

4. COLOR OR RACE

W

5. SINGLE, MARRIED, WIDOWED OR DIVORCED.

Married
(Write the word.)

6. DATE OF BIRTH

July 1 1940
(Month) (Day) (Year)

7. AGE

73 yrs. 19 mos. 19 ds.

IF LESS than 1 day
how many hrs. or mins.?

8. OCCUPATION

(a) Trade, profession or particular kind of work:

retired

(b) General nature of industry business, or establishment in which employed (or employer)

9. BIRTHPLACE

(State or Country)

Germany

10. NAME OF FATHER

Mr. Alexander

11. BIRTHPLACE OF FATHER

(State or Country)

Germany

12. MAIDEN NAME OF MOTHER

not known

13. BIRTHPLACE OF MOTHER

(State or Country)

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

D. C. Alexander

(Address)

Lawson

15.

Filed

Aug 10

1913

L. C. Alexander

Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH

July 19 1913
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from

July 1 1913, to July 19 1913,
that I last saw him alive on July 19 1913.

and that death occurred on the date stated above, at 7:30 P. M.

The CAUSE OF DEATH* was as follows:

Lobular Pneumonia

(Duration) yrs. mos. ds.

Contributory (Secondary)

Chronic Bronchitis

(Duration) yrs. mos. ds.

(Signed)

J. F. Hurlbut M. D.

721913 (Address) Lawson

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death.....yrs.....mos.....days. In the State.....yrs.....mos.....days.

Where was disease contracted if not at place of death?

Former or usual residence.....

19. PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

Lewiston Idaho

July 21 1913

20. UNDERTAKER

ADDRESS

C. J. Vassar

Lewiston

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Form V. S. No. 5 20M.1-16-12

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics
File No. 5619
Registered No. 6

1. PLACE OF DEATH.

Registration District No. 96

County of Negundo

Primary Registration District No. 1009

City of Lewiston

(No. Cor. Negundo and Lew. St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Francis Shuey

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX M

4. COLOR OR RACE W.

5. SINGLE, MARRIED, WIDOWED OR DIVORCED. Single
(Write the word.)

6. DATE OF BIRTH Jan 17 1908
(Month) (Day) (Year)

7. AGE 5 yrs. 5 mos. 5 ds.

IF LESS than 1 day
how many hrs. or mins.?

8. OCCUPATION

(a) Trade, profession or particular kind of work schoolgirl

(b) General nature of industry, business, or establishment in which employed (or employer)

9. BIRTHPLACE

(State or Country) Lewiston

10. NAME OF FATHER Paul Shuey

11. BIRTHPLACE OF FATHER

(State or Country) Vermont

12. MAIDEN NAME OF MOTHER Swa Triller

13. BIRTHPLACE OF MOTHER

(State or Country) Wash.

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) F. Shuey

(Address) 7. Shuey

15.

Filed Aug 10 1913

R. B. Benson

Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH Jul 20 20 1913
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from Jul 19 1913, to Jul 20 1913, that I last saw him alive on Jul 20 1913, and that death occurred on the date stated above, at 5 A. M.

The CAUSE OF DEATH* was as follows:
Typhoid fever

(Duration) 5 yrs. 5 mos. 5 ds.

Contributory (Secondary)

(Duration) 5 yrs. 5 mos. 5 ds.

(Signed) J. B. Benson M. D.

July 21 1913 (Address) Lewiston Idaho

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death 5 yrs. 5 mos. 5 days. In the State 5 yrs. 5 mos. 5 days.

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

Lewiston Idaho

7-21 1913

20. UNDERTAKER

ADDRESS

O. J. Vassar

Lewiston

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Form V. S. No. 5 20M.1-16-12

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH.

Registration District No. 96

County of Nez Perce

Primary Registration District No. 1009

City of Lewiston

(No. 771, 7th Ave. Cor. 18th St.)

File No. 5020

Registered No. 7

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Anna Rosalia

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX

F

4. COLOR OR RACE

W

5. SINGLE, MARRIED, WIDOWED OR DIVORCED.

widow
(Write the word.)

6. DATE OF BIRTH

not known
(Month) (Day) (Year)

7. AGE

40 yrs. mos. ds.

IF LESS than 1 day
how many hrs. or mins.?

8. OCCUPATION

(a) Trade, profession or particular kind of work

none

(b) General nature of industry business, or establishment in which employed (or employer)

9. BIRTHPLACE

(State or Country)

England

10. NAME OF FATHER

not known

11. BIRTHPLACE OF FATHER

(State or Country)

" "

12. MAIDEN NAME OF MOTHER

" "

13. BIRTHPLACE OF MOTHER

(State or Country)

" "

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

J. Vassar
Lewiston

(Address)

15.

Filed

Aug-10

1918

L. J. Perkins

Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH

July 2nd 1918
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from

1918, to 1918,

that I last saw him alive on 1918,

and that death occurred on the date stated above, at M.

The CAUSE OF DEATH* was as follows:

Not known. Had no attending physician

(Duration) yrs. mos. ds.

Contributory
(Secondary)

(Duration) yrs. mos. ds.

(Signed)

L. J. Perkins M. D.
July 23 1918 (Address) Lewiston

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death. yrs. mos. days. In the State. yrs. mos. days.

Where was disease contracted if not at place of death?

Former or usual residence.

19. PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

Lewiston

July 23 1918

20. UNDERTAKER

ADDRESS

C. J. Vassar

Lewiston

13-21630

Form V. S. No. 5 20M.1-16-12

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH. Registration District No. 96
County of Nevada Primary Registration District No. 1009
City of Lewiston (No. 44 St.)

File No. 5621
Registered No. 8

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

Shepard S. Gato

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX M 4. COLOR OR RACE W 5. SINGLE, MARRIED, WIDOWED OR DIVORCED. Married
(Write the word.)

6. DATE OF BIRTH

May 29 1873
(Month) (Day) (Year)

7. AGE

40 yrs. - mos. - ds.

IF LESS than 1 day
how many hrs. or mins.?

8. OCCUPATION

(a) Trade, profession or particular kind of work
(b) General nature of industry, business, or establishment in which employed (or employer)

Laborer

9. BIRTHPLACE

(State or Country)

Nevada

10. NAME OF FATHER

S. S. Gato

11. BIRTHPLACE OF FATHER

(State or Country)

Wis.

12. MAIDEN NAME OF MOTHER

Delia T. Williams

13. BIRTHPLACE OF MOTHER

(State or Country)

Ohio

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

(Address)

Jessie M. Mollan
Kennish, Idaho

15.

Filed

Aug. 10

1913

R. J. Becken
Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH

July 24 Thursday 1913
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from

26th Dec 1913, to 24th July 1913
that I last saw him alive on Thursday 6th Dec 1913
and that death occurred on the date stated above, at 7:15 P.M.

The CAUSE OF DEATH* was as follows:

Septicemia

42 (Duration) yrs. mos. 42 ds.

Contributory
(Secondary)

(Duration) yrs. mos. ds.

(Signed)

C. S. Whitford M. D.
July 1913 (Address) Lewiston Idaho

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death.....yrs.....mos.....days. In the State.....yrs.....mos.....days.

Where was disease contracted if not at place of death?

Lewiston

Former or usual residence.....

Don't know

19. PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

Lewiston Idaho

July 26 1913

20. UNDERTAKER

ADDRESS

C. J. Vassar

Lewiston

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Form V. S. No. 5 20M.1-16-12

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics
File No. 5622

1. PLACE OF DEATH. Registration District No. 96
County of Naz Perce Primary Registration District No. 1009
City of Lewiston (No. East Lewiston St.)
If death occurs away from usual residence, give facts called for under special information. 2. FULL NAME Geo Howard Ruddle

Registered No. 9
If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX M 4. COLOR OR RACE W 5. SINGLE, MARRIED, WID-
OWED OR DIVORCED. Single
(Write the word.)
6. DATE OF BIRTH Aug 25
1886
(Month) (Day) (Year)
7. AGE 4 yrs. 11 mos. ds.
IF LESS than 1 day
how many hrs. or
mins.?

8. OCCUPATION
(a) Trade, profession or particular kind of work none
(b) General nature of industry business, or establishment in which employed (or employer)

9. BIRTHPLACE
(State or Country) Lewiston

10. NAME OF FATHER Geo Ruddle

11. BIRTHPLACE OF FATHER Ind.
(State or Country)

12. MAIDEN NAME OF MOTHER Edith Truensee

13. BIRTHPLACE OF MOTHER Iowa
(State or Country)

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) J. L. Goodnight
(Address)

15. Filed Aug 10 1913 L. J. Perkins
Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH July 25
1913
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from 7/24 1913, to 7/24 1913,
that I last saw him alive on July 24 1913,
and that death occurred on the date stated above, at 2 P.M.

The CAUSE OF DEATH* was as follows:

Exhaustion due to destruction of red blood corpuscles

(Duration) yrs. 1 mos. 12 ds.
Contributory S. cholerae - Asiatic
(Secondary)

(Duration) yrs. mos. ds.
(Signed) A. H. McFarland
7/25 1913 (Address) Lewiston Ida

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death. yrs. mos. days. In the State. yrs. mos. days.

Where was disease contracted if not at place of death?

Former or usual residence.

19. PLACE OF BURIAL OR REMOVAL Lewiston DATE OF BURIAL July 26 1913

20. UNDERTAKER C. J. Vassar ADDRESS Lewiston

Form V. S. No. 5 20M.1-16-12

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics
File No. 5623
Registered No. _____

1. PLACE OF DEATH _____ Registration District No. 39
County of Adair Primary Registration District No. 2087
City of Buhl (No. _____, _____ St.)

If death occurs after from usual residence, give facts called for under special information.

2. FULL NAME

Not Named

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX Female 4. COLOR OR RACE White 5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.)

6. DATE OF BIRTH

July 8 1913
(Month) (Day) (Year)

7. AGE

X yrs. X mos. X ds.

IF LESS than 1 day
how many _____ hrs. or
_____ mins.

8. OCCUPATION

- (a) Trade, profession or particular kind of work
(b) General nature of industry business, or establishment in which employed (or employer)

9. BIRTHPLACE

(State or Country) California

10. NAME OF FATHER

Wm H. Caddy

11. BIRTHPLACE OF FATHER

(State or Country) Colorado

12. MAIDEN NAME OF MOTHER

Leona Eriker

13. BIRTHPLACE OF MOTHER

(State or Country) Arkansas

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Wm H. Caddy(Address) Buhl Ida

15.

Filed July 8 1913

Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH

July 8 1913
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from

July 7 1913, to July 8 1913,
that I last saw her alive on July 7 1913,
and that death occurred on the date stated above, at 2:30 P.M.

The CAUSE OF DEATH* was as follows:

Prematurity

(Duration) _____ yrs. _____ mos. _____ ds.

Contributory
(Secondary)

(Duration) _____ yrs. _____ mos. _____ ds.

(Signed) C. F. McChesney M. D.July 8, 1913 (Address) Buhl Ida

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death _____ yrs. _____ mos. _____ days. In the State _____ yrs. _____ mos. _____ days.

Where was disease contracted if not at place of death?

Former or usual residence _____

19. PLACE OF BURIAL OR REMOVAL

at Home

DATE OF BURIAL

July 9 1913

20. UNDERTAKER

None

ADDRESS

MARGIN RESERVED FOR BINDING
WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Form V. S. No. 5. 12½ M. 7-24-11

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics
File No. 5021
Registered No. _____

1. PLACE OF DEATH.
County of Power Falls
City of Buhl
Registration District No. 39
Primary Registration District No. 2087
(No. _____, _____ St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

Baby Strunk

If death occurred in a hospital, institution or camp give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX male 4. COLOR OR RACE white 5. SINGLE, MARRIED, WIDOWED OR DIVORCED. single
(Write the word.)

6. DATE OF BIRTH July 14 1913
(Month) (Day) (Year)

7. AGE 3 hrs. IF LESS than 1 day
_____ yrs. _____ mos. _____ ds. how many _____ hrs. or _____ min?

8. OCCUPATION
(a) Trade, profession or particular kind of work _____
(b) General nature of industry business or establishment in which employed (or employer) _____

9. BIRTHPLACE
(State or Country) Buhl

10. NAME OF FATHER Noah W. Strunk

11. BIRTHPLACE OF FATHER
(State or Country) Idaho

12. MAIDEN NAME OF MOTHER Rena Thompson

13. BIRTHPLACE OF MOTHER
(State or Country) Cal.

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Noah W. Strunk
(Address) Buhl

15. Filed 7-15 1913 J. Murphy
Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH July 14 1913
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from July 14 1913, to July 14 1913
that I last saw him alive on July 14 1913
and that death occurred on the date stated above, at 8 M.

The CAUSE OF DEATH* was as follows:
Premature birth
child lived about
3 hrs.

_____ (Duration) _____ yrs. _____ mos. _____ ds.

Contributory _____
(Secondary)

_____ (Duration) _____ yrs. _____ mos. _____ ds.

(Signed) Chas. Welcher M. D.
July 15 1913 (Address) Buhl Idaho

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place _____ In the _____
of death _____ yrs. _____ mos. _____ ds. State _____ yrs. _____ mos. _____ ds.
Where was disease contracted, _____
If not at place of death? _____
Former or _____
usual residence _____

19. PLACE OF BURIAL OR REMOVAL Buhl DATE OF BURIAL 7-15 1913

20. UNDERTAKER Kouze ADDRESS _____

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Form V. S. No. 5. 12½ M. 7-24-11

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics
File No. 5625
Registered No.

1. PLACE OF DEATH.

Registration District No. 63

County of Latah

Primary Registration District No. 2143

City of Kendrick

(No. , St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

Mrs Jennie Humean

If death occurred in a hospital, institution or camp give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX

Female

4. COLOR OR RACE

White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED.

Widowed
(Write the word.)

6. DATE OF BIRTH

April 9

(Month) (Day)

1874 (Year)

7. AGE

39 yrs. 9 mos. 12 ds.

IF LESS than 1 day
how many... hrs. or
... min?

8. OCCUPATION

(a) Trade, profession or particular kind of work.
(b) General nature of industry business or establishment in which employed (or employer)

Housewife

9. BIRTHPLACE

(State or Country)

Kington Pennsylvania

10. NAME OF FATHER

James Collins

11. BIRTHPLACE OF FATHER

(State or Country)

Pennsylvania

12. MAIDEN NAME OF MOTHER

Mary Sullivan

13. BIRTHPLACE OF MOTHER

(State or Country)

Pennsylvania

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

(Address)

J. J. Collins
Lewiston Idaho

15.

Filed Aug 2 1913

Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH

June 21 1913
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from

December 1910, to June 21, 1913.

that I last saw her alive on June 21, 1913.

and that death occurred on the date stated above, at 11 P. M.

The CAUSE OF DEATH* was as follows:

Pulmonary Tuberculosis

(Duration) 2 yrs. 7 mos. ds.

Contributory
(Secondary)

(Duration) yrs. mos. ds.

(Signed) W. G. Rowlands M. D.

June 22 1913. (Address) Kendrick Idaho

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place In the
of death yrs. mos. ds. State yrs. mos. ds.
Where was disease contracted,
If not at place of death?
Former or
usual residence.

19. PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

Kendrick Idaho June 24, 1913

20. UNDERTAKER

ADDRESS

H. J. Rowlands Kendrick Idaho

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Form V. S. No. 5. 12½ M. 7-24-11

CERTIFICATE OF DEATH

1. PLACE OF DEATH. Registration District No. 63
County of _____ Primary Registration District No. 2143
City of _____ (No. _____, _____ St.)

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics
File No. 5626
Registered No. _____

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

Orlando Hupp

If death occurred in a hospital, institution or camp give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX Male 4. COLOR OR RACE White 5. SINGLE, MARRIED, WIDOWED OR DIVORCED. Married
(Write the word.)

6. DATE OF BIRTH Sept 9 1849
(Month) (Day) (Year)

7. AGE 63 yrs. 10 mos. 13 ds. IF LESS than 1 day how many _____ hrs. or _____ min?

8. OCCUPATION

- (a) Trade, profession or particular kind of work. Farmer
(b) General nature of industry business or establishment in which employed (or employer) _____

9. BIRTHPLACE

(State or Country)

Indiana

10. NAME OF FATHER

Abram Hupp

11. BIRTHPLACE OF FATHER

(State or Country)

Virginia

12. MAIDEN NAME OF MOTHER

13. BIRTHPLACE OF MOTHER

(State or Country)

unknown

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

(Address)

Harry Hupp
Ken drick Idaho

15.

Filed Aug 2 1913

J. E. Koyh
Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

July 22 1913
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from

May 5 1912, to July 22 1913
that I last saw him alive on July 20th 1913

and that death occurred on the date stated above, at 5 P. M.

The CAUSE OF DEATH* was as follows:

Bulbar Paralysis

(Duration) 1 yrs. 2 mos. 17 ds.

Contributory
(Secondary)

(Duration) _____ yrs. _____ mos. _____ ds.

(Signed) W. A. Rortwell M. D.

July 28 1913. (Address) Ken drick Idaho
(State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place _____ In the _____
of death _____ yrs. _____ mos. _____ ds. State _____ yrs. _____ mos. _____ ds.
Where was disease contracted, _____
If not at place of death? _____
Former or _____
usual residence _____

19. PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

Little Bear Ridge Cemetery July 23 1913
near Ken drick Idaho

20. UNDERTAKER

ADDRESS

August Johnson Tray Idaho

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Form V. S. No. 5. 12½ M. 7-24-11

CERTIFICATE OF DEATH

1. PLACE OF DEATH.

County of Polk

City of Kendrick

Registration District No. 63

Primary Registration District No. 2143

(No. _____, _____ St.)

State of Idaho

BOARD OF HEALTH
Bureau of Vital Statistics

File No. 5627

Registered No. _____

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Andrew Johnson

If death occurred in a hospital, institution or camp give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX

Male

4. COLOR OR RACE

White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED.

Married
(Write the word.)

6. DATE OF BIRTH

Oct.

25

1829

(Month)

(Day)

(Year)

7. AGE

82 yrs. 8 mos. 0 ds.

IF LESS than 1 day
how many _____ hrs. or
_____ min?

8. OCCUPATION

(a) Trade, profession or particular kind of work.
(b) General nature of industry business or establishment in which employed (or employer)

Wagon maker

9. BIRTHPLACE

(State or Country)

Norway

10. NAME OF FATHER

Andrew Johnson

11. BIRTHPLACE OF FATHER

(State or Country)

Norway

12. MAIDEN NAME OF MOTHER

Unknown

13. BIRTHPLACE OF MOTHER

(State or Country)

Norway

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

(Address)

J. E. Hoyt
Kendrick Idaho

15.

Filed Aug 2 1913

Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH

June

24

1913

(Month)

(Day)

(Year)

17. I HEREBY CERTIFY, That I attended deceased from

191 , to

191

that I last saw him alive on June 1st 1913

and that death occurred on the date stated above, at 12:30 AM

The CAUSE OF DEATH* was as follows:

Divide Gangrene

(Duration) _____ yrs. 2 mos. 1 ds.

Contributory (Secondary)

(Duration) _____ yrs. _____ mos. _____ ds.

(Signed)

W. A. Roshore M. D.

June 25th 1913 (Address) Kendrick Idaho

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place

In the

of death _____ yrs. _____ mos. _____ ds. State _____ yrs. _____ mos. _____ ds.

Where was disease contracted,

If not at place of death?

Former or

usual residence.

19. PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

Funeral Home
Kendrick Idaho

June 25-1913

20. UNDERTAKER

ADDRESS

D. J. Rowlands

Kendrick Idaho

County of Canyon
City of Emmett

Primary Registration District No. _____

File No. 5624

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

E. S. Twillegar

St.)

Registered No. _____

If death occurred in a hospital, institution or camp give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX

4. COLOR OR RACE

5. SINGLE, MARRIED, WIDOWED OR DIVORCED.
married
(Write the word.)

6. DATE OF BIRTH

7. AGE

8. OCCUPATION

(a) Trade, profession, or particular kind of work
(b) General nature of industry, business, or establishment in which employed (or employer)

9. BIRTHPLACE

(State or Country)

10. NAME OF FATHER

11. BIRTHPLACE OF FATHER

(State or Country)

12. MAIDEN NAME OF MOTHER

13. BIRTHPLACE OF MOTHER

(State or Country)

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

(Address)

15.

Filed 7-29 1913

Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

17. I HEREBY CERTIFY, That I attended deceased from

that I last saw h. alive on

and that death occurred on the date stated above, at

The CAUSE OF DEATH* was as follows:

Contributory (Secondary)

(Signed)

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place In the

of death. yrs. mos. ds. State. yrs. mos. ds.

Where was Disease contracted,

If not at place of death?

Former or

usual residence.

19. PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

20. UNDERTAKER

ADDRESS

MARGIN RESERVED FOR BINDING
WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Form V. S. No. 5. 10M. 6-

OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics
File No. 5629

1. PLACE OF DEATH. Registration District No. 2010
County of Canyon Primary Registration District No.
City of Emmett (No. _____)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Infant

Registered No. _____
If death occurred in a hospital, institution or camp give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX male 4. COLOR OR RACE White 5. SINGLE, MARRIED, WIDOWED OR DIVORCED.
(Write the word.)

6. DATE OF BIRTH 7- 20 1913
(Month) (Day) (Year)

7. AGE 1 yrs. 1 mos. 1 ds. IF LESS than 1 day how many hrs. or min.?

8. OCCUPATION

- (a) Trade, profession or particular kind of work
(b) General nature of industry business or establishment in which employed (or employer)

9. BIRTHPLACE Canyon Co.
(State or Country)

10. NAME OF FATHER Roy J. Saunders

11. BIRTHPLACE OF FATHER Iowa
(State or Country)

12. MAIDEN NAME OF MOTHER Susie Gary

13. BIRTHPLACE OF MOTHER Iowa
(State or Country)

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) B. O. Clark
(Address) Emmett

15. Filed 7-28 1913 J. L. Reynolds
Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH 7- 21 1913
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from 7-20- 1913, to 1913

that I last saw him alive on above date 1913, and that death occurred on the date stated above, at 1 P. M.

The CAUSE OF DEATH* was as follows:
Inanition

(Duration) yrs. mos. ds. Premature birth
Contributory (Secondary)

(Duration) yrs. mos. ds. (Signed) B. O. Clark M. D.
7-22-1913 (Address) Emmett

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death yrs. mos. ds. State yrs. mos. ds.
Where was disease contracted,
If not at place of death?
Former or usual residence.

19. PLACE OF BURIAL OR REMOVAL DATE OF BURIAL
7-22 1913

20. UNDERTAKER ADDRESS
None

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Form V. S. No. 5. 10M. 6-20-11.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics
File No. 5630
Registered No. _____

1. PLACE OF DEATH.
County of Canyon
City of Emmett

Registration District No. 2010
Primary Registration District No. 1010
(No. _____ St.)

If death occurs away from usual residence, give facts called for under special information.

If death occurred in a hospital, institution or camp give its NAME instead of street and number.

2. FULL NAME Rose Washburn

PERSONAL AND STATISTICAL PARTICULARS

3. SEX female 4. COLOR OR RACE white 5. SINGLE, MARRIED, WIDOWED OR DIVORCED. married
(Write the word.)

6. DATE OF BIRTH Nov 30 1886
(Month) (Day) (Year)

7. AGE 26 yrs 7 mos 10 ds IF LESS than 1 day how many _____ hrs. or _____ min.?

8. OCCUPATION housewife
(a) Trade, profession, or particular kind of work
(b) General nature of industry, business, or establishment in which employed (or employer)

9. BIRTHPLACE North Carolina
(State or Country)

10. NAME OF FATHER Eli Martin

11. BIRTHPLACE OF FATHER North Carolina
(State or Country)

12. MAIDEN NAME OF MOTHER Sallie Burns

13. BIRTHPLACE OF MOTHER North Carolina
(State or Country)

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) J. D. Washburn
(Address) Emmett Idaho

15. _____

Filed July 15 1913 J. D. Washburn
Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH July 10 1913
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from Jan 1913, to July 2 1913
that I last saw her alive on July 2 1913,
and that death occurred on the date stated above, at 10:30 M.
The CAUSE OF DEATH* was as follows:
Pulmonary Tuberculosis

(Duration) 8 yrs. _____ mos. _____ ds.
Contributory (Secondary) _____

(Duration) _____ yrs. _____ mos. _____ ds.
(Signed) J. D. Reynolds M. D.
705 1913 (Address) Emmett

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL,

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place _____ In the _____
of death. _____ yrs. _____ mos. _____ ds. State. _____ yrs. _____ mos. _____ ds.
Where was Disease contracted,
If not at place of death?
Former or
usual residence. _____

19. PLACE OF BURIAL OR REMOVAL Emmett Cemetery DATE OF BURIAL July 12 1913

20. UNDERTAKER D. Buckner ADDRESS Emmett

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Form V. S. No. 5. 10M. 6-20-11.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics
File No. 5631

1. PLACE OF DEATH.
County of Canyon
City of Emmett

Registration District No. 2012
Primary Registration District No.
(No. , St.)

Registered No.

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Infant Son of Geo & Mabel Rynearson

If death occurred in a hospital, institution or camp give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX male
4. COLOR OR RACE white
5. SINGLE, MARRIED, WIDOWED OR DIVORCED. Infant
(Write the word.)

6. DATE OF BIRTH July 19 1913
(Month) (Day) (Year)

7. AGE new born
IF LESS than 1 day
how many hrs. or
yrs. mos. ds. min.?

8. OCCUPATION
(a) Trade, profession, or particular kind of work Infant
(b) General nature of industry business, or establishment in which employed (or employer)

9. BIRTHPLACE Idaho
(State or Country)

10. NAME OF FATHER Geo. Rynearson

11. BIRTHPLACE OF FATHER Utah
(State or Country)

12. MAIDEN NAME OF MOTHER Mabel Hopkins

13. BIRTHPLACE OF MOTHER Wash.
(State or Country)

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Geo. Rynearson
(Address) Emmett Ida

15.

Filed 7-30-1913 J. L. Reynolds
Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH July 19 1913
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from 7-19-1913, to 191
that I last saw him alive on Above date 191
and that death occurred on the date stated above, at 6 A. M.
The CAUSE OF DEATH* was as follows:

Institution
due to premature birth
(Duration) yrs. mos. ds.

Contributory (Secondary)
(Duration) yrs. mos. ds.
(Signed) B. O. Clark M. D.
July 20 1913 (Address) Emmett

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place In the
of death yrs. mos. ds. State yrs. mos. ds.
Where was Disease contracted,
If not at place of death?
Former or
usual residence

19. PLACE OF BURIAL OR REMOVAL DATE OF BURIAL
Emmett Cemetery July 19 1913
20. UNDERTAKER ADDRESS
C. D. Bucknum Emmett

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Form V. S. No. 5. 10M. 6-20-11.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics
File No. 5632

1. PLACE OF DEATH.
County of Canyon
City of Emmett

Registration District No. 2010
Primary Registration District No. _____
(No. _____, St.)

Registered No. _____

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Infant Son of Geo & Mabel Rynearson

If death occurred in a hospital, institution or camp give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX male 4. COLOR OR RACE white 5. SINGLE, MARRIED, WIDOWED OR DIVORCED.
Infant
(Write the word.)

6. DATE OF BIRTH July 19 1913
(Month) (Day) (Year)

7. AGE new Born IF LESS than 1 day
yrs. mos. ds. how many hrs. or min.?

8. OCCUPATION
(a) Trade, profession, or particular kind of work Infant
(b) General nature of industry business, or establishment in which employed (or employer) _____

9. BIRTHPLACE Idaho
(State or Country)

10. NAME OF FATHER Geo Rynearson

11. BIRTHPLACE OF FATHER Utah
(State or Country)

12. MAIDEN NAME OF MOTHER Mabel Hopkins

13. BIRTHPLACE OF MOTHER Nash
(State or Country)

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Geo Rynearson
(Address) Emmett

15. _____

Filed 7-30 1913 J. P. Reynolds
Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH July 19 1913
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from 7-19- 1913, to 191

that I last saw him alive on about date 191

and that death occurred on the date stated above, at 6 9, M.

The CAUSE OF DEATH* was as follows:

Immaturity

(Duration) yrs. mos. ds.

Contributory (Secondary) Premature birth

(Duration) yrs. mos. ds.

(Signed) B. O. Clark M. D.

19. (Address) Emmett Idaho

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL,

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place In the
of death. yrs. mos. ds. State. yrs. mos. ds.

Where was Disease contracted,
If not at place of death?

Former or
usual residence.

19. PLACE OF BURIAL OR REMOVAL Emmett Cemetery DATE OF BURIAL July 19 1913

20. UNDERTAKER C. S. Bucknum ADDRESS Emmett

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Form V. S. No. 5 20M.1-16-12

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH.

Registration District No.

34

County of ElmorePrimary Registration District No. 2020File No. 5633City of Pine

(No. _____, _____ St.)

Registered No. 18

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

Robert C. Graff

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX

Male

4. COLOR OR RACE

White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED

Single
(Write the word.)

6. DATE OF BIRTH

_____ 1849
(Month) (Day) (Year)

7. AGE

64 yrs. — mos. — ds.

IF LESS than 1 day
how many hrs. or
..... mins.?

8. OCCUPATION

(a) Trade, profession or particular kind of work
(b) General nature of industry business, or establishment in which employed (or employer)

Miner

9. BIRTHPLACE

(State or Country)

Germany

10. NAME OF FATHER

Unknown

11. BIRTHPLACE OF FATHER

(State or Country)

Unknown

12. MAIDEN NAME OF MOTHER

Unknown

13. BIRTHPLACE OF MOTHER

(State or Country)

Unknown

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Lee Knox - per B. W. M.(Address) Pine, Idaho

15.

Filed July 15th 1913B. W. M.
Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH

July 14th 1913
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from

1913, to 1913,
that I last saw him alive on July 14th 1913,
and that death occurred on the date stated above, at 10 P.M.

The CAUSE OF DEATH* was as follows:

Laudanum Poisoning - (accidental)

(Duration) yrs. mos. 1 ds.

Contributory
(Secondary)

none

(Duration) yrs. mos. ds.

(Signed)

B. W. M. M. D.

7/15 1913 (Address) Mountain Home

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death yrs. mos. days. In the State yrs. mos. days.

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL

Pine

DATE OF BURIAL

July 15th 1913

20. UNDERTAKER

Lee Knox

ADDRESS

Pine, Idaho

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Form V. S. No. 5 20M.1-16-12

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics
File No. 5634

1. PLACE OF DEATH

Registration District No. 79

County of Bonner

Primary Registration District No. 2156

City of Bonner Ferry

(No. St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

Jane Roach

Registered No.

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX

Male

4. COLOR OR RACE

White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED.

Single
(Write the word.)

6. DATE OF BIRTH

 (Month) 1 (Day) (Year)

7. AGE

49 yrs. mos. ds.

IF LESS than 1 day
how many hrs. or
 mins.

8. OCCUPATION

(a) Trade, profession or particular kind of work

Laborer

(b) General nature of industry business, or establishment in which employed (or employer)

9. BIRTHPLACE

(State or Country)

Germany

10. NAME OF FATHER

11. BIRTHPLACE OF FATHER

(State or Country)

12. MAIDEN NAME OF MOTHER

13. BIRTHPLACE OF MOTHER

(State or Country)

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

Michael H. Gannon

(Address)

Post Office, Idaho

15.

Filed

Aug. 4th 1913

E. E. Tre
Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

August 3rd 1913
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from

191 , to 191 ,

that I last saw h. alive on 191 ,

and that death occurred on the date stated above, at M.

The CAUSE OF DEATH* was as follows:

Broken neck - Accidental

(Duration) yrs. mos. ds.

Contributory
(Secondary)

(Duration) yrs. mos. ds.

(Signed)

19 (Address) Bonner Ferry, Idaho

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death yrs. mos. days. In the State yrs. mos. days.

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

Four Hill, Idaho Aug 6th 1913

20. UNDERTAKER

ADDRESS

John J. Moore Bonner Ferry, Idaho

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Form V. S. No. 5 20M.1-16-12

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics
File No. 5635

1. PLACE OF DEATH Registration District No. 79
County of Bonner Primary Registration District No. 2156
City of Bonner (No.) St.)

Registered No. _____
If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

Michael Arthur McCoy

PERSONAL AND STATISTICAL PARTICULARS

3. SEX 4. COLOR OR RACE 5. SINGLE, MARRIED, WIDOWED OR DIVORCED.

Male White Single (Write the word.)

6. DATE OF BIRTH

March 17 1883
(Month) (Day) (Year)

7. AGE

30 yrs. 4 mos. 13 ds.

IF LESS than 1 day
how many hrs. or
..... mins.?

8. OCCUPATION

(a) Trade, profession or particular kind of work

Engineer

(b) General nature of industry business, or establishment in which employed (or employer)

9. BIRTHPLACE

(State or Country)

East Grand Fork Minn.

10. NAME OF FATHER

John McCoy

11. BIRTHPLACE OF FATHER

(State or Country)

Canada

12. MAIDEN NAME OF MOTHER

Ellen McGuire

13. BIRTHPLACE OF MOTHER

(State or Country)

Canada

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

J. S. McCoy

(Address)

East Grand Fork Minn.

15.

Filed

July 31 st. 1913.

E. E. Moore
Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

July 30 1913
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from July 7th. 1913, to July 30th. 1913, that I last saw him alive on July 30th. 1913.

and that death occurred on the date stated above, at 1 P. M.

The CAUSE OF DEATH* was as follows:

Typhoid Fever.

(Duration) yrs. mos. ds.

Contributory (Secondary)

(Duration) yrs. mos. ds.

(Signed)

July 31 1913 (Address) Bonner Ferry, Ida.

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death yrs. mos. days. In the State yrs. mos. days.

Where was disease contracted if not at place of death?

Former or usual residence

Grand Forks, N. D.

19. PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

Grand Fork N.D. 1913

20. UNDERTAKER

ADDRESS

John J. Moore Bonner Ferry

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Form V. S. No. 5 20M.1-16-12

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics
File No. 5635

1. PLACE OF DEATH.

Registration District No. 79

County of Bonner

Primary Registration District No. 2156

City of Bonner Ferry, Idaho No. St.)

Registered No. If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

Bohster Alfred Troker

PERSONAL AND STATISTICAL PARTICULARS

3. SEX

Male

4. COLOR OR RACE

White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED.

Single (Write the word.)

6. DATE OF BIRTH

Oct 26 1910 (Month) (Day) (Year)

7. AGE

2 yrs. 8 mos. 15 ds.

IF LESS than 1 day how many hrs. or mins.?

8. OCCUPATION

(a) Trade, profession or particular kind of work
(b) General nature of industry business, or establishment in which employed (or employer)

9. BIRTHPLACE

(State or Country)

Spokane, Idaho

10. NAME OF FATHER

Adopted Father: Thomas Troker

11. BIRTHPLACE OF FATHER

(State or Country)

Not known.

12. MAIDEN NAME OF MOTHER

Margaret Connolly

13. BIRTHPLACE OF MOTHER

(State or Country)

unknown.

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Mrs. Ella Storker

(Address) Bonner Ferry, Idaho

15.

Filed June 11 th 1913

Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH

June 11 1913 (Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from May 26 th 1913, to June 11 th 1913, that I last saw him alive on June 5 th 1913, and that death occurred on the date stated above, at 1 P.M.

The CAUSE OF DEATH* was as follows:

Broncho - Pneumonia

(Duration) yrs. - mos. 16 ds.

Contributory (Secondary)

(Duration) yrs. - mos. - ds.

(Signed) E. E. Inc. M. D.

June 11 1913 (Address) Bonner Ferry, Idaho

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death. yrs. - mos. - days. In the State. yrs. - mos. - days.

Where was disease contracted if not at place of death?

Former or usual residence.

19. PLACE OF BURIAL OR REMOVAL DATE OF BURIAL

Bonner Ferry, Idaho June 12 1913

20. UNDERTAKER

ADDRESS

John J. Brown Bonner Ferry, Idaho

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Form V. S. No. 5 20M.1-16-12

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH.

Registration District No. 79

County of Bonner

Primary Registration District No. 2156

File No. 5637

City of Bonner Ferry

(No. _____, St.)

Registered No. _____

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Harry Conrad Hanson

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX

Male

4. COLOR OR RACE

White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED.

married
(Write the word.)

6. DATE OF BIRTH

Sept 27th 1877
(Month) (Day) (Year)

7. AGE

35 yrs. 8 mos. 4 ds.

IF LESS than 1 day
how many hrs. or mins.?

8. OCCUPATION

(a) Trade, profession or particular kind of work

(b) General nature of industry business, or establishment in which employed (or employer)

Mechanic

9. BIRTHPLACE

(State or Country)

Norway

10. NAME OF FATHER

Martin Hanson

11. BIRTHPLACE OF FATHER

(State or Country)

Norway

12. MAIDEN NAME OF MOTHER

Cary Hanson

13. BIRTHPLACE OF MOTHER

(State or Country)

Norway

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Henry Hanson

(Address) Chippewa Falls Wis.

15.

Filed June 1st 1913

Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH

May 31 1913
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from

191, to 191, that I last saw h. alive on 191

and that death occurred on the date stated above, at 8:30 P. M.

The CAUSE OF DEATH* was as follows:

Probably apo embolus

(Duration) yrs. mos. ds.

Contributory (Secondary) Probably endocarditis

(Duration) yrs. mos. ds.

(Signed) E. E. Fry, M. D.

June 1 1913. (Address) Bonner Ferry, Ida.

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death yrs. mos. days. In the State yrs. mos. days.

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

191

20. UNDERTAKER

ADDRESS

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Form V. S. No. 5 20M.1-16-12

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH.

Registration District No.

County of *Bannock*

Primary Registration District No.

City of *Pocatello*

(No.)

St.)

File No.

Registered No.

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

Charles Demetrius Chandler

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX

4. COLOR OR RACE

5. SINGLE, MARRIED, WIDOWED OR DIVORCED.

Male *White* *Married*

6. DATE OF BIRTH

March — *1873*
(Month) (Day) (Year)

7. AGE

40 yrs. *5* mos. ds.IF LESS than 1 day
how many hrs. or
..... mins.?

8. OCCUPATION

(a) Trade, profession or particular kind of work

(b) General nature of industry business, or establishment in which employed (or employer)

Machine Shop Foreman
O.S.L. RR.

9. BIRTHPLACE

(State or Country)

Cedar Rapids Iowa

10. NAME OF FATHER

David D Chandler

11. BIRTHPLACE OF FATHER

(State or Country)

Mass.

12. MAIDEN NAME OF MOTHER

Elizabeth Usher

13. BIRTHPLACE OF MOTHER

(State or Country)

New York

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

(Address)

San Florence M. Chandler
Pocatello, Idaho
48 North Harrison

15.

Filed

1913

Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

Unknown
(Month) (Day) (Year) *1913*

17. I HEREBY CERTIFY, That I attended deceased from

191 to *191*that I last saw him alive on *191*and that death occurred on the date stated above, at *M.*

The CAUSE OF DEATH* was as follows:

Probably
Exhaustion while
laboring on
and possibly injured by falling
on rocks
(Duration) yrs. mos. ds.Contributory
(Secondary)

(Duration) yrs. mos. ds.

(Signed)

O. B. Hagerman M. D.
7-23 1913 (Address)

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents)

At place of death. yrs. mos. days. In the State. yrs. mos. days.

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

Springfield Mo *July 10* 1913

20. UNDERTAKER

ADDRESS

Ray Chandler Pocatello

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Form V. S. No. 5 20M.1-16-12

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH.
County of *Bannock*
City of *Procatello*
Registration District No. *28*
Primary Registration District No. *1002*
(No. *150, So. 6th Ave.* St.)
If death occurs away from usual residence, give facts called for under special information.

File No. *25639*
Registered No. *67*
If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME *Anna Blomw.*

PERSONAL AND STATISTICAL PARTICULARS

3. SEX *Female* 4. COLOR OR RACE *White* 5. SINGLE, MARRIED, WIDOWED OR DIVORCED *Married*

6. DATE OF BIRTH *1883*
(Month) (Day) (Year)

7. AGE *30* yrs. mos. ds.
IF LESS than 1 day how many hrs. or mins.?

8. OCCUPATION
(a) Trade, profession or particular kind of work *Nurse Girl*
(b) General nature of industry, business, or establishment in which employed (or employer) *Domest*

9. BIRTHPLACE *Austria*
(State or Country)

10. NAME OF FATHER ✓

11. BIRTHPLACE OF FATHER ✓
(State or Country)

12. MAIDEN NAME OF MOTHER ✓

13. BIRTHPLACE OF MOTHER ✓
(State or Country)

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) *C. D. Matthews*
(Address) *Procatello Ida.*

15. Filed *July 14, 1913* *W. J. Steady*
Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH *July 12, 1913*
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from *July 4th* 191*3*, to *July 12* 191*3*, that I last saw him alive on *July 12* 191*3*, and that death occurred on the date stated above, at *7:30 P.M.*

The CAUSE OF DEATH was as follows:
Nephritis
(Duration) yrs. mos. ds. *8*

Contributory (Secondary)
(Duration) yrs. mos. ds. *8*
(Signed) *A. Smith* M. D.
(Address) *Procatello Idaho*
July 12, 1913

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death yrs. mos. days. In the State yrs. mos. days. *8*

Where was disease contracted if not at place of death?
Former or usual residence

19. PLACE OF BURIAL OR REMOVAL *Procatello Idaho* DATE OF BURIAL *July 14, 1913*

20. UNDERTAKER *W. J. Steady* ADDRESS *Procatello Idaho*

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Form V. S. No. 5 20M.1-16-42

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH

Registration District No. 28

County of

Primary Registration District No. 1002

City of

(No. 830, W. Harrison St.)

File No. 25641

Registered No. 70

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

Leonard Sullivan

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX

4. COLOR OR RACE

5. SINGLE, MARRIED, WIDOWED OR DIVORCED.

Male

White

(Write the word.)

6. DATE OF BIRTH

August 1891

(Month)

(Day)

(Year)

7. AGE

21 yrs. 9 mos. ds.

IF LESS than 1 day
how many hrs. or mins.?

8. OCCUPATION

(a) Trade, profession or particular kind of work

(b) General nature of industry business, or establishment in which employed (or employer)

Farmer

9. BIRTHPLACE

(State or Country)

England

10. NAME OF FATHER

11. BIRTHPLACE OF FATHER

(State or Country)

12. MAIDEN NAME OF MOTHER

13. BIRTHPLACE OF MOTHER

(State or Country)

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

H. N. Dant

(Address)

Salt Lake City Utah

15.

Filed

July 13, 1913

1913

O. J. Keegan

Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH

May 14 1913

(Month)

14

(Day)

3

(Year)

17. I HEREBY CERTIFY, That I attended deceased from

May 13 1913, to May 14 1913

that I last saw him alive on May 14 1913

and that death occurred on the date stated above, at 3:30 P. M.

The CAUSE OF DEATH* was as follows:

Diabetes

(Duration) yrs. mos. ds.

Contributory

(Secondary)

(Duration) yrs. mos. ds.

(Signed)

H. N. Dant M. D.

May 13 1913 (Address) Salt Lake City

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death. yrs. mos. days. In the State. yrs. mos. days.

Where was disease contracted if not at place of death?

Former or usual residence.

19. PLACE OF BURIAL OR REMOVAL DATE OF BURIAL

Salt Lake City Utah May 15 1913

20. UNDERTAKER

ADDRESS

H. N. Dant Procatello

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Form V. S. No. 5 20M.1-16-12

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics
File No. 2-5641
Registered No. 71
If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

1. PLACE OF DEATH. Registration District No. 28
County of Bannock Primary Registration District No. 1002
City of Locatello, Idaho (No. 905, South Harrison St.)
If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Budlow Munn

PERSONAL AND STATISTICAL PARTICULARS

3. SEX Male 4. COLOR OR RACE White 5. SINGLE, MARRIED, WIDOWED OR DIVORCED. Single
(Write the word.)

6. DATE OF BIRTH September 24 1912
(Month) (Day) (Year)

7. AGE 9 yrs. 11 mos. 11 ds.
IF LESS than 1 day how many hrs. or mins.

8. OCCUPATION
(a) Trade, profession or particular kind of work None
(b) General nature of industry, business, or establishment in which employed (or employer)

9. BIRTHPLACE Locatello Idaho
(State or Country)

10. NAME OF FATHER Joseph Munn

11. BIRTHPLACE OF FATHER Montpelier Idaho
(State or Country)

12. MAIDEN NAME OF MOTHER Grace Cunningham

13. BIRTHPLACE OF MOTHER Illinois
(State or Country)

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) J. R. Munn
(Address) 657 South Hayes

15. Filed July 6, 1913 3 O. R. Lee
Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH July 5 1913
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from June 20 1913, to July 25 1913, that I last saw him alive on July 5 1913, and that death occurred on the date stated above, at 4 P. M.

The CAUSE OF DEATH* was as follows:
Euthanasia

(Duration) 5 yrs. 11 mos. 11 ds.

Contributory (Secondary)
(Duration) 5 yrs. 11 mos. 11 ds.
(Signed) Wm. H. Wadley, M. D.
July 6 1913 (Address) Prater Idaho

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death 5 yrs. 11 mos. 11 days. In the State 5 yrs. 11 mos. 11 days.

Where was disease contracted if not at place of death?
Former or usual residence

19. PLACE OF BURIAL OR REMOVAL At Home DATE OF BURIAL July 6 1913

20. UNDERTAKER W. H. Wadley ADDRESS Locatello

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Form V. S. No. 5 20M.1-16-12

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics
File No. 2 5642
Registered No. 69

1. PLACE OF DEATH.

Registration District No. 28

Country of Banrock

Primary Registration District No. 100 ~

City of Pocatello

(No. 621 St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

Frederick Jones

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX

4. COLOR OR RACE

5. SINGLE, MARRIED, WIDOWED OR DIVORCED.

6. DATE OF BIRTH

7. AGE

IF LESS than 1 day
how many hrs. or
..... mins?

8. OCCUPATION

(a) Trade, profession or particular kind of work

(b) General nature of industry business, or establishment in which employed (or employer)

9. BIRTHPLACE

(State or Country)

10. NAME OF FATHER

11. BIRTHPLACE OF FATHER

(State or Country)

12. MAIDEN NAME OF MOTHER

13. BIRTHPLACE OF MOTHER

(State or Country)

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

(Address)

15.

Filed

191 3

Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH

17.

I HEREBY CERTIFY, That I attended deceased from

that I last saw him alive on

and that death occurred on the date stated above, at

The CAUSE OF DEATH* was as follows:

Gun Shot Wound
Suicide

Contributory
(Secondary)

(Signed)

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death yrs mos days. In the State yrs mos days.

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

20. UNDERTAKER

ADDRESS

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Form V. S. No. 5 20M.1-16-12

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics
File No. 2 5643
Registered No. 68

1. **PLACE OF DEATH.** Registration District No. 28
County of Pannock Primary Registration District No. 1002
City of Oryol (No. Railroad Tracks St.)
If death occurs away from usual residence, give facts called for under special information. 2. **FULL NAME** William D. Sheen

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. **SEX** Male 4. **COLOR OR RACE** White 5. **SINGLE, MARRIED, WIDOWED OR DIVORCED.** Single
6. **DATE OF BIRTH** Dec 15 1906
(Month) (Day) (Year)
7. **AGE** 6 yrs. 6 mos. 16 ds.
IF LESS than 1 day how many hrs. or mins.?

8. **OCCUPATION**
(a) Trade, profession or particular kind of work None
(b) General nature of industry business, or establishment in which employed (or employer)
9. **BIRTHPLACE** Salt Lake City
(State or Country)
10. **NAME OF FATHER** Benjamin N. Sheen
11. **BIRTHPLACE OF FATHER** Palmer Ohio
(State or Country)
12. **MAIDEN NAME OF MOTHER** Cathel N. Mullett
13. **BIRTHPLACE OF MOTHER** Salt Lake City
(State or Country)
14. **THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE**
(Informant) Benjamin Sheen
(Address) Salt Lake City, Utah
15. **Filed** July 2nd 1913 O. B. Sheen
Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. **DATE OF DEATH** July 1st 1913
(Month) (Day) (Year)
17. **I HEREBY CERTIFY, That I attended deceased from** 1913, to 1913,
that I last saw him alive on 1913,
and that death occurred on the date stated above, at 6:45 P. M.
The CAUSE OF DEATH* was as follows:
Killed R R accident

(Duration) yrs. mos.
Contributory (Secondary)
(Duration) yrs. mos.
(Signed) O. B. Sheen
July 2 1913 (Address) Pocatello Idaho
*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.
18. **LENGTH OF RESIDENCE** (For Hospitals, Institutions Transients or Recent Residents.)
At place of death yrs. mos. days. In the State yrs. mos.
Where was disease contracted if not at place of death?
Former or usual residence
19. **PLACE OF BURIAL OR REMOVAL** Salt Lake City **DATE OF BURY** July 2nd 1913
20. **UNDERTAKER** R. D. Walker **ADDRESS** Pocatello

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Form V. S. No. 5 20M.1-16-12

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH.

Registration District No.

County of

Primary Registration District No.

City of

(No.)

St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

File No.

Registered No.

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX

4. COLOR OR RACE

5. SINGLE, MARRIED, WIDOWED OR DIVORCED.

6. DATE OF BIRTH

7. AGE

IF LESS than 1 day
how many hrs. or mins.?

8. OCCUPATION

(a) Trade, profession or particular kind of work

(b) General nature of industry business, or establishment in which employed (or employer)

9. BIRTHPLACE

(State or Country)

10. NAME OF FATHER

11. BIRTHPLACE OF FATHER

(State or Country)

12. MAIDEN NAME OF MOTHER

13. BIRTHPLACE OF MOTHER

(State or Country)

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

(Address)

15.

Filed

191

Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH

17. I HEREBY CERTIFY, That I attended deceased from

that I last saw her alive on

and that death occurred on the date stated above, at

The CAUSE OF DEATH* was as follows:

Contributory
(Secondary)

(Signed)

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death. yrs. mos. days. In the State. yrs. mos. days.

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL DATE OF BURIAL

20. UNDERTAKER

ADDRESS

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Form V. S. No. 5 20M.1-16-12

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH.

Registration District No.

County of GordonsPrimary Registration District No. 2013City of Hagerman

(No.)

St.)

Registered No.

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

Sen Macmillan

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX

4. COLOR OR RACE

5. SINGLE, MARRIED, WIDOWED OR DIVORCED.

malewhitemarried

(Write the word.)

6. DATE OF BIRTH

May261897

(Month)

(Day)

(Year)

7. AGE

36

yrs.

1

mos.

27

ds.

IF LESS than 1 day
how many hrs. or
..... mins.?

8. OCCUPATION

(a) Trade, profession or particular kind of work

(b) General nature of industry business, or establishment in which employed (or employer)

ButcherHubbun Out Canada

9. BIRTHPLACE

(State or Country)

10. NAME OF FATHER

Sen Macmillan

11. BIRTHPLACE OF FATHER

(State or Country)

Ont Canada

12. MAIDEN NAME OF MOTHER

Mary Macmillan

13. BIRTHPLACE OF MOTHER

(State or Country)

Scotland

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

Mrs Macmillan

(Address)

Hagerman

15.

Filed

Aug 6

191

3W H Marshall

Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH

July211913

(Month)

(Day)

(Year)

17. I HEREBY CERTIFY, That I attended deceased from

July 21 1913 to July 21 1913that I last saw him alive on July 21 1913and that death occurred on the date stated above, at 5:30 PM

The CAUSE OF DEATH* was as follows:

Drowning

(Duration) yrs. mos. ds.

Contributory

(Secondary)

(Duration) yrs. mos. ds.

(Signed)

W H Marshall

M. D.

19

(Address)

Hagerman

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death yrs. mos. days. In the State yrs. mos. days.

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

ThompsonJuly 23 1913

20. UNDERTAKER

ADDRESS

ThompsonThompson

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Form V. S. No. 5 20M.1-16-12

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH.

Registration District No.

County of

Primary Registration District No.

City of

(No.

St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

Ida Maud Reville

File No.

5647

Registered No.

82

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX

Female

4. COLOR OR RACE

White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED.

Married
(Write the word.)

6. DATE OF BIRTH

March

1-

1891

(Month)

(Day)

(Year)

7. AGE

22

yrs.

4

mos.

ds.

IF LESS than 1 day
how many hrs. or
..... mins.?

8. OCCUPATION

(a) Trade, profession or particular kind of work

Housewife

(b) General nature of industry business, or establishment in which employed (or employer)

9. BIRTHPLACE

(State or Country)

Utah

10. NAME OF FATHER

John F. Jones

11. BIRTHPLACE OF FATHER

(State or Country)

Missouri

12. MAIDEN NAME OF MOTHER

Alice Beebe

13. BIRTHPLACE OF MOTHER

(State or Country)

Missouri

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

E. H. Reville

(Address)

Wapato Idaho

15.

Filed

July 7

1913

W. H. Hunt

Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH

July

4

1913

(Month)

(Day)

(Year)

17. I HEREBY CERTIFY, That I attended deceased from *July 3*, 191*3*, to *July 4*, 191*3*, that I last saw her alive on *July 4*, 191*3*, and that death occurred on the date stated above, at *100* A.M.

The CAUSE OF DEATH* was as follows:

Lobar pneumonia

(Duration)

yrs.

mos.

ds.

Contributory
(Secondary)

Pulmonary Embolism

(Duration)

yrs.

mos.

ds.

(Signed)

7/5 1913

John F. Miller
Idaho Falls

*State the DISEASE CAUSING DEATH; or in cases from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDE or HOMICIDE.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death

yrs.

mos.

days.

In the State

yrs.

mos.

days.

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

Blackfoot Idaho

6-7

191*3*

20. UNDERTAKER

E. H. Hunt

ADDRESS

Idaho Falls Idaho

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Form V. S. No. 5 20M.1-16-12

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH

Registration District No. 93

County of Bonner

Primary Registration District No. 2450

City of _____

(No. _____, _____ St.)

File No. 5648

Registered No. 5-3

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

Jessie Amanda Sylvester

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX

4. COLOR OR RACE

5. SINGLE, MARRIED, WIDOWED OR DIVORCED.

Female White

(Write the word.)

6. DATE OF BIRTH

July 16 1913
(Month) (Day) (Year)

7. AGE

1 yrs. 0 mos. 0 ds.

IF LESS than 1 day
how many 3 hrs. or
mins?

8. OCCUPATION

- (a) Trade, profession or particular kind of work
(b) General nature of industry, business, or establishment in which employed (or employer)

9. BIRTHPLACE

(State or Country)

Idaho

10. NAME OF FATHER

Ronald H Sylvester

11. BIRTHPLACE OF FATHER

(State or Country)

Colorado

12. MAIDEN NAME OF MOTHER

Anna Johnson

13. BIRTHPLACE OF MOTHER

(State or Country)

Illinois

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

R. H. Sylvester

(Address)

Highway Idaho R. 2450

15.

Filed

June 11 1913 C. C. Cunniff

Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

July 11 1913
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from

July 11 1913, to July 11 1913,

that I last saw h alive on July 11 1913,

and that death occurred on the date stated above, at 5:30 P.M.

The CAUSE OF DEATH* was as follows:

Atelctasis -
no medical
attendance - 3 hours
(Duration) 3 hrs. 0 mos. 0 ds.

Contributory
(Secondary)

(Duration) 0 yrs. 0 mos. 0 ds.

(Signed) W. C. Cunniff M. D.

July 11 1913 (Address) Idaho Falls Idaho

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death 0 yrs. 0 mos. 0 days. In the State 0 yrs. 0 mos. 0 days.

Where was disease contracted if not at place of death? _____

Former or usual residence _____

19. PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

Idaho Cemetery

July 11 1913

20. UNDERTAKER

ADDRESS

None

MARGIN RESERVED FOR BINDING
WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Form V. S. No. 5 20M.1-16-12

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH.

Registration District No. 73

County of Bonanza

Primary Registration District No. 2427

City of Idaho Falls

(No.) St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

Henry A. Ferguson

File No. 5649

Registered No. 54

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX

male

4. COLOR OR RACE

white

5. SINGLE, MARRIED, WIDOWED OR DIVORCED.

widowed
(Write the word.)

6. DATE OF BIRTH

Apr 6 1880
(Month) (Day) (Year)

7. AGE

73 yrs. 3 mos. 13 ds.

IF LESS than 1 day
how many hrs. or mins.?

8. OCCUPATION

(a) Trade, profession or particular kind of work

Carpenter

(b) General nature of industry business, or establishment in which employed (or employer)

9. BIRTHPLACE

(State or Country)

Ohio

10. NAME OF FATHER

Henry A. Ferguson

11. BIRTHPLACE OF FATHER

(State or Country)

Ohio

12. MAIDEN NAME OF MOTHER

Matilda

13. BIRTHPLACE OF MOTHER

(State or Country)

Ohio

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

Charles Ferguson

(Address)

Idaho Falls

15.

Filed July 19 1913

Local

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH

July 18th 1913
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from

July 15th 1913, to July 18th 1913,
that I last saw him alive on July 18th 1913

and that death occurred on the date stated above, at 3:30 P.M.

The CAUSE OF DEATH* was as follows:

Peritonitis

(Duration) yrs. mos. ds.

Contributory (Secondary) Perforated ulcer of stomach

(Duration) yrs. mos. ds.

(Signed) J. H. Hollister, M. D.

7/19 1913 (Address) Idaho Falls, Ida.

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death yrs. mos. days. In the State yrs. mos. days.

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

Salt Lake City July 19 1913

20. UNDERTAKER

ADDRESS

E. H. Hunt

Idaho Falls

-SUPPLEMENTARY DEATH CERTIFICATE-

(Please reply on this sheet to
the registrar of Vital Statistics)

Death Certificate No.

Name..... Henry A. Ferguson.....

Date of Death..... July 18th

Cause of Death..... *Peritonitis*

Contributory Cause of death..... *Perforating Ulcer of Stomach.*

(Sign here)..... *J. C. Hollister,* M.D.

WRITE PLAINLY, WITH UNFADING INK.—THIS IS A PERMANENT RECORD.
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Form V. S. No. 5 20M.1-16-12

CERTIFICATE OF DEATH

 State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH

Registration District No. 73County of BonnevillePrimary Registration District No. 2150City of Idaho Falls

(No. _____ St.)

File No. 5650

Registered No. _____

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

Harry L. Vigus

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX

Male

4. COLOR OR RACE

White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED.

unknown
(Write the word.)

6. DATE OF BIRTH

Unknown

(Month) (Day) (Year)

7. AGE

38- about

yrs. mos. ds.

 IF LESS than 1 day
how many hrs. or
..... mins.

8. OCCUPATION

(a) Trade, profession or particular kind of work

(b) General nature of industry business, or establishment in which employed (or employer)

Labour

9. BIRTHPLACE

(State or Country)

Unknown

10. NAME OF FATHER

11. BIRTHPLACE OF FATHER

(State or Country)

12. MAIDEN NAME OF MOTHER

13. BIRTHPLACE OF MOTHER

(State or Country)

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

(Address)

G. H. Hunt
Idaho Falls

15.

Filed Aug 2 1913

Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

June 29 1913
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from

June 22 1913, to June 29 1913
that I last saw him alive on June 29 1913

 and that death occurred on the date stated above, at 2 P.M.

The CAUSE OF DEATH* was as follows:

Cholecystitis(Duration) yrs. 6 mos. ds.

Contributory (Secondary)

Cholecystitis
10 years(Duration) yrs. mos. 7 ds.

(Signed)

Aug 1 1913 (Address) Idaho Falls, Id. M. D.

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL OR HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death yrs. mos. days. In the State yrs. mos. days.

Where was disease contracted if not at place of death?

Former or usual residence.

19. PLACE OF BURIAL OR REMOVAL DATE OF BURIAL

Idaho Falls July 2 1913

20. UNDERTAKER

ADDRESS

G. H. Hunt Idaho Falls

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Form V. S. No. 5. 12½ M. 7-24-11

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics
File No. 5651
Registered No. 69

1. PLACE OF DEATH
County of Blaine
City of Samarra
Registration District No. 76
Primary Registration District No. 2069
(No. _____, St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

Jonah Evans Thompson
If death occurred in a hospital, institution or camp give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX male 4. COLOR OR RACE white 5. SINGLE, MARRIED, WIDOWED OR DIVORCED.
(Write the word.)

6. DATE OF BIRTH Sept 17 1913
(Month) (Day) (Year)

7. AGE 9 yrs. 21 mos. 21 ds. IF LESS than 1 day how many _____ hrs. or _____ min?

8. OCCUPATION

- (a) Trade, profession or particular kind of work.
(b) General nature of industry business or establishment in which employed (or employer)

9. BIRTHPLACE

(State or Country)

10. NAME OF FATHER

11. BIRTHPLACE OF FATHER

(State or Country)

12. MAIDEN NAME OF MOTHER

13. BIRTHPLACE OF MOTHER

(State or Country)

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

(Address)

15.

Filed 7-15 191 3

Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH

July 3 191 3
(Month) (Day) (Year)

17. I HEREBY CERTIFY That I attended deceased from

191____, to 191____

that I last saw h_____ alive on 191____

and that death occurred on the date stated above, at _____ M.

The CAUSE OF DEATH* was as follows:

no physician attendance
possibly acute gastritis

____ (Duration) _____ yrs. _____ mos. _____ ds.

Contributory

(Secondary)

____ (Duration) _____ yrs. _____ mos. _____ ds.

(Signed)

Dr. Ray County Physician
July 2 1913 (Address) Malad City, Idaho

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place _____ In the _____
of death _____ yrs. _____ mos. _____ ds. State _____ yrs. _____ mos. _____ ds.

Where was disease contracted,

If not at place of death?

Former or

usual residence.

19. PLACE OF BURIAL OR REMOVAL DATE OF BURIAL

Samarra Idaho July 6 191 3

20. UNDERTAKER

ADDRESS

D E Johnson Malad City Idaho

CERTIFICATE OF DEATH.

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH.

County of Oneida
City of MaladRegistration District No. 26
Primary Registration District No. 2069
(No. _____ St.)File No. 5652
Registered No. 70If death occurs away from
usual residence, give facts
called for under special
information.2. FULL NAME William WilliamsIf death occurred in a hos-
pital, institution or camp,
give its NAME instead of
street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX Male 4. COLOR OR RACE White 5. SINGLE, MARRIED, WID-
OWED OR DIVORCED. Single
(Write the word.)

6. DATE OF BIRTH.

Mar 7 1908
(Month) (Day) (Year)

7. AGE

6 Yrs. 4 Mos. 1 ds.IF LESS than 1 day
how many hrs. or
..... min.?

8. OCCUPATION

(a) Trade, profession or
particular kind of work.....
(b) General nature of in-
dustry, business, or estab-
lishment in which employ-
ed (or employer).....

9. BIRTHPLACE

(State or Country) Malad Idaho10. NAME OF
FATHERMorge Williams11. BIRTHPLACE
OF FATHER(State or Country) Sherry Creek, Ida12. MAIDEN NAME
OF MOTHERAlice Evans13. BIRTHPLACE
OF MOTHER(State or Country) Malad Idaho

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Agnes Jones(Address) St John Ida

15.

Filed July 18 19133D C Ray

Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

July 8 1913
(Month) (Day) (Year)17. I HEREBY CERTIFY, That I attended deceased from
July 8 1913 to 1913
that I last saw him alive on July 8 1913
and that death occurred on the date stated above, at 6 P.M.

The CAUSE OF DEATH* was as follows:

accidental. fell off load
of hay. - wagon run over
left side and bowels.

(Duration) _____ Yrs. _____ mos. _____ ds.

Contributory
(Secondary)

(Duration) _____ yrs. _____ mos. _____ ds.

(Signed) D C Ray M. D.July 10 1913 (Address) Malad City Idaho*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1)
MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.18. LENGTH OF RESIDENCE (For Hospitals, Institutions,
Transients or Recent Residents.)

At place of death.....yrs.....mos.....days In the State.....yrs.....mos.....days

Where was disease contracted
if not at place of death?.....Former or
usual residence

19. PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

Malad IdahoJuly 11 1913

20. UNDERTAKER

ADDRESS

A S JohnsonMalad

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

CERTIFICATE OF DEATH

State of Idaho

BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH

Registration District No. KeCounty of OneidaPrimary Registration District No. 2569City of Pleasant View

(No. _____, _____ St.)

File No. 5653Registered No. 71

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Ester Jenkins Morse

If death occurred in a hospital, institution or camp give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX

4. COLOR OR RACE

5. SINGLE, MARRIED, WIDOWED OR DIVORCED.

Female White Married

6. DATE OF BIRTH

Feb 1 1895
(Month) (Day) (Year)

7. AGE

68 yrs. 5 mos. 20 ds.IF LESS than 1 day
how many _____ hrs. or
_____ min?

8. OCCUPATION

(a) Trade, profession or particular kind of work.
(b) General nature of industry, business or establishment in which employed (or employer).Housewife

9. BIRTHPLACE

(State or Country)

South Wales

10. NAME OF FATHER

David Jenkins

11. BIRTHPLACE OF FATHER

(State or Country)

South Wales

12. MAIDEN NAME OF MOTHER

Anna Evans

13. BIRTHPLACE OF MOTHER

(State or Country)

South Wales

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

(Address)

S. Parker Morse
Samaria Ida

15.

Filed Aug, 1913

Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH

July 21 1913
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from

July 2 1913 to July 21 1913that I last saw her alive on July 21 1913and that death occurred on the date stated above, at 10:30 A.M.

The CAUSE OF DEATH* was as follows:

Bronchitis
(Chronic)

_____ (Duration) _____ yrs. _____ mos. _____ ds.

Contributory
(Secondary)

_____ (Duration) _____ yrs. _____ mos. _____ ds.

(Signed)

D. C. Ray M. D.
7-22 1913 (Address) Malad City, Ida

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place _____ In the _____
of death _____ yrs. _____ mos. _____ ds. State _____ yrs. _____ mos. _____ ds.

Where was disease contracted,

If not at place of death?

Former or

usual residence

19. PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

Samaria Ida July 23 1913

20. UNDERTAKER

ADDRESS

D. S. Johnson Malad Ida

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PH. CH. should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

-SUPPLEMENTARY DEATH CERTIFICATE-

(Please reply on this sheet to
the registrar of Vital Statistics)

Death Certificate No. 71

Name Esther Jenkins Morse

Date of Death July 21, 1913

Cause of Death Bronchitis Chronic

Contributory Cause of death _____

(Sign here)

J. C. Ray M.D.

CERTIFICATE OF DEATH

State of Idaho

BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH.

Registration District No. 26

County of *Boise*

Primary Registration District No. 2069

City of *Malad*

(No. _____, _____ St.)

File No. 5654

Registered No. 72

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

James Rakerd

If death occurred in a hospital, institution or camp give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX

4. COLOR OR RACE

5. SINGLE, MARRIED, WIDOWED OR DIVORCED.

*Male white**Single*
(Write the word.)

6. DATE OF BIRTH

Feb 1896
(Month) (Day) (Year)

7. AGE

*17 yrs. mos. ds.*IF LESS than 1 day
how many _____ hrs. or
_____ min?

8. OCCUPATION

- (a) Trade, profession or particular kind of work.
-
- (b) General nature of industry business or establishment in which employed (or employer)

Laborer farming

9. BIRTHPLACE

(State or Country)

Idaho

10. NAME OF FATHER

Bert Rakerd

11. BIRTHPLACE OF FATHER

(State or Country)

Unknown

12. MAIDEN NAME OF MOTHER

Genette Lynch

13. BIRTHPLACE OF MOTHER

(State or Country)

Kansas

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) *W. L. Showalter*(Address) *Black Pine, Idaho*

15.

Filed *July 26 1913**W. L. Ray*
Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH

July 26 1913
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from

*July 25 1913, to July 26 1913*that I last saw him alive on *7-26 1913*and that death occurred on the date stated above, at *9:30 A.M.*

The CAUSE OF DEATH* was as follows:

Gun shot wound of head inflicted by self. Suicidal

_____ (Duration) _____ yrs. _____ mos. _____ ds.

Contributory (Secondary)

_____ (Duration) _____ yrs. _____ mos. _____ ds.

(Signed) *W. L. Ray* M. D.*7-26 1913* (Address) *Malad City**State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, STATE MEANS OF INJURY; (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL. *Ida*

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place _____ In the _____
of death _____ yrs. _____ mos. _____ ds. State _____ yrs. _____ mos. _____ ds.

Where was disease contracted,

If not at place of death?

Former or

usual residence.

19. PLACE OF BURIAL OR REMOVAL DATE OF BURIAL

Black Pine Ida July 28 1913

20. UNDERTAKER

ADDRESS

W. E. Johnson Malad

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK.—THIS IS A PERMANENT RECORD.
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

FORM V. S. No. 5-25 M. 1-16-13

CERTIFICATE OF DEATH

1. PLACE OF DEATH

County of Salah
City of _____Registration District No. 15
Primary Registration District No. 2066
(No. _____ St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

Julius J AustinState of Idaho
BOARD OF HEALTH
Bureau of Vital StatisticsFile No. 5655Registered No. 102

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX

Male

4. COLOR OR RACE

White5. SINGLE, MARRIED, WID-
OWED OR DIVORCED.married
(Write the word.)

6. DATE OF BIRTH.

March 30 1888
(Month) (Day) (Year)

7. AGE

75 Yrs. 2 Mos. 23 ds.IF LESS than 1 day
how many hrs. or
..... min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work...
(b) General nature of industry, business, or establishment in which employed (or employer)...Post Master

9. BIRTHPLACE

(State or Country)

Kentucky

10. NAME OF FATHER

John P Austin

11. BIRTHPLACE OF FATHER

(State or Country)

Not known

12. MAIDEN NAME OF MOTHER

41

13. BIRTHPLACE OF MOTHER

(State or Country)

1111

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant)

John J Austin

(Address)

Rubens Dr

15.

Filed June 24 1913 D J Thompson

Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

June 23 1913
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from

Feb 12 1913 to June 22 1913
that I last saw him alive on June 22 1913and that death occurred on the date stated above, at 5 A M.

The CAUSE OF DEATH* was as follows:

Paralysis

(Duration) Yrs. mos. ds.

Contributory (Secondary)

Cerebral hemorrhage

(Duration) yrs. mos. ds.

(Signed)

W B Cook

M. D.

7-2419-13 (Address) Presiden

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL OR HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death.....yrs.....mos.....days In the State.....yrs.....mos.....days

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL

Cath Cemetery

DATE OF BURIAL

June 24 1913

20. UNDERTAKER

O Anderson

ADDRESS

Palo Alto

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Form V. S. No. 5. 12½ M. 7-24-11

CERTIFICATE OF DEATH

1. PLACE OF DEATH.
County of Latah
City of Idaho

Registration District No. 15
Primary Registration District No. 2065
(No. _____, St.)

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics
File No. 5656
Registered No. 104

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Maria Olson

If death occurred in a hospital, institution or camp give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX Female 4. COLOR OR RACE white 5. SINGLE, MARRIED, WIDOWED OR DIVORCED Widowed
(Write the word.)

6. DATE OF BIRTH May 7 1887
(Month) (Day) (Year)

7. AGE 76 yrs. 1 mos. 24 ds. IF LESS than 1 day how many _____ hrs. or _____ min?

8. OCCUPATION
(a) Trade, profession or particular kind of work nurse
(b) General nature of industry business or establishment in which employed (or employer)

9. BIRTHPLACE
(State or Country) Sweden

10. NAME OF FATHER Erick Erickson

11. BIRTHPLACE OF FATHER
(State or Country) Sweden

12. MAIDEN NAME OF MOTHER Christina ?

13. BIRTHPLACE OF MOTHER
(State or Country) Sweden

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Peter Olson
(Address) Idaho

15. Filed July 1st 1913 J. W. Olson
Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH June 30 1913
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from June 29 1913, to June 30 1913 that I last saw her alive on June 29 1913 and that death occurred on the date stated above, at 4 P.M. The CAUSE OF DEATH* was as follows:

Senility
arthritis deformans since 1875

(Duration) _____ yrs. _____ mos. _____ ds.
Contributory Diarrhoea. Bed Sores
(Secondary)

(Duration) _____ yrs. _____ mos. _____ ds.
(Signed) J. W. Olson M. D.
July 1 1913 (Address) J. W. Olson

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place _____ In the _____
of death _____ yrs. _____ mos. _____ ds. State _____ yrs. _____ mos. _____ ds.
Where was disease contracted,
If not at place of death? _____
Former or
usual residence _____

19. PLACE OF BURIAL OR REMOVAL DATE OF BURIAL

Buried Ridge, Troy Ida. July 2 1913
20. UNDERTAKER ADDRESS
Sofia Anderson Troy Idaho

MARGIN RESERVED FOR BINDING
WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICI-
CIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact state-
ment of OCCUPATION is very important. See instructions on back of certificate.

Form V. S. No. 20M.1-16-12

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics
File No. 5657
Registered No. 104

1. PLACE OF DEATH.

Registration District No. 15

County of Latah

Primary Registration District No. 2062

City of Moscow

(No. St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Albert I Town.

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX

4. COLOR OR RACE

5. SINGLE, MARRIED, WID-
OWED OR DIVORCED.

Male

White

Married
(Write the word.)

6. DATE OF BIRTH

Feb 9 1857
(Month) (Day) (Year)

7. AGE

62 yrs 7 mos 13 ds.

IF LESS than 1 day
how many hrs. or
mins.?

8. OCCUPATION

(a) Trade, profession or
particular kind of work

Farmer

(b) General nature of industry
business, or establishment in
which employed (or employer)

9. BIRTHPLACE

(State or Country)

Wis

10. NAME OF
FATHER

Athome, Town

11. BIRTHPLACE
OF FATHER

(State or Country)

12. MAIDEN NAME
OF MOTHER

Elden Gale

13. BIRTHPLACE
OF MOTHER

(State or Country)

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

Sherman Town

(Address)

Moscow Idaho

15.

Filed

July 22 1913

D.F. Rae

Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH

July 22 1913
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from

Feb 17 1913, to July 22 1913

that I last saw him alive on July 20 1913,

and that death occurred on the date stated above, at 5 P.M.

The CAUSE OF DEATH* was as follows:

Cancer of Stomach

Contributory
(Secondary)

(Duration) 2 yrs about mos ds.

(Duration) yrs mos ds.

(Signed) J. N. Clarke M. D.

19. (Address)

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death yrs mos days. In the State yrs mos days.

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

Moscow

July 27 1913

20. UNDERTAKER

ADDRESS

Geo. Stetz

Moscow

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Form V. S. No. 5 20M.1-16-12

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH

Registration District No.

County of

Primary Registration District No.

City of

(No.

St.)

File No.

Registered No.

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX

4. COLOR OR RACE

5. SINGLE, MARRIED, WIDOWED OR DIVORCED.

6. DATE OF BIRTH

7. AGE

IF LESS than 1 day
how many hrs. or
..... mins.?

8. OCCUPATION

- (a) Trade, profession or particular kind of work
(b) General nature of industry business, or establishment in which employed (or employer)

9. BIRTHPLACE

(State or Country)

10. NAME OF FATHER

11. BIRTHPLACE OF FATHER

(State or Country)

12. MAIDEN NAME OF MOTHER

13. BIRTHPLACE OF MOTHER

(State or Country)

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

(Address)

15.

Filed

1913

Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

17. I HEREBY CERTIFY, That I attended deceased from

that I last saw him alive on

and that death occurred on the date stated above, at

The CAUSE OF DEATH* was as follows:

(Duration) yrs. mos. ds.

Contributory
(Secondary)

(Duration) yrs. mos. ds.

(Signed) M. D.

19 (Address)

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death yrs. mos. days. In the State yrs. mos. days.

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

20. UNDERTAKER

ADDRESS

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Form V. S. No. 5. 12½M.7-24-11

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics
File No. 5659
Registered No. 78

1. PLACE OF DEATH. Registration District No. 15
County of Salah Primary Registration District No. 2062
City of Moscow (No. _____ St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Betty Nichols

If death occurred in a hospital, institution or camp give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX Female 4. COLOR OR RACE White 5. SINGLE, MARRIED, WIDOWED OR DIVORCED. Married
(Write the word.)
6. DATE OF BIRTH June 17 1830
(Month) (Day) (Year)

7. AGE 22 yrs. 7 mos. 15 ds. IF LESS than 1 day
how many _____ hrs. or _____ min?

8. OCCUPATION
(a) Trade, profession or particular kind of work. House Wife
(b) General nature of industry business or establishment in which employed (or employer)

9. BIRTHPLACE (State or Country) Id

10. NAME OF FATHER John Rancey

11. BIRTHPLACE OF FATHER (State or Country) _____

12. MAIDEN NAME OF MOTHER _____

13. BIRTHPLACE OF MOTHER (State or Country) _____

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) J. M. Nichols
(Address) Viola Idaho

15. Filed July 2 1913 J. F. Rancey
Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH July 1 1913
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from _____ 191____, to _____ 191____
that I last saw h. _____ alive on _____ 191____
and that death occurred on the date stated above, at _____ M.
The CAUSE OF DEATH* was as follows:

old age

_____ (Duration) _____ yrs. _____ mos. _____ ds.

Contributory (Secondary) _____

_____ (Duration) _____ yrs. _____ mos. _____ ds.
(Signed) W. M. Gifford S. O. P.
1-2- 1912 (Address) Moscow Idaho

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place _____ In the _____
of death _____ yrs. _____ mos. _____ ds. State _____ yrs. _____ mos. _____ ds.
Where was disease contracted, _____
If not at place of death? _____
Former or _____
usual residence _____

19. PLACE OF BURIAL OR REMOVAL DATE OF BURIAL

Viola July 2 1913
20. UNDERTAKER ADDRESS
Geo Stetz Moscow

WRITE PLAINLY IN INK—THIS IS A PERMANENT RECORD. N. B.—Every item of information should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Form V. S. No. 5. 12½ M. 7-24-11

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics
File No. 5669
Registered No. 99

1. PLACE OF DEATH.
County of Latah
City of Moscow
Registration District No. 15
Primary Registration District No. 1008
(No. Critchman Hospital St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Frank Culton

If death occurred in a hospital, institution or camp give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX Male 4. COLOR OR RACE White 5. SINGLE, MARRIED, WIDOWED OR DIVORCED. Single
(Write the word.)

6. DATE OF BIRTH Don't Know 1861
(Month) (Day) (Year)

7. AGE 51 yrs. 51 mos. 51 ds. IF LESS than 1 day how many hrs. or min?

8. OCCUPATION
(a) Trade, profession or particular kind of work. Farmer
(b) General nature of industry business or establishment in which employed (or employer)

9. BIRTHPLACE Ill
(State or Country)

10. NAME OF FATHER John Culton

11. BIRTHPLACE OF FATHER Ill
(State or Country)

12. MAIDEN NAME OF MOTHER

13. BIRTHPLACE OF MOTHER Ill
(State or Country)

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Jesse Culton
(Address) Roselia M.

15. Filed July 8 1913 J F Roe
Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH July 8 1913
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from July 4th 1913, to 8-July 1913, that I last saw him alive on July 8 1913, and that death occurred on the date stated above, at 7:45 A.M.

The CAUSE OF DEATH* was as follows:

Prostatitis General Infection
(Duration) 8 yrs. 8 mos. 8 ds.

Contributory (Secondary)
(Duration) 8 yrs. 8 mos. 8 ds.
(Signed) Chas. S. Critchman M. D.
July 8 1913 (Address) Moscow, Idaho

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death 8 yrs. 8 mos. 8 ds. State 8 yrs. 8 mos. 8 ds.
Where was disease contracted,
first at place of death?
Former or usual residence.

19. PLACE OF BURIAL OR REMOVAL Garfield Trach DATE OF BURIAL July 10 1913

20. UNDERTAKER Geo. Steg ADDRESS Moscow

Form V. S. No. 5 20M.1-16-12

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics
File No. 5661
Registered No. 100

1. PLACE OF DEATH

Registration District No. 13

County of

Primary Registration District No. 1008

City of

(No. _____)

(St. _____)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

Elmer Trilbert Benson

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX

4. COLOR OR RACE

5. SINGLE, MARRIED, WIDOWED OR DIVORCED.

Male

White

Single
(Write the word.)

6. DATE OF BIRTH

May 15

1901

(Month) (Day) (Year)

7. AGE

17 yrs. 2 mos. 2 ds.

IF LESS than 1 day
how many hrs. or
..... mins.?

8. OCCUPATION

(a) Trade, profession or particular kind of work
(b) General nature of industry business, or establishment in which employed (or employer)

9. BIRTHPLACE

(State or Country)

N. Dak

10. NAME OF FATHER

Ole S. Benson

11. BIRTHPLACE OF FATHER

(State or Country)

Norway

12. MAIDEN NAME OF MOTHER

Johane Steward

13. BIRTHPLACE OF MOTHER

(State or Country)

Minnesota

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

Ole S. Benson

(Address)

Idaho

15.

Filed

July 18 1913

3

D. F. Rae

Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

July 18

(Month) (Day)

1913 (Year)

17. I HEREBY CERTIFY, That I attended deceased from

July 12 1913, to July 18 1913,

that I last saw him alive on July 17 1913,

and that death occurred on the date stated above, at 5 A.M.

The CAUSE OF DEATH* was as follows:

Diffuse hepatic necrosis

(Duration) yrs. mos. ds.

Contributory (Secondary)

(Duration) yrs. mos. ds.

(Signed)

D. F. Rae

M. D.

7-18-13 (Address) Moscow

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death yrs. mos. days. In the State yrs. mos. days.

Where was disease contracted if not at place of death?

Former or usual residence.

19. PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

Idaho

July 20 1913

20. UNDERTAKER

ADDRESS

Geo. Shultz

Moscow

MARGIN RESERVED FOR BINDING
WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Form V. S. No. 5. 12½ M. 7-24-11

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

File No. 5662

Registered No. 101

If death occurred in a hospital, institution or camp give its NAME instead of street and number.

1. PLACE OF DEATH.
County of Butte
City of Butte (No. _____, St.)
Registration District No. 13
Primary Registration District No. 1008

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

Eva Griner

PERSONAL AND STATISTICAL PARTICULARS

3. SEX Female 4. COLOR OR RACE white 5. SINGLE, MARRIED, WIDOWED OR DIVORCED.
Married
(Write the word.)

6. DATE OF BIRTH Dec 2 1857
(Month) (Day) (Year)

7. AGE 55 yrs. 7 mos. 18 ds. IF LESS than 1 day
how many hrs. or min?

8. OCCUPATION
(a) Trade, profession or particular kind of work. Housewife
(b) General nature of industry business or establishment in which employed (or employer)

9. BIRTHPLACE
(State or Country) Illinois

10. NAME OF FATHER William W. Williamson

11. BIRTHPLACE OF FATHER
(State or Country) Ohio

12. MAIDEN NAME OF MOTHER Mariam Myers

13. BIRTHPLACE OF MOTHER
(State or Country) Ohio

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Edw. Griner
(Address) Butte, Idaho

15. July 20 1913
Filed Dr. R. R. R.
Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH July 20 1913
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from July 1 1913, to July 18 1913
that I last saw him alive on July 18 1913
and that death occurred on the date stated above, at 6 A. M.

The CAUSE OF DEATH* was as follows:

Cancer of Stomach

(Duration) 4 yrs. about mos. ds.

Contributory (Secondary)

(Duration) _____ yrs. _____ mos. _____ ds.
(Signed) J. M. Clarke M. D.
July 20 1913 (Address) Butte

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death _____ yrs. _____ mos. _____ ds. In the State _____ yrs. _____ mos. _____ ds.
Where was disease contracted, If not at place of death?
Former or usual residence.

19. PLACE OF BURIAL OR REMOVAL DATE OF BURIAL

Breeze July 21 1913
20. UNDERTAKER ADDRESS

Geo. Stoth

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Form V. S. No. 5 20M.1-16-12

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH

Registration District No.

County of

Primary Registration District No.

City of

(No.

St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

File No.

Registered No.

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX

4. COLOR OR RACE

5. SINGLE, MARRIED, WIDOWED OR DIVORCED

6. DATE OF BIRTH

7. AGE

IF LESS than 1 day
how many hrs. or
mins.?

8. OCCUPATION

(a) Trade, profession or particular kind of work

(b) General nature of industry business, or establishment in which employed (or employer)

9. BIRTHPLACE

(State or Country)

10. NAME OF FATHER

11. BIRTHPLACE OF FATHER

(State or Country)

12. MAIDEN NAME OF MOTHER

13. BIRTHPLACE OF MOTHER

(State or Country)

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

(Address)

15.

Filed

191

Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

17. I HEREBY CERTIFY, That I attended deceased from

that I last saw him alive on

and that death occurred on the date stated above, at

The CAUSE OF DEATH* was as follows:

Contributory
(Secondary)

(Signed)

(Address)

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place
of death

In the
State

Where was disease contracted
if not at place of death?

Former or
usual residence

19. PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

20. UNDERTAKER

ADDRESS

MARGIN RESERVED FOR BINDING
WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Form V. S. No. 5 20M.1-16-12

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH
County of Banner Registration District No. 27
City of Camden Primary Registration District No. 2119
(No. _____ St.)

File No. 5664
Registered No. 2

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Rita Pala

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX Male 4. COLOR OR RACE White 5. SINGLE, MARRIED, WIDOWED OR DIVORCED. Married
(Write the word.)

6. DATE OF BIRTH Michigan
not known 1 (Month) (Day) (Year)

7. AGE about 40 yrs. mos. ds.
IF LESS than 1 day how many hrs. or mins.?

8. OCCUPATION
(a) Trade, profession or particular kind of work Labourer
(b) General nature of industry business, or establishment in which employed (or employer)

9. BIRTHPLACE
(State or Country) Italy

10. NAME OF FATHER don't know

11. BIRTHPLACE OF FATHER
(State or Country) don't know

12. MAIDEN NAME OF MOTHER don't know

13. BIRTHPLACE OF MOTHER
(State or Country) don't know

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) D. H. Kauffield
(Address) Preston Idaho

15. Filed July 6 1913 Allen R. Carter
Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH July 4 1913
(Month) 7 (Day) 4 (Year) 1913

17. I HEREBY CERTIFY, That I attended deceased from July 4 1913, to July 5 1913,
that I last saw him alive on July 5 1913,
and that death occurred on the date stated above, at 1 A.M.

The CAUSE OF DEATH* was as follows:
accidental explosion of
Powder Fracture shells
in several places
(Duration) _____ yrs. mos. ds.
Contributory none
(Secondary)
(Duration) _____ yrs. mos. ds.
(Signed) D. H. Kauffield M. D.
July 1913 (Address) Preston Idaho

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death _____ yrs. _____ mos. _____ days. In the State _____ yrs. _____ mos. _____ days.
Where was disease contracted if not at place of death?
Former or usual residence _____

19. PLACE OF BURIAL OR REMOVAL Preston Idaho DATE OF BURIAL July 6 1913
20. UNDERTAKER D. H. Kauffield ADDRESS Preston

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Form V. S. No. 5 20M.1-16-12

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics
File No. 5665
Registered No. 7

1. PLACE OF DEATH
County of Franklin
City of Clifton
Registration District No. 27
Primary Registration District No. 2119
(No. St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Julia Mary Davis

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX Male 4. COLOR OR RACE White 5. SINGLE, MARRIED, WIDOWED OR DIVORCED. Married (Write the word.)

6. DATE OF BIRTH 11/4/1872 (Month) (Day) (Year)

7. AGE 41 yrs. 7 mos. 30 ds. IF LESS than 1 day how many hrs. or mins.

8. OCCUPATION (a) Trade, profession or particular kind of work Farmer Wife (b) General nature of industry business, or establishment in which employed (or employer)

9. BIRTHPLACE (State or Country) Spanish Fork Utah

10. NAME OF FATHER Edwin H. Hooker

11. BIRTHPLACE OF FATHER New England State (State or Country)

12. MAIDEN NAME OF MOTHER Mary Bolter

13. BIRTHPLACE OF MOTHER (State or Country)

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE (Informant) Thos. H. Howell (Address) Clifton Idaho

15. Filed 7-29-1913 Allie Plaut Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH July 3 1913 (Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from 191 to 191, that I last saw him alive on 191, and that death occurred on the date stated above, at 9 A.M.

The CAUSE OF DEATH* was as follows:

Probable Consumption and heart trouble (Duration) yrs. mos. 21 ds.

Contributory Rheumatism (Secondary) (Duration) yrs. mos. ds. (Signed) Allie Plaut M. D. 19 (Address) Preston Idaho

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.) At place of death yrs. mos. days. In the State yrs. mos. days.

Where was disease contracted if not at place of death? Former or usual residence

19. PLACE OF BURIAL OR REMOVAL Clifton DATE OF BURIAL July 5-1913 20. UNDERTAKER None ADDRESS

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Form V. S. No. 5 20M.1-16-12

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH

Registration District No. 27County of FranklinPrimary Registration District No. 2119File No. 5666City of Dayton

(No. _____ St.)

Registered No. 698

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

Miala E Taylor

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX

4. COLOR OR RACE

5. SINGLE, MARRIED, WIDOWED OR DIVORCED.

Female White

(Write the word.)

6. DATE OF BIRTH

Mar 28 1913
(Month) (Day) (Year)

7. AGE

1 yrs. 11 mos. 12 ds.IF LESS than 1 day
how many hrs. or
..... mins.

8. OCCUPATION

(a) Trade, profession or particular kind of work

(b) General nature of industry business, or establishment in which employed (or employer)

9. BIRTHPLACE

(State or Country)

Dayton

10. NAME OF FATHER

Leroy Taylor

11. BIRTHPLACE OF FATHER

(State or Country)

Idaho

12. MAIDEN NAME OF MOTHER

Smith

13. BIRTHPLACE OF MOTHER

(State or Country)

Utah

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Leroy Taylor(Address) Dayton

15.

Filed July 28 1913 Alfred Leuter
Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH

May 8 1913
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from

7th May 1913, to 8th May 1913,that I last saw her alive on May 7th 1913,and that death occurred on the date stated above, at 3 AM

The CAUSE OF DEATH* was as follows:

Laryngitis(Duration) yrs. mos. 5 ds.Contributory
(Secondary)

(Duration) yrs. mos. ds.

(Signed) G. T. Parkinson, M. D.19. (Address) Preston, Ida

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death yrs. mos. days. In the State yrs. mos. days.

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

Dayton May 8 1913

20. UNDERTAKER

ADDRESS

G. T. Parkinson Preston

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
 Bureau of Vital Statistics
 File No. 5667
 Registered No. _____

1. PLACE OF DEATH. Registration District No. 27
 County of Franklin Primary Registration District No. 2119
 City of Preston (No. _____, _____ St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

Lucy May Gilbert

If death occurred in a hospital, institution or camp give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX 4. COLOR OR RACE 5. SINGLE, MARRIED, WIDOWED OR DIVORCED.

Female White Married
 (Write the word.)

6. DATE OF BIRTH

_____. 1.
 (Month) (Day) (Year)

7. AGE

34 yrs. ____ mos. ____ ds. IF LESS than 1 day
 how many ____ hrs. or ____ min?

8. OCCUPATION

(a) Trade, profession or particular kind of work.
 (b) General nature of industry business or establishment in which employed (or employer)

Housewife

9. BIRTHPLACE

(State or Country)

Clifton Idaho

10. NAME OF FATHER

W. M. Vandusen

11. BIRTHPLACE OF FATHER

(State or Country)

12. MAIDEN NAME OF MOTHER

Julia Fiske

13. BIRTHPLACE OF MOTHER

(State or Country)

Albert C

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

(Address)

Albert Gilbert

15.

Filed 11/15 1913

Albert C. Gilbert
 Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH

July 29 1913
 (Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from

May 25 1913, to July 25 1913

that I last saw her alive on July 25 1913

and that death occurred on the date stated above, at 7:20 AM

The CAUSE OF DEATH* was as follows:

Hodgkins disease

_____. (Duration) ____ yrs. ____ mos. ____ ds.

Contributory

(Secondary)

_____. (Duration) ____ yrs. ____ mos. ____ ds.

(Signed) Allen R. Curtis M. D.

729 1913 (Address)

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place _____ In the _____
 of death ____ yrs. ____ mos. ____ ds. State ____ yrs. ____ mos. ____ ds.

Where was disease contracted,

If not at place of death?

Former or

usual residence.

19. PLACE OF BURIAL OR REMOVAL DATE OF BURIAL

Idaho Aug 1st 1913

20. UNDERTAKER ADDRESS

J. Hansen Preston

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Form V. S. No. 5. 12½ M. 7-24-11

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics
File No. 5668
Registered No. 8

1. PLACE OF DEATH. Registration District No. 27
County of Franklin Primary Registration District No. 2119
City of Fairview (No. _____ St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

Charles Peterson

If death occurred in a hospital, institution or camp give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX 4. COLOR OR RACE 5. SINGLE, MARRIED, WIDOWED OR DIVORCED.

Male White Married
(Write the word.)

6. DATE OF BIRTH

May 19 1899
(Month) (Day) (Year)

7. AGE

34 yrs. 2 mos. — ds.

IF LESS than 1 day
how many hrs. or
..... min?

8. OCCUPATION

(a) Trade, profession or particular kind of work.
(b) General nature of industry business or establishment in which employed (or employer)

Carpenter

9. BIRTHPLACE

(State or Country)

Sveeden

10. NAME OF FATHER

Olson

11. BIRTHPLACE OF FATHER

(State or Country)

Sveeden

12. MAIDEN NAME OF MOTHER

—

13. BIRTHPLACE OF MOTHER

(State or Country)

Sveeden

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

Mrs Chas Peterson

(Address)

Preston R. F. D.

15.

Filed

7-19 1913

Chas Peterson

Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH

July 18 1913
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from

Sunday July 15 1913, to July 18 1913

that I last saw him alive on July 18 1913

and that death occurred on the date stated above, at 11:45 P.M.

The CAUSE OF DEATH* was as follows:

leakage of heart from
valvular insufficiency

(Duration) 7 yrs. 7 mos. — ds.

Contributory
(Secondary)

Rheumatism

(Duration) 1 yrs. — mos. — ds.

(Signed)

Chas Peterson M. D.

7/19 1913 (Address) Preston

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place In the
of death yrs. mos. ds. State yrs. mos. ds.

Where was disease contracted,

If not at place of death?

Former or

usual residence.

19. PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

Fairview

7/21 1913

20. UNDERTAKER

ADDRESS

None

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIAN should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

1. PLACE OF DEATH. _____ Registration District No. 2119
 County of _____ Primary Registration District No. 2119
 City of _____ (No. _____, _____ St.)
 File No. 5671
 Registered No. 4
 If death occurs away from usual residence, give facts called for under special information. 2. FULL NAME Mary McGregor
 If death occurred in a hospital, institution or camp give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX Female 4. COLOR OR RACE White 5. SINGLE, MARRIED, WIDOWED OR DIVORCED. Married
 (Write the word.)
 6. DATE OF BIRTH 4 26 1854
 (Month) (Day) (Year)
 7. AGE 59 yrs. 2 mos. 14 ds. IF LESS than 1 day how many hrs. or min?
 8. OCCUPATION (a) Trade, profession or particular kind of work. Housewife
 (b) General nature of industry business or establishment in which employed (or employer)
 9. BIRTHPLACE (State or Country) England
 10. NAME OF FATHER Joseph Perry
 11. BIRTHPLACE OF FATHER (State or Country) England
 12. MAIDEN NAME OF MOTHER Mary Adey
 13. BIRTHPLACE OF MOTHER (State or Country) England

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
 (Informant) W. W. Williams
 (Address) Perry, Idaho
 15. 7/19 1913 Alfred C. Williams
 Filed Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH 7 14 1913
 (Month) (Day) (Year)
 17. I HEREBY CERTIFY, That I attended deceased from no doctor in attendance
deceased by will to 1913
 that I last saw him alive on 7/9 1913
 and that death occurred on the date stated above, at 4:30 AM,
 The CAUSE OF DEATH* was as follows:
Valvular defect of heart - accompanied by dropsy -
 (Duration) 11 yrs. - mos. - ds.
 Contributory Is not known
 (Secondary)
 (Signed) Alfred C. Williams M. D.
know personally of the physician
19 (Address) Perry, Idaho
 *State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.
 18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
 At place In the
 of death yrs. mos. ds. State yrs. mos. ds.
 Where was disease contracted,
 If not at place of death?
 Former or
 usual residence.
 19. PLACE OF BURIAL OR REMOVAL DATE OF BURIAL
Perry, Idaho 7/12 1913
 20. UNDERTAKER ADDRESS
None

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Form V. S. No. 5. 12½ M. 7-24-11

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics
File No. 5671
Registered No. 49

1. PLACE OF DEATH. Registration District No. 26
County of Washington Primary Registration District No. 2113
City of Midvale (No. _____, _____ St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Lori Keithley

If death occurred in a hospital, institution or camp give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX Male 4. COLOR OR RACE White 5. SINGLE, MARRIED, WIDOWED OR DIVORCED. married
(Write the word.)

6. DATE OF BIRTH Aug 15 1840
(Month) (Day) (Year)

7. AGE 72 yrs. 10 mos. 15 ds. IF LESS than 1 day
how many _____ hrs. or _____ min?

8. OCCUPATION
(a) Trade, profession or particular kind of work. Rancher
(b) General nature of industry business or establishment in which employed (or employer)

9. BIRTHPLACE (State or Country) Missouri

10. NAME OF FATHER Daniel Keithley

11. BIRTHPLACE OF FATHER (State or Country) Don't know

12. MAIDEN NAME OF MOTHER Elizabeth Hoffstatter

13. BIRTHPLACE OF MOTHER (State or Country) Don't know

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) L. P. S. Ashmud
(Address) Midvale Ida

15. Filed July 2 1913 Faschnig
Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH July 1 1913
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from May 1 1913, to July 1 1913
that I last saw him alive on July 1 1913
and that death occurred on the date stated above, at 1.00 P.M.
The CAUSE OF DEATH* was as follows:

Pneumonia

(Duration) _____ yrs. _____ mos. 3 ds.
Contributory Heart Dropsy
(Secondary)

(Duration) _____ yrs. 3 mos. _____ ds.
(Signed) Faschnig M. D.
July 1 1913 (Address) Midvale Ida

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place In the
of death _____ yrs. _____ mos. _____ ds. State _____ yrs. _____ mos. _____ ds.
Where was disease contracted,
If not at place of death? _____
Former or
usual residence. _____

19. PLACE OF BURIAL OR CREMATION DATE OF BURIAL

Midvale Ida July 2 1913

20. UNDERTAKER ADDRESS

L. P. S. Ashmud Midvale Ida

-SUPPLEMENTARY DEATH CERTIFICATE-

(Please reply on this sheet to
the registrar of Vital Statistics)

Death Certificate No. July 1st 1913

Name Levi Keithley

Date of Death July 1st 1913

Cause of Death Broncho Pneumonia
Cardiac

Contributory Cause of death ~~Primary~~ Insufficiency

(Sign here) T. A. Schmitz M.D.

I do not know cause of softening of brain in the case of Jacob M. Fleener

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Form V. S. No. 5 20M.1-16-12

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics
File No. 5672
Registered No. 50

1. PLACE OF DEATH' Registration District No. 26
County of Washington Primary Registration District No. 1010
City of Waseca (No. , St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

Joseph Warren

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX 4. COLOR OR RACE 5. SINGLE, MARRIED, WIDOWED OR DIVORCED.

Male

White

(Write the word.)

6. DATE OF BIRTH

(Month) (Day) (Year)

7. AGE

55 yrs. — mos. — ds.

IF LESS than 1 day
how many hrs. or
mins.

8. OCCUPATION

(a) Trade, profession or particular kind of work
(b) General nature of industry, business, or establishment in which employed (or employer)

Miner

9. BIRTHPLACE

(State or Country)

Missouri

10. NAME OF FATHER

11. BIRTHPLACE OF FATHER

(State or Country)

12. MAIDEN NAME OF MOTHER

13. BIRTHPLACE OF MOTHER

(State or Country)

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

Deceased refused to give any information
(Informant)

(Address)

L. C. Northam

15.

Filed

July 17 1913

1913

W. R. Northam
Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH

July 16 1913
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from

May 19 1913, to July 15 1913

that I last saw him alive on July 15 1913

and that death occurred on the date stated above, at 4:15 P.M.

The CAUSE OF DEATH* was as follows:

Tuberculosis of Left Hip Joint

(Duration) yrs. 3 mos. 0 ds.

Contributory
(Secondary)

(Duration) yrs. mos. ds.

(Signed) Canaff C. Canaff M. D.

7/16 1913 (Address) Weiser Idaho

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death yrs. mos. days. In the State yrs. mos. days.

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

Weiser Ida

7/16 1913

20. UNDERTAKER

ADDRESS

L. C. Northam

RESERVED FOR BINDING
UNFADING INK—THIS IS A PERMANENT RECORD.
AGE should be carefully supplied. AGE should be stated EXACTLY. PHYSI-
DEATH in plain terms, so that it may be properly classified. Exact state-
is very important. See instructions on back of certificate.

Form V. S. No. 5. 12½ M. 7-24-11

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH. Registration District No. 26
County of Washington Primary Registration District No. 2113
City of Minwale (No. _____, _____ St.)

File No. 5672
Registered No. 51

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Willis Earl Shaw

If death occurred in a hospital, institution or camp give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX Male 4. COLOR OR RACE White 5. SINGLE, MARRIED, WIDOWED OR DIVORCED. Single
(Write the word.)

6. DATE OF BIRTH July 17 1913
(Month) (Day) (Year)

7. AGE 17 yrs. 10 mos. 28 ds. IF LESS than 1 day how many _____ hrs. or _____ min?

8. OCCUPATION

(a) Trade, profession or particular kind of work Prod. employee
(b) General nature of industry business or establishment in which employed (or employer)

9. BIRTHPLACE

(State or Country) Idaho

10. NAME OF FATHER Wm Berry Shaw

11. BIRTHPLACE OF FATHER

(State or Country) Iowa

12. MAIDEN NAME OF MOTHER Helen Kunning

13. BIRTHPLACE OF MOTHER

(State or Country) Iowa

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Helen Shaw

(Address) Minwale

July 17 1913

Falschmidt
Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

July 17 1913
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from

July 3 1913, to July 17 1913
that I last saw him alive on July 16 1913

and that death occurred on the date stated above, at S. A. M.

The CAUSE OF DEATH* was as follows:

Bronchopneumonia

..... (Duration) yrs. mos. 15 ds.

Contributory
(Secondary)

..... (Duration) yrs. mos. ds.

(Signed) Falschmidt M. D.

July 17 1913 (Address) Minwale Idaho

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place In the
of death yrs. mos. ds. State yrs. mos. ds.

Where was disease contracted,

If not at place of death?

Former or

usual residence

19. PLACE OF BURIAL OR REMOVAL DATE OF BURIAL

Minwale Idaho July 17 1913

20. UNDERTAKER

ADDRESS

F. Kay Minwale

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Form V. S. No. 5 20M.1-16-12

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH.

Registration District No. 26

County of Wash.

Primary Registration District No. 2612

City of Weiser

(No. 8. *Myrtle Monroe Crk* St.)

File No. 5671

Registered No. 52

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

Mrs Orpha Hopkins

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX

Female

4. COLOR OR RACE

White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED.

Widow
(Write the word.)

6. DATE OF BIRTH

June - 28 - 1873
(Month) (Day) (Year)

7. AGE

40 yrs. — *23* mos. — *23* ds.IF LESS than 1 day
how many hrs. or
..... mins.?

8. OCCUPATION

(a) Trade, profession or particular kind of work

Farming &

(b) General nature of industry business, or establishment in which employed (or employer)

Housekeeper

9. BIRTHPLACE

(State or Country)

Morgan Co. Illinois

10. NAME OF FATHER

C. P. Long

11. BIRTHPLACE OF FATHER

(State or Country)

Brown Co. Indiana

12. MAIDEN NAME OF MOTHER

Melvina Ray

13. BIRTHPLACE OF MOTHER

(State or Country)

State of Ky.

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

John Long

(Address)

Weiser Ida

15.

Filed

*July 23 - 1913**D. R. Humblum*

Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH

July - 22 - 1913
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from

*Jan 18 1913, to July 21st 1913*that I last saw her alive on *July 21 1913*and that death occurred on the date stated above, at *3:38 P.M.*

The CAUSE OF DEATH* was as follows:

Pulmonary Tuberculosis(Duration) *about 3* yrs. — *3* mos. — *3* ds.Contributory
(Secondary)

(Duration) yrs. — mos. — ds.

(Signed)

*Emmett C. Gavant M. D.**723 1913* (Address) *Weiser Idaho*

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death yrs. — mos. — days. In the State yrs. — mos. — days.

Where was disease contracted if not at place of death?

Former or usual residence.

19. PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

*Myrtle Crk Cemetery**723 1913*

20. UNDERTAKER

ADDRESS

*C. C. Cordell**Weiser Ida*

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Form V. S. No. 5 20M.1-16-12

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics
File No. 5675
Registered No. 1

1. PLACE OF DEATH. Registration District No. 8
County of Ada Primary Registration District No. 2004
City of Boise (No. Infant St.)
If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Emmehiser

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX boy 4. COLOR OR RACE white 5. SINGLE, MARRIED, WIDOWED OR DIVORCED.
(Write the word.)

6. DATE OF BIRTH July 13 1913
(Month) (Day) (Year)

7. AGE 1 yrs. 1 mos. 1 ds.
IF LESS than 1 day how many 4 hrs. or 2 mins.

8. OCCUPATION
(a) Trade, profession or particular kind of work
(b) General nature of industry business, or establishment in which employed (or employer)

9. BIRTHPLACE
(State or Country) Idaho Ada Co.

10. NAME OF FATHER Frank Emmehiser

11. BIRTHPLACE OF FATHER
(State or Country) Indiana

12. MAIDEN NAME OF MOTHER Emma Crisler

13. BIRTHPLACE OF MOTHER
(State or Country) Texas

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) R. E. Hunt
(Address) Boise Idaho

15. Filed 7-14 1913 MS Parker
Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH July 13 1913
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from July 13 1913, to July 13 1913, that I last saw him alive on 13 1913, and that death occurred on the date stated above, at 3 P. M.
The CAUSE OF DEATH* was as follows:

Premature Birth

(Duration) yrs. mos. ds.
Contributory (Secondary) Premature birth

(Duration) yrs. mos. ds.
(Signed) R. E. Hunt M. D.
19 (Address) Boise

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death yrs. mos. days. In the State yrs. mos. days.
Where was disease contracted if not at place of death?
Former or usual residence

19. PLACE OF BURIAL OR REMOVAL DATE OF BURIAL
Ranch near Dry Creek 7/15 1913

20. UNDERTAKER ADDRESS
Schmidt & Widenfaden Boise

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Form V. S. No. 5 20M.1-16-12

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH.

Registration District No. 2

County of Ada

Primary Registration District No. 1004

City of Boise

(No. 410, State St.)

File No. 5676

Registered No. 157

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Nellie Wilkison

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX

Female

4. COLOR OR RACE

White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED.

Married
(Write the word.)

6. DATE OF BIRTH

Aug 4 1862
(Month) (Day) (Year)

7. AGE

50 yrs. 10 mos. 29 ds.

IF LESS than 1 day
how many hrs. or
mins.?

8. OCCUPATION

(a) Trade, profession or particular kind of work

Housekeeper

(b) General nature of industry business, or establishment in which employed (or employer)

9. BIRTHPLACE

(State or Country)

Ireland

10. NAME OF FATHER

Mr. Roach

11. BIRTHPLACE OF FATHER

(State or Country)

Ireland

12. MAIDEN NAME OF MOTHER

Not obtainable

13. BIRTHPLACE OF MOTHER

(State or Country)

Ireland

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

L. P. Wilkison

(Address)

Boise

15.

Filed

7-2

1913

M. S. Parker

Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH

July 12 1913
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from

Nov 16 1913, to July 12 1913,

that I last saw her alive on June 30 1913,

and that death occurred on the date stated above, at 7 A.M.

The CAUSE OF DEATH* was as follows:

General paresis

(Duration) 2 yrs. mos. ds.

Contributory (Secondary)

Aneurysm of aorta

(Duration) 3 yrs. mos. ds.

(Signed) Maurice Henry Tallman, M. D.

7/2 1913 (Address) Boise, Idaho

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death St. Alphonsus yrs. mos. 45 days. In the State yrs. mos. days.

Where was disease contracted if not at place of death?

Former or usual residence.

19. PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

St. John's Cemetery 7/3 1913

20. UNDERTAKER

ADDRESS

Schreiber & Sidenfaden Boise, Ida

Tallman

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Form V. S. No. 5 20M.1-16-12

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics
File No. 567
Registered No. 158

1. PLACE OF DEATH. Registration District No. 2
County of Ada Primary Registration District No. 1004
City of Boise, Idaho (No. 112 E. Bannock St.)
If death occurs away from usual residence, give facts called for under special information.

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Eugenia Prior

PERSONAL AND STATISTICAL PARTICULARS

3. SEX Female 4. COLOR OR RACE White 5. SINGLE, MARRIED, WIDOWED OR DIVORCED. Widow
(Write the word.)

6. DATE OF BIRTH April 29 1855
(Month) (Day) (Year)

7. 58 yrs. 2 mos. 1 ds.
IF LESS than 1 day how many hrs. or mins.?

8. OCCUPATION
(a) Trade, profession or particular kind of work retired Housekeeper
(b) General nature of industry, business, or establishment in which employed (or employer)

9. BIRTHPLACE Alabama
(State or Country)

10. NAME OF FATHER M. Partaining

11. BIRTHPLACE OF FATHER Ala.
(State or Country)

12. MAIDEN NAME OF MOTHER not obtainable

13. BIRTHPLACE OF MOTHER not obtainable
(State or Country)

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Mrs. Reed
(Address) Boise

15. Filed 7 - 2 1913 W. S. Parker
Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH July 1 1913
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from June 15 1913, to June 30 1913, that I last saw her alive on June 30 1913, and that death occurred on the date stated above, at 2 A.M.

The CAUSE OF DEATH* was as follows:

acute pulmonary edema due to loss of compensatory + dilatation of heart

(Duration) yrs. mos. ds.
Contributory endocarditis
(Secondary)

(Duration) yrs. mos. ds.
(Signed) L. R. McCall M. D.
(Address) Boise, Idaho

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place St. Luke's Hospital In the State yrs. mos. days.
of death yrs. mos. days.

Where was disease contracted if not at place of death?

Former or usual residence, Boise, Idaho

19. PLACE OF BURIAL OR REMOVAL Parma Idaho DATE OF BURIAL 7/3 1913

20. UNDERTAKER Schreiber & Siderfaden ADDRESS Boise

Dr. McCall

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

1. PLACE OF DEATH
County of Adair
City of Boise
Registration [Redacted] 2
Primary Reg. 1004
(No. 26 [Redacted] St.)

If death occurs away from usual residence, give facts called for under special information.
2. FULL NAME Mary E. Seymour

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX Female
4. COLOR OR RACE White
5. SINGLE, MARRIED, WIDOWED OR DIVORCED. Widow
(Write the word.)

6. DATE OF BIRTH
Mar 12 1885
(Month) (Day) (Year)

7. AGE 38
62 yrs. 3 mos. 24 ds.
IF LESS than 1 day how many hrs. or mins.

8. OCCUPATION
(a) Trade, profession or particular kind of work Housework
(b) General nature of industry business, or establishment in which employed (or employer)

9. BIRTHPLACE
(State or Country) Missouri

10. NAME OF FATHER Washington Barber

11. BIRTHPLACE OF FATHER
(State or Country) Not obtainable

12. MAIDEN NAME OF MOTHER E. Liza Shufflett

13. BIRTHPLACE OF MOTHER
(State or Country) Not obtainable

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) J. W. Rye
(Address) Boise, Id.

15. Filed 7-5 1913 M. S. Parker
Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH
July 4 1913
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from June 24 1913 to July 4 1913
that I last saw him alive on July 3 1913
and that death occurred on the date stated above, at 11:30 M.

The CAUSE OF DEATH* was as follows:
acute dilatation of heart

(Duration) yrs. mos. ds.
Contributory mitral regurgitation
(Secondary)

(Duration) yrs. mos. ds.
(Signed) J. A. Springer M. D.
July 5 1913 (Address) Boise, Id.

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death yrs. mos. days. In the State yrs. mos. days.
Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL Meridian, Idaho DATE OF BURIAL July 6 1913

20. UNDERTAKER Tray Summers ADDRESS Boise, Id.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Form V. S. No. 5 20M.1-16-12

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH

Registration District No. 2004County of AdaPrimary Registration District No. 1004City of Boise

(No. _____ St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

Tessie Grace MayFile No. 5679Registered No. 160

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX

Female

4. COLOR OR RACE

White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED.

Married
(Write the word.)

6. DATE OF BIRTH

Aug 3rd 1870

(Month)

(Day)

(Year)

7. AGE

42 yrs. 11 mos. 2 ds.IF LESS than 1 day
how many _____ hrs. or
_____ min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work

Housekeeper

(b) General nature of industry, business, or establishment in which employed (or employer)

9. BIRTHPLACE

(State or Country)

Ontario, Canada

10. NAME OF FATHER

Wm Bedford

11. BIRTHPLACE OF FATHER

(State or Country)

England

12. MAIDEN NAME OF MOTHER

Mary Daly

13. BIRTHPLACE OF MOTHER

(State or Country)

New York State

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

Thos G. May

(Address)

1175 E 7th South St

15.

Salt Lake City

Filed

7-5

1913

M. S. Barker

Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

July 5th 1913
(Month) (Day) (Year)17. I HEREBY CERTIFY, That I attended deceased from Apr 28 1912 to July 5 1913that I last saw her alive on July 4 1913and that death occurred on the date stated above, at 1 AM

The CAUSE OF DEATH* was as follows:

Valvular Heart Disease

(Duration) _____ yrs. _____ mos. _____ ds.

Contributory
(Secondary)

(Duration) _____ yrs. _____ mos. _____ ds.

(Signed)

16 1913 (Address) Boise

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents)

At place of death _____ yrs. _____ mos. _____ days. In the State _____ yrs. _____ mos. _____ days.

Where was disease contracted if not at place of death?

Former or usual residence

Salt Lake City Utah

19. PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

Salt Lake City UtahJuly 6 1913

20. UNDERTAKER

ADDRESS

Schreibers Undertaking Boise

SYMS - YORK CO., PTRS. & BDRS. 19760

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Form V. S. No. 5 20M.1-16-12

CERTIFICATE OF DEATH

1. PLACE OF DEATH.

County of Banner
City of Sandpoint

Registration District No.

Primary Registration District No.

(No.

St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

Fred Kircheck

Bureau of Vital Statistics

File No.

Registered No.

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX

4. COLOR OR RACE

5. SINGLE, MARRIED, WIDOWED OR DIVORCED.

Male White Married
(Widowed or Divorced)
6. DATE OF BIRTH March 13 - 1862
(Month) (Day) (Year)

7. AGE

51 yrs. 5 mos. 2 ds.

IF LESS than 1 day
how many hrs. or
..... mins.)

8. OCCUPATION

(a) Trade, profession or particular kind of work
(b) General nature of industry, business, or establishment in which employed (or employer)

Carpenter

9. BIRTHPLACE

(State or Country)

Wis.

10. NAME OF FATHER

Friedrich Kircheck

11. BIRTHPLACE OF FATHER

(State or Country)

Prussia

12. MAIDEN NAME OF MOTHER

Louisa Arndt

13. BIRTHPLACE OF MOTHER

(State or Country)

Prussia

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

Mrs Eda Kircheck

(Address)

Sandpoint, Ida.

15.

Filed

Aug 15

1913

M. M. McKee

Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

Aug. 15, 1913
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from

Aug 1 1913, to Aug 15 1913,

that I last saw him alive on Aug 15 1913,

and that death occurred on the date stated above, at 5 A.M.

The CAUSE OF DEATH* was as follows:

Con a blood meningitis

Probably tumor

(Duration) yrs. mos. ds.

Contributory
(Secondary)

(Duration) yrs. mos. ds.

(Signed) M. M. McKee M. D.

Aug 6 1913 (Address) Sandpoint

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death yrs. mos. days. In the State yrs. mos. days.

Where was disease contracted if not at place of death?

Former or usual residence.

19. PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

Fountain City Wis Aug 16 1913

20. UNDERTAKER

ADDRESS

Ernest Brown Ida

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Form V. S. No. 5 20M.1-16-12

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH.

Registration District No.

County of

Primary Registration District No.

City of

(No.

St.)

File No.

Registered No.

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX

4. COLOR OR RACE

5. SINGLE, MARRIED, WIDOWED OR DIVORCED.

6. DATE OF BIRTH

7. AGE

IF LESS than 1 day
how many hrs. or mins.?

8. OCCUPATION

- (a) Trade, profession or particular kind of work
(b) General nature of industry business, or establishment in which employed (or employer)

9. BIRTHPLACE

(State or Country)

10. NAME OF FATHER

11. BIRTHPLACE OF FATHER

(State or Country)

12. MAIDEN NAME OF MOTHER

13. BIRTHPLACE OF MOTHER

(State or Country)

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

(Address)

15.

Filed

Aug. 19 - 1913

Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

17. I HEREBY CERTIFY, That I attended deceased from

that I last saw h. alive on

and that death occurred on the date stated above, at M.

The CAUSE OF DEATH* was as follows:

(a premature birth - a 7 months baby)
no physician
(Duration) yrs. mos. ds.

Contributory
(Secondary)

(Duration) yrs. mos. ds.

(Signed) M. D.

19 (Address)

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death yrs. mos. days. In the State yrs. mos. days.

Where was disease contracted if not at place of death?

Former or usual residence Caldwell, Idaho.

19. PLACE OF BURIAL OR REMOVAL DATE OF BURIAL

20. UNDERTAKER

ADDRESS

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Form V. S. No. 5. 10M.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH
County of *Camp*
City of *Emmett*

Registration District No. *2010*
Primary Registration District No. _____
(No. _____ St.)

File No. *5683*
Registered No. _____

If death occurred in a hospital, institution or camp give its NAME instead of street and number.

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

William Sayne

PERSONAL AND STATISTICAL PARTICULARS

3. SEX *male* 4. COLOR OR RACE *white* 5. SINGLE, MARRIED, WIDOWED OR DIVORCED.
Single
(Write the word.)

6. DATE OF BIRTH

— — — — — *1829*
(Month) (Day) (Year)

7. AGE

84 yrs. — mos. — ds. IF LESS than 1 day
how many hrs. or
..... min.?

8. OCCUPATION

(a) Trade, profession, or particular kind of work
(b) General nature of industry, business, or establishment in which employed (or employer)

Laborer

9. BIRTHPLACE

(State or Country)

Ohio

10. NAME OF FATHER

Don't know

11. BIRTHPLACE OF FATHER

(State or Country)

"

"

12. MAIDEN NAME OF MOTHER

"

"

13. BIRTHPLACE OF MOTHER

(State or Country)

"

"

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

M. R. Nanthorn

(Address)

Emmett Idaho

15.

Filed *10-1* 191*3*

Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

Sept 10 191*3*
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from 191..... to 191.....

that I last saw h..... alive on 191.....

and that death occurred on the date stated above, at..... M.

The CAUSE OF DEATH* was as follows:

Not known

No physician employed
(Duration) yrs. mos. ds.

Contributory (Secondary)

was in bed for two years but refused medicine and
(Duration) yrs. mos. ds.

(Signed)

J. R. Reynolds M. D.
19..... (Address) *Emmett*

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL,

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place yrs. mos. ds. In the yrs. mos. ds.

Where was Disease contracted,

If not at place of death?

Former or

usual residence.

19. PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

Emmett Cemetery *Sept 13, 1913*
20. UNDERTAKER *J. R. Reynolds* ADDRESS *Emmett*

MARGIN RESERVED FOR BINDING. IS A PERMANENT RECORD. N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Form V. S. No. 5. 10M. 6-20-11

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH. Registration District No. 2010
County of Canyon Primary Registration District No. _____
City of Emmett No. _____

File No. 5684

Registered No. _____
If death occurred in a hospital, institution or camp give its NAME instead of street and number.

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

Christina Yergers

PERSONAL AND STATISTICAL PARTICULARS

3. SEX female 4. COLOR OR RACE white 5. SINGLE, MARRIED, WIDOWED OR DIVORCED. widow
(Write the word.)

6. DATE OF BIRTH Jan 10 1836
(Month) (Day) (Year)

7. AGE 77 yrs. 8 mos. 2 ds. IF LESS than 1 day how many hrs. or min.?

8. OCCUPATION

(a) Trade, profession, or particular kind of work
(b) General nature of industry, business, or establishment in which employed (or employer)

housewife

9. BIRTHPLACE

(State or Country)

Denmark

10. NAME OF FATHER

Michael Poulsen

11. BIRTHPLACE OF FATHER

(State or Country)

Denmark

12. MAIDEN NAME OF MOTHER

Don't Know

13. BIRTHPLACE OF MOTHER

(State or Country)

Denmark

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

Mrs. W. H. Hall

(Address)

Emmett, Ida

15.

Filed 10-2 1913

J. R. Reynolds
Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

Sept 12 1913
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from

Aug 14 1913, to Sept 11 1913

that I last saw her alive on Sept 11 1913,

and that death occurred on the date stated above, at _____ M.

The CAUSE OF DEATH* was as follows:

Chronic myocarditis

(Duration) _____ yrs. _____ mos. _____ ds.

Contributory (Secondary)

(Duration) _____ yrs. _____ mos. _____ ds.

(Signed) R. B. Cummings M. D.

Sept 11 1913 (Address) Emmett, Idaho

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place _____ In the _____

of death.....yrs.....mos.....ds. State.....yrs.....mos.....ds.

Where was Disease contracted,

If not at place of death?

Former or

usual residence.

19. PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

Emmett Cemetery

Sept 14 1913

20. UNDERTAKER

ADDRESS

C. D. Buckner

Emmett

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Form V. S. No. 5. 12½ M. 7-24-11

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH.
County of Idaho
City of Kamiah

Registration District No. 49
Primary Registration District No. 2125
(No. _____ St.)

File No. 5686
Registered No. _____

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Luke Williams

If death occurred in a hospital, institution or camp give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX male 4. COLOR OR RACE Indian 5. SINGLE, MARRIED, WIDOWED OR DIVORCED. married
(Writes the word.)

6. DATE OF BIRTH Don't know
(Month) (Day) (Year)

7. AGE 59 yrs. mos. ds. IF LESS than 1 day how many hrs. or min?

8. OCCUPATION
(a) Trade, profession or particular kind of work. Farmer
(b) General nature of industry business or establishment in which employed (or employer)

9. BIRTHPLACE Idaho
(State or Country)

10. NAME OF FATHER Jonathan Williams

11. BIRTHPLACE OF FATHER Idaho
(State or Country)

12. MAIDEN NAME OF MOTHER Taklasommy

13. BIRTHPLACE OF MOTHER Washington
(State or Country)

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) John Frank
(Address) Friedman Idaho

15. Filed Oct 9 1913 E. Taylor Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH Luke Williams 1913
Sept. (Month) 21 (Day) 13 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Sept 17th 1913, to Sept 21st 1913 that I last saw him alive on Sept 20th 1913 and that death occurred on the date stated above, at 4 P. M. The CAUSE OF DEATH* was as follows:
Cancer of Stomach
invasive

(Duration) Three yrs. mos. ds.
Contributory Remission of L. Intestine
(Secondary) and Rheumatism
(Duration) 4 yrs. mos. ds.
(Signed) Dr. Bryan M. D.
Sept. 23 1913 (Address) Kamiah

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; (2) whether ACCIDENTAL, SUICIDAL OR HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place In the
of death yrs. mos. ds. State yrs. mos. ds.
Where was disease contracted,
If not at place of death?
Former or usual residence

19. PLACE OF BURIAL OR REMOVAL DATE OF BURIAL

Kamiah Sept 23 1913
20. UNDERTAKER ADDRESS
E. Taylor Kamiah

CERTIFICATE OF DEATH.

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH.

County of Idaho
City of _____

Registration District No. _____

Primary Registration District No. _____

(No. _____ St.)

File No. 568

Registered No. _____

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

Ernest Schultz

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX M 4. COLOR OR RACE W 5. SINGLE, MARRIED, WIDOWED OR DIVORCED. married

6. DATE OF BIRTH.

Sept (Month) 1843 (Year)

7. AGE

70

Yrs. _____ Mos. _____ ds. _____

IF LESS than 1 day
how many _____ hrs. or
_____ min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work...
(b) General nature of industry, business, or establishment in which employed (or employer).....Beeman

9. BIRTHPLACE

(State or Country)

Germany

10. NAME OF FATHER

Do not know

11. BIRTHPLACE OF FATHER

(State or Country)

Do not know

12. MAIDEN NAME OF MOTHER

Do not know

13. BIRTHPLACE OF MOTHER

(State or Country)

Do not know

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant)

Case

(Address)

Parma Ida

15.

Filed

Sept 301913R. H. H. H.
Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

Sept 29 (Month) 1913 (Year)

17. I HEREBY CERTIFY, That I attended deceased from

Sept 10 1913 to Sept 29 1913that I last saw him alive on Sept 28 1913and that death occurred on the date stated above, at 4 M.

The CAUSE OF DEATH* was as follows:

Interstitial Nephritis
Complicated by Hematuria(Duration) Yrs. 3 mos. 10 ds.Contributory (Secondary) Exhaustion(Duration) Yrs. 3 mos. 10 ds.(Signed) William J. H. H. M. D.19 (Address) Idaho

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death.....yrs.....mos. 28 days. In the State Idaho yrs.....mos.....daysWhere was disease contracted if not at place of death? At place of deathFormer or usual residence Parma, Idaho

19. PLACE OF BURIAL OR REMOVAL

Parma

DATE OF BURIAL

Sept 30 1913

20. UNDERTAKER

Platt & Graham Co

ADDRESS

Parma

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

PLACE OF DEATH.

Registration District No. 2Primary Registration District No. 1004

(No. _____ St.)

File No. 56886Registered No. 56886

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

Elizabeth Bergman DeBlois
If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX Female 4. COLOR OR RACE White 5. SINGLE, MARRIED, WIDOWED OR DIVORCED. Divorced
(Write the word.)6. DATE OF BIRTH not obtainable 1913
(Month) (Day) (Year)7. AGE 71 yrs. — mos. — ds.
IF LESS than 1 day how many hrs. or mins.?8. OCCUPATION
(a) Trade, profession or particular kind of work Housekeeper
(b) General nature of industry business, or establishment in which employed (or employer)9. BIRTHPLACE Belgium
(State or Country)10. NAME OF FATHER Not obtainable11. BIRTHPLACE OF FATHER Not obtainable
(State or Country)12. MAIDEN NAME OF MOTHER Not obtainable13. BIRTHPLACE OF MOTHER Not obtainable
(State or Country)

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Lester M. Guntan
(Address) Boise

15. _____

Filed 9-4 1913 _____
Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH Aug 31 1913
(Month) (Day) (Year)17. I HEREBY CERTIFY, That I attended deceased from Aug. 26 1913, to Aug 31 1913 that I last saw her alive on Aug 31 1913 and that death occurred on the date stated above, at 4 P.M.

The CAUSE OF DEATH* was as follows:

Acute dysentery(Duration) yrs. mos. 5 ds.Contributory None
(Secondary)

(Duration) yrs. mos. ds.

(Signed) L. P. McCall M. D.8/31/1913 (Address) Boise Idaho

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
St. Alphonsus Hosp.At place of death. yrs. mos. 3 days. In the State. yrs. mos. days.Where was disease contracted if not at place of death? Near Boise

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL DATE OF BURIAL

Morris & Hel Cemetery 9/4 1913

20. UNDERTAKER ADDRESS

Schneider & Widneyaden Boise, IdahoMARGIN RESERVED FOR BINDING
WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. CLAIMS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. PLACEMENT OF OCCUPATION is very important. See instructions on back of certificate.

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. CLANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. If death occurs away from usual residence, give facts called for under special information. 2. FULL NAME. See instructions on back of certificate.

V. S. No. 5 20M.1-16-12

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

PLACE OF DEATH.

Registration District No. 2
Primary Registration District No. 1004
(No. 902, N. 20th St.)

File No. 5689
Registered No. 204

County of Ada
City of Boise

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME John Thomas Browning

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX Male 4. COLOR OR RACE White 5. SINGLE, MARRIED, WIDOWED OR DIVORCED. Widowed (Use the word.)

6. DATE OF BIRTH July 22 1885
(Month) (Day) (Year)

7. AGE 88 yrs. 1 mos. 8 ds. IF LESS than 1 day how many hrs. or mins.?

8. OCCUPATION (a) Trade, profession or particular kind of work Dairyman (b) General nature of industry, business, or establishment in which employed (or employer) Retired 23 years

9. BIRTHPLACE (State or Country) Maritta, Ohio

10. NAME OF FATHER Jacob Browning

11. BIRTHPLACE OF FATHER (State or Country) Penn

12. MAIDEN NAME OF MOTHER Edna Bodwell

13. BIRTHPLACE OF MOTHER (State or Country) Penn

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE (Informant) Belle B. Burroughs (Address) 902 N 20th Boise Idaho

15. Filed 9-4 1913 M. S. O'Brien Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH Sept 1st 1913
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from dead 1913 to Sept 1913 that I last saw him alive on 1913 and that death occurred on the date stated above, at 6 P. M.

The CAUSE OF DEATH* was as follows:
Apoplexy Apoplexy
fell dead on street
(Duration) yrs. mos. ds.

Contributory (Secondary) (Duration) yrs. mos. ds. (Signed) Adolph Schreiber M.D. 19 (Address) Boise Coeur d'Alene

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death yrs. mos. days. In the State yrs. mos. days. Where was disease contracted if not at place of death? Former or usual residence Chehalis Wash.

19. PLACE OF BURIAL OR REMOVAL Chehalis Wash DATE OF BURIAL 9/5 1913

20. UNDERTAKER Schreiber & Sidenfaden ADDRESS Boise Ida

MARGIN RESERVED FOR BINDING
WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Form V. S. No. 5 20M.1-16-12

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

PLACE OF DEATH.

Registration District No. 2

County of Ada

Primary Registration District No. 1004

City of Boise

(No. 409, Washington St.)

File No. 5690

Registered No. 708

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Baby Sloan

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX M 4. COLOR OR RACE White 5. SINGLE, MARRIED, WIDOWED OR DIVORCED. Single
(Write the word.)

6. DATE OF BIRTH Sept 6th 1913
(Month) (Day) (Year)

7. AGE _____ yrs. _____ mos. _____ ds.
IF LESS than 1 day how many 2 hrs. or _____ mins.?

8. OCCUPATION
(a) Trade, profession or particular kind of work none
(b) General nature of industry, business, or establishment in which employed (or employer)

9. BIRTHPLACE Boise, Idaho,
(State or Country)

10. NAME OF FATHER W. G. Sloan

11. BIRTHPLACE OF FATHER Ills. Widener
(State or Country)

12. MAIDEN NAME OF MOTHER Fay Widener

13. BIRTHPLACE OF MOTHER Iowa
(State or Country)

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) W. G. Sloan

(Address) 915 Washington, Barn, Ida.

15. _____

Filed 9-6 1913 M. S. Parker
Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH Sept 6th 1913
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from Sept 6 1913, to Sept 6 1913, that I last saw him alive on Sept 6 1913, and that death occurred on the date stated above, at 9:20 A.M.

The CAUSE OF DEATH* was as follows:

Infantile

(Duration) _____ yrs. _____ mos. _____ ds.
Contributory 7-months child
(Secondary)

(Duration) _____ yrs. _____ mos. _____ ds.
(Signed) Maurice H. Tallman M. D.
9/6 1913 (Address) Boise, Ida.

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.) St. Alphonsus Hosp.

At place of death _____ yrs. _____ mos. _____ days. In the State _____ yrs. _____ mos. _____ days.

Where was disease contracted if not at place of death? _____

Former or usual residence 915 Wash. Boise, Idaho

19. PLACE OF BURIAL OR REMOVAL Marriott Hill Cemetery DATE OF BURIAL 9/8 1913

20. UNDERTAKER Schreiber & Widener ADDRESS Boise, Idaho

Dr. Tallman

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Form V. S. No. 5 20M.1-16-12

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH.

Registration District No. 2

County of Ada

Primary Registration District No. 1004

City of Boise

(No. St. Luke's Hospital)

File No. 5691

Registered No. 210

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Geo Miller

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX

Male

4. COLOR OR RACE

white American

5. SINGLE, MARRIED, WIDOWED OR DIVORCED.

not known
(Write the word.)

6. DATE OF BIRTH

not obtainable

(Month)

(Day)

(Year)

7. AGE

About 23 yrs.

IF LESS than 1 day
how many hrs. or
..... mins.?

8. OCCUPATION

(a) Trade, profession or particular kind of work

R. B. Brakeman

(b) General nature of industry business, or establishment in which employed (or employer)

9. BIRTHPLACE

(State or Country)

not obtainable

10. NAME OF FATHER

11. BIRTHPLACE OF FATHER

(State or Country)

12. MAIDEN NAME OF MOTHER

13. BIRTHPLACE OF MOTHER

(State or Country)

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

P. L. Euy.

(Address)

Boise Ida.

15.

Filed

9-8

1913

M. S. Parker

Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH

Sept

2

1913

(Month)

(Day)

(Year)

17. I HEREBY CERTIFY, That I attended deceased from

1913

to Sept 2

1913

that I last saw him alive on Sept 2 1913

and that death occurred on the date stated above, at 3 P.M.

The CAUSE OF DEATH* was as follows:

Fracture of Skull

(Duration)

yrs.

mos.

ds.

Contributory
(Secondary)

(Duration)

yrs.

mos.

ds.

(Signed)

9/8

1913

(Address)

Boise

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place

of death.

yrs.

mos.

days.

In the

State.

yrs.

mos.

days.

Where was disease contracted if not at place of death?

Former or usual residence.

19. PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

Marion Hill Cem.

Sept 8 1913

20. UNDERTAKER

ADDRESS

Euy & Summers

Boise

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Form V. S. No. 5 20M.1-16-12

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH.

Registration District No. 2County of AdaPrimary Registration District No. 1004City of Boise(No. 2626 Harrison Blvd.)File No. 5692Registered No. 278

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Baby Brunger

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX

4. COLOR OR RACE

5. SINGLE, MARRIED, WID-
OWED OR DIVORCED.Female WhiteSingle
(Write the word.)

6. DATE OF BIRTH

Sept 5 1913
(Month) (Day) (Year)

7. AGE

2 yrs. 2 mos. 2 ds.

IF LESS than 1 day
how many hrs. or
..... mins.?

8. OCCUPATION

(a) Trade, profession or
particular kind of work(b) General nature of industry
business, or establishment in
which employed (or employer)none

9. BIRTHPLACE

(State or Country)

Boise10. NAME OF
FATHERW. J. Brunger11. BIRTHPLACE
OF FATHER

(State or Country)

Ida12. MAIDEN NAME
OF MOTHEREmma C. Brunger13. BIRTHPLACE
OF MOTHER

(State or Country)

Idaho

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

(Address) 2008 Harrison Blvd.

15.

Filed 7-11 1913W. S. Parker

Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH

Sept 7 1913
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from

Sept 5 1913, to Sept 7 1913,that I last saw him alive on Sept 7 1913,and that death occurred on the date stated above, at 2 P.M.

The CAUSE OF DEATH* was as follows:

Premature birth -
supported period of gestation
120 to 220 days

(Duration) yrs. mos. ds.

Contributory
(Secondary)

(Duration) yrs. mos. ds.

(Signed)

J. M. Taylor M. D.
Sept 1913 (Address) Boise Ida

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1)
MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL OR HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions,
Transients or Recent Residents.)

At place of death yrs. mos. days. In the State yrs. mos. days.

Where was disease contracted
if not at place of death?Former or
usual residence

19. PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

Marion Hill Cemetery
Ada Co. Plat.Sept 12 1913

20. UNDERTAKER

ADDRESS

Schreiber & Widemeyer BoiseTaylor

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Form V. S. No. 5 20M.1-16-12

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH.

Registration District No. 2County of AdaPrimary Registration District No. 1004City of Boise(No. 1619, North 5th St.)File No. 5692Registered No. 212

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

James Francis Mc Guire

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX

Male

4. COLOR OR RACE

White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED.

Single
(Write the word.)

6. DATE OF BIRTH

Jan
(Month)19
(Day)1912
(Year)

7. AGE

1 yrs.7 mos.22 ds.IF LESS than 1 day
how many hrs. or
..... mins.?

8. OCCUPATION

(a) Trade, profession or particular kind of work.

none

(b) General nature of industry business, or establishment in which employed (or employer)

9. BIRTHPLACE

(State or Country)

Boise Idaho

10. NAME OF FATHER

Joseph Mc Guire

11. BIRTHPLACE OF FATHER

(State or Country)

Kan.

12. MAIDEN NAME OF MOTHER

Lena Miller

13. BIRTHPLACE OF MOTHER

(State or Country)

Illin.

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

Mrs Lena Mc Guire

(Address)

Boise

15.

Filed 9-131913Mrs. S. Parker

Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH

Sept.
(Month)12th
(Day)1913
(Year)

17. I HEREBY CERTIFY, That I attended deceased from

Sept-7th1913, toSept-12th1913,that I last saw him alive on Sept-12 1913and that death occurred on the date stated above, at 12:40 P.M.

The CAUSE OF DEATH* was as follows:

acute Gastro-enteritis

(Duration)

yrs.

mos.

ds.

Contributory
(Secondary)probably - mumps

(Duration)

yrs.

mos.

ds.

(Signed)

J. M. Taylor

M. D.

Sept 12 1913 (Address) Boise Idaho

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place

of death yrs. mos. days.

In the

State yrs. mos. days.

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

Boise CemeterySept 13 1913

20. UNDERTAKER

ADDRESS

Edw. J. Hiden Boise

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
MARGIN RESERVED FOR BINDING

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statements of OCCUPATION is very important. See instructions on back of certificate.

Form V. S. No. 5 20M.1-16-12

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

PLACE OF DEATH.

Registration District No. 2

County of Ada

Primary Registration District No. 1004

City of Boise

(No. St. Luke's Hospital St.)

File No. 5691

Registered No. 213

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Wm. Sparks

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX

4. COLOR OR RACE

5. SINGLE, MARRIED, WIDOWED OR DIVORCED.

Male

white
American

not known
(Write the word.)

6. DATE OF BIRTH

not obtainable

(Month) (Day) (Year)

7. AGE

about 39

yrs. mos. ds.

IF LESS than 1 day
how many hrs. or mins.?

8. OCCUPATION

(a) Trade, profession or particular kind of work

Farmer

(b) General nature of industry business, or establishment in which employed (or employer)

9. BIRTHPLACE

(State or Country)

not obtainable

10. NAME OF FATHER

11. BIRTHPLACE OF FATHER

(State or Country)

12. MAIDEN NAME OF MOTHER

13. BIRTHPLACE OF MOTHER

(State or Country)

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

Fry Summers Co

(Address)

Boise

15.

Filed 9-20

191

Wm. Sparks

Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH

Sept 16

191

(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from

July 20, 1913, to Sept 16, 1913,

that I last saw h. Sept 16, 1913

and that death occurred on the date stated above, at 39 M.

The CAUSE OF DEATH* was as follows:

Cerebral Apoplexy

(Duration) 2 yrs. mos. ds.

Contributory (Secondary)

Epilepsy

(Duration) 2 yrs. mos. ds.

(Signed)

R. E. Shumaker M. D.

19. (Address) Boise Idaho

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death.....yrs.....mos.....days. In the State.....yrs.....mos.....days.

Where was disease contracted if not at place of death?.....

Former or usual residence.....

19. PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

Philadelphia Penn.

Sept 20, 1913

20. UNDERTAKER

ADDRESS

Fry Summers Co

Boise Ida

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Form V. S. No. 5 20M.1-16-12

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH.

Registration District No. 2County of AdaPrimary Registration District No. 1004City of Boise(No. South Boise St.)File No. 5695Registered No. 216

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

Wilma Myrtle Jarrett

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX

Female

4. COLOR OR RACE

White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED.

Married
(Write the word.)

6. DATE OF BIRTH

Nov. 26 1884
(Month) (Day) (Year)

7. AGE

28 yrs. 9 mos. 26 ds.IF LESS than 1 day
how many hrs. or mins.?

8. OCCUPATION

(a) Trade, profession or particular kind of work

Housekeeper
(b) General nature of industry, business, or establishment in which employed (or employer)

9. BIRTHPLACE

(State or Country)

Iowa

10. NAME OF FATHER

W. H. Ballinger

11. BIRTHPLACE OF FATHER

(State or Country)

Ky.

12. MAIDEN NAME OF MOTHER

Martha E. Pace

13. BIRTHPLACE OF MOTHER

(State or Country)

Ohio

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

T. B. Jackson

(Address)

P.O. Box 412, Boise

15.

Filed

9-231913M. S. Parker

Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH

Sept. 21 1913
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from

Sept. 12 1913 to Sept. 21 1913that I last saw h.e. alive on Sept. 21 1913and that death occurred on the date stated above, at 5:30 P.M.

The CAUSE OF DEATH* was as follows:

Septic Peritonitis caused by ruptured appendix.(Duration) yrs. mos. 6 ds.Contributory appendicitis chronic
(Secondary)

(Duration) yrs. mos. ds.

(Signed) H. M. Holmerson M. D.Sept. 2 1913 (Address) Boise

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death.....yrs.....mos.....days. In the State.....yrs.....mos.....days.

Where was disease contracted if not at place of death?.....

Former or usual residence.....

19. PLACE OF BURIAL OR REMOVAL DATE OF BURIAL

Morris Hill Cemetery Sept. 23 1913

20. UNDERTAKER ADDRESS

Schreiber & Hidenfaden BoiseHolmerson

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Form V. S. No. 5 20M.1-16-12

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH.

Registration District No. 2County of AdaPrimary Registration District No. 1004City of Boise(No. 105 East Burrows St.)File No. 5695Registered No. 217

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

Herman Urgisa Jr.

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX

4. COLOR OR RACE

5. SINGLE, MARRIED, WIDOWED OR DIVORCED.

(Write the word.)

6. DATE OF BIRTH

June 4 1913
(Month) (Day) (Year)

7. AGE

3 yrs. 16 mos. 16 ds.IF LESS than 1 day
how many hrs. or
..... mins.?

8. OCCUPATION

(a) Trade, profession or particular kind of work

(b) General nature of industry, business, or establishment in which employed (or employer)

none

9. BIRTHPLACE

(State or Country)

Boise, Idaho.

10. NAME OF FATHER

Herman Urgisa

11. BIRTHPLACE OF FATHER

(State or Country)

Spain

12. MAIDEN NAME OF MOTHER

Anna Kent

13. BIRTHPLACE OF MOTHER

(State or Country)

Idaho.

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

Ida Kent

(Address)

Boise, Idaho

15.

Filed

7-231913M. S. Parker

Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH

Sept. 21 1913
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from

July 1913, to Sept 20 1913,
that I last saw him alive on Sept 20 1913and that death occurred on the date stated above, at 34 M.

The CAUSE OF DEATH* was as follows:

Malnutrition(Duration) yrs. 3 mos. _____ ds.

Contributory (Secondary)

Neglect

(Duration) yrs. _____ mos. _____ ds.

(Signed)

R. E. Shurtz M. D.

19

(Address)

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death.....yrs.....mos.....days.

In the State.....yrs.....mos.....days.

Where was disease contracted if not at place of death?.....

Former or usual residence.....

19. PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

Morris Hill Ada Co. PlakSept 22 1913

20. UNDERTAKER

ADDRESS

Schreiber & LidenfadenBoiseDr. Shurtz

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Form V. S. No. 5 20M.1-16-12

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH.

Registration District No. 2

County of Ada

Primary Registration District No. 164

City of Boise

(No. St. Luke's Hospital, St.)

If death occurs away from usual residence, give facts call for under special information.

2. FULL NAME

George L Roy Baker

File No. 5697

Registered No. 218

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX

4. COLOR OR RACE

5. SINGLE, MARRIED, WID-
OWED OR DIVORCED.

Male White

Married
(Write the word.)

6. DATE OF BIRTH

Dec 23 1880
(Month) (Day) (Year)

7. AGE

32 yrs. 8 mos. 25 ds.

IF LESS than 1 day
how many hrs. or
..... mins.

8. OCCUPATION

(a) Trade, profession or
particular kind of work

(b) General nature of industry
business, or establishment in
which employed (or employer)

Drug Clerk

9. BIRTHPLACE

(State or Country)

Colorado

10. NAME OF
FATHER

George L Baker

11. BIRTHPLACE
OF FATHER

(State or Country)

New York

12. MAIDEN NAME
OF MOTHER

Elizabeth Turner

13. BIRTHPLACE
OF MOTHER

(State or Country)

Missouri

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

(Address)

Frank Baker
Boise, Idaho

15.

Filed

7-22-1913

Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH

Sept 21 1913
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from

Sept 7 1913, to Sept 21 1913,

that I last saw him alive on Sept 21 1913,

and that death occurred on the date stated above, at 2 P. M.

The CAUSE OF DEATH* was as follows:

Acute Nephritis

(Duration) yrs. mos. 10 ds.

Contributory
(Secondary)

Excess Intoxication

(Duration) yrs. mos. 10 ds.

(Signed)

Edward B. B. M. D.

Sept 21 1913 (Address) 208 S. Main St.

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death yrs. mos. days. In the State yrs. mos. days.

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

Masonic Cemetery Sept 25 1913

20. UNDERTAKER

ADDRESS

W. B. Summers Boise, Idaho

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Form V. S. No. 5 20M.1-16-12

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH.

Registration District No. 2

File No. 5698

County of Ada

Primary Registration District No. 1004

Registered No. 219

City of Boise

(No. St. Luke's Hospital St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

Robert Arthur Badley

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX

Male

4. COLOR OR RACE

White American

5. SINGLE, MARRIED, WIDOWED OR DIVORCED.

Married
(Write the word.)

6. DATE OF BIRTH

Jan 20 1845
(Month) (Day) (Year)

7. AGE

68 yrs. 8 mos. 2 ds.

IF LESS than 1 day
how many hrs. or
..... mins?

8. OCCUPATION

(a) Trade, profession or particular kind of work

Farmer

(b) General nature of industry business, or establishment in which employed (or employer)

9. BIRTHPLACE

(State or Country)

Indiana

10. NAME OF FATHER

H. H. Badley

11. BIRTHPLACE OF FATHER

(State or Country)

not obtainable

12. MAIDEN NAME OF MOTHER

" "

13. BIRTHPLACE OF MOTHER

(State or Country)

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

E. C. Badley

(Address)

15.

Filed

9-22-1913

M. D. [Signature]
Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH

September 23 1913
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from

9/18 1913, to 9/22 1913,
that I last saw him alive on 9/22 1913,
and that death occurred on the date stated above, at 2 A.M.

The CAUSE OF DEATH* was as follows:

Exhaustion - Septic

(Duration) yrs. mos. ds.

Contributory (Secondary)

Enlarged Prostate Gland

(Duration) yrs. mos. ds.

(Signed)

Paul A. Dillingham, M. D.

9/23 1913 (Address) Jack Badley

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death. yrs. mos. days. In the State. yrs. mos. days.

Where was disease contracted if not at place of death?

Former or usual residence

Sweet Idaho

19. PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

Sweet Idaho

Sept 25 1913

20. UNDERTAKER

ADDRESS

Frederick [Signature]

Boise Ida.

Form V. S. No. 5 20M.1-16-12

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH.

Registration District No. 9County of AdaPrimary Registration District No. 1004City of Boise(No. So. Boise St.)File No. 5699Registered No. 221

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Seraphine A. Morrison

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX

4. COLOR OR RACE

5. SINGLE, MARRIED, WIDOWED OR DIVORCED.

FemaleWhiteMarried

6. DATE OF BIRTH

Sept
(Month)19
(Day)1836
(Year)

7. AGE

77 yrs. 3 mos. 3 ds.IF LESS than 1 day
how many hrs. or
..... mins.?

8. OCCUPATION

(a) Trade, profession or particular kind of work
(b) General nature of industry business, or establishment in which employed (or employer)Retired

9. BIRTHPLACE

(State or Country)

Canada

10. NAME OF FATHER

James Leury.

11. BIRTHPLACE OF FATHER

(State or Country)

Ireland.

12. MAIDEN NAME OF MOTHER

Maria Wood.

13. BIRTHPLACE OF MOTHER

(State or Country)

Canada.

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

James Morrison.

(Address)

R.F.D. #4. Boise, Ida

15.

Filed 9-251913M.S. Parker

Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH

Sept.
(Month)23rd
(Day)1913
(Year)

17. I HEREBY CERTIFY, That I attended deceased from

Sept. 18th1913to Sept. 18th1913that I last saw her alive on Sept. 18th1913and that death occurred on the date stated above, at 11:40 M.

The CAUSE OF DEATH* was as follows:

No specific disease noted
a gradual failing for
months

(Duration) yrs. mos. ds.

Contributory
(Secondary)Old age

(Duration) yrs. mos. ds.

(Signed)

J. M. Taylor

M. D.

Sept. 18th (Address) Boise, Ida

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place

of death yrs. mos. days.

In the

State yrs. mos. days.

Where was disease contracted if not at place of death?

Former or usual residence

Manitou & 4th St.

19. PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

Masonic Cemetery9/25th 1913

20. UNDERTAKER

ADDRESS

Schreiber & SiderfaderBoise, Ida

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Form V. S. No. 5 20M.1-16-12

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH.

Registration District No. 2County of AdaPrimary Registration District No. 1014File No. 57011City of Boise(No.)

St.)

Registered No. 223

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Peter Horve

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX

4. COLOR OR RACE

5. SINGLE, MARRIED, WIDOWED OR DIVORCED.

MaleWhiteMarried
(Write the word.)

6. DATE OF BIRTH

Dec.61865

(Month)

(Day)

(Year)

7. AGE

47 yrs. 9 mos. 18 ds.IF LESS than 1 day
how many hrs. or
..... mins.?

8. OCCUPATION

(a) Trade, profession or particular kind of work

Baker and Cook

(b) General nature of industry business, or establishment in which employed (or employer)

9. BIRTHPLACE

(State or Country)

Germany

10. NAME OF FATHER

Peter Horve

11. BIRTHPLACE OF FATHER

(State or Country)

Germany

12. MAIDEN NAME OF MOTHER

Kathrine Blein

13. BIRTHPLACE OF MOTHER

(State or Country)

Germany

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

Bliss L. L. L.

(Address)

Boise Ida.

15.

Filed 9-271913M. S. Parker

Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH

Sept.281913

(Month)

(Day)

(Year)

17. I HEREBY CERTIFY, That I attended deceased from

Sept. 22nd 1913, to Sept. 24th 1913,that I last saw him alive on Sept. 24 1913,and that death occurred on the date stated above, at 1 P.M.

The CAUSE OF DEATH* was as follows:

Pneumonia
(Specify)

(Duration)

yrs.

mos.

ds.

Contributory

(Secondary)

Le Grippe

(Duration)

yrs.

mos.

ds.

(Signed)

Sept 16 1913 (Address) Boise Ida

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place

of death

yrs.

mos.

days.

In the

State

yrs.

mos.

days.

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

Morris Hill Cemetery Sept 28 1913

20. UNDERTAKER

ADDRESS

Schreiber & Sons Boise

-SUPPLEMENTARY DEATH CERTIFICATE-

(Please reply on this sheet to
the registrar of Vital Statistics)

Death Certificate No. _____

Name _____

William Henry

Date of Death _____

Aug 24 1913

Cause of Death _____

Brucella - Pneumonia

Contributory Cause of death _____

Acute Bronchitis

(Sign here) _____

John B. Davis

M.D.

Form V. S. No. 5 20M.1-16-12

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH

Registration District No. 2County of AdaPrimary Registration District No. 1004File No. 5701City of Boise(No. 218, E. Idaho)Registered No. 224

If death occurs away from usual residence, give facts called for under special information.

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Elvira Aldecoa

PERSONAL AND STATISTICAL PARTICULARS

3. SEX

Female

4. COLOR OR RACE

White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED.

Single
(Write the word.)

6. DATE OF BIRTH

Nov 12 1913
(Month) (Day) (Year)

7. AGE

10 yrs. 10 mos. 13 ds.IF LESS than 1 day
how many hrs. or
mins.?

8. OCCUPATION

(a) Trade, profession or particular kind of work
(b) General nature of industry, business, or establishment in which employed (or employer)none

9. BIRTHPLACE

(State or Country)

Boise

10. NAME OF FATHER

Marcelino Aldecoa

11. BIRTHPLACE OF FATHER

(State or Country)

Spain

12. MAIDEN NAME OF MOTHER

Anastasia Navarrodia

13. BIRTHPLACE OF MOTHER

(State or Country)

Spain

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

Narcisa Gestal

(Address)

224 E. Idaho

15.

Filed

9-271913M. S. Parker

Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

Sept 25 1913
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from

1913, to 1913,that I last saw h. alive on 1913,and that death occurred on the date stated above, at 10 AM.

The CAUSE OF DEATH* was as follows:

Cholera infantum

(Duration) yrs. mos. ds.

Contributory

(Secondary)

(Duration) yrs. mos. ds.

(Signed)

Geo. C. Smith, M. D.

19 (Address)

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death yrs. mos. days. In the State yrs. mos. days.

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL DATE OF BURIAL

St. John's Cemetery 9/26 1913

20. UNDERTAKER

ADDRESS

Schreiber & Hidenfaden Boise, Idaho

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Form V. S. No. 5 20M.1-16-12

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH.

Registration District No.

County of Ada

Primary Registration District No.

City of Boise(No. North 21st. St.)File No. 3702Registered No. 225

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Luna Henry

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX

Female

4. COLOR OR RACE

white American

5. SINGLE, MARRIED, WIDOWED OR DIVORCED.

married
(Write the word.)

6. DATE OF BIRTH

Apr 28 1883
(Month) (Day) (Year)

7. AGE

28 yrs. 4 mos. 27 ds.IF LESS than 1 day
how many hrs. or
..... mins.?

8. OCCUPATION

(a) Trade, profession or particular kind of work
(b) General nature of industry business, or establishment in which employed (or employer)House work

9. BIRTHPLACE

(State or Country)

Tenn

10. NAME OF FATHER

J. W. Farmer

11. BIRTHPLACE OF FATHER

(State or Country)

Tenn

12. MAIDEN NAME OF MOTHER

Mary Latham

13. BIRTHPLACE OF MOTHER

(State or Country)

Tenn

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

J. W. Farmer

(Address)

Boise

15.

Filed 9 - 27 1913M. S. Parker

Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH

Sep 25 1913
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from

Sep 24 1913, to 1913,that I last saw her alive on Sep 24 1913,and that death occurred on the date stated above, at 7 P.M.

The CAUSE OF DEATH* was as follows:

Tuberculous Enteritis(Duration) Two yrs. mos. ds.Contributory Exhaustion
(Secondary)(Duration) yrs. mos. 4 ds.(Signed) J. M. Brayton M. D.Sep 27 1913 (Address) Boise Idaho

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death yrs. mos. days. In the State yrs. mos. days.

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL DATE OF BURIAL

Morris Hill Cem Sep 28 1913

20. UNDERTAKER

ADDRESS

Fry & Summers & Co Boise

MARGIN RESERVED FOR BINDING
WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Form V. S. No. 5 20M.1-16-12

CERTIFICATE OF DEATH

1. PLACE OF DEATH

Registration District No.

County of

Primary Registration District No.

City of

(No.

St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

File No.

Registered No.

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX

4. COLOR OR RACE

5. SINGLE, MARRIED, WIDOWED OR DIVORCED.

Male white married
(Write the word.)

6. DATE OF BIRTH

Not obtainable

(Month)

(Day)

(Year)

7. AGE

about 54 years old
yrs. mos. ds.

IF LESS than 1 day
how many hrs. or mins.?

8. OCCUPATION

(a) Trade, profession or particular kind of work

(b) General nature of industry business, or establishment in which employed (or employer)

Miner

9. BIRTHPLACE

(State or Country)

West Virginia

10. NAME OF FATHER

Not obtainable

11. BIRTHPLACE OF FATHER

(State or Country)

American

12. MAIDEN NAME OF MOTHER

Not obtainable

13. BIRTHPLACE OF MOTHER

(State or Country)

American

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

L. Frank C. Bond

(Address)

15.

Filed

9-27

1913

M. S. Parker

Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

9 27 1913
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from

July 27 1913 to Sept. 27 1913

that I last saw him alive on Sept. 26 1913

and that death occurred on the date stated above, at 6 A.M.

The CAUSE OF DEATH* was as follows:

Chronic Valvular Disease

(Duration) yrs. mos. ds.

Contributory
(Secondary)

(Duration) yrs. mos. ds.

(Signed) Fred A. Blythe M. D.

9/27 1913 (Address) Salt Lake City

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death yrs. mos. days. In the State yrs. mos. days.

Where was disease contracted if not at place of death?

Former or usual residence.

19. PLACE OF BURIAL OR REMOVAL DATE OF BURIAL

Reynolds Hill W. Va. 1913

20. UNDERTAKER

ADDRESS

Schreiber & Sidenfaden Boise

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Form V. S. No. 5 20M.1-16-12

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH.

Registration District No. 2County of AdaPrimary Registration District No. 1004City of Bonco(No. 410 State St.)File No. 5704Registered No. 227

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Walter Cochran

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX

Male

4. COLOR OR RACE

White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED.

Married
(Write the word.)

6. DATE OF BIRTH

June51913

(Month)

(Day)

(Year)

7. AGE

29 yrs. 3 mos. 22 ds.

IF LESS than 1 day
how many hrs. or
..... mins.?

8. OCCUPATION

(a) Trade, profession or particular kind of work

Labor

(b) General nature of industry, business, or establishment in which employed (or employer)

9. BIRTHPLACE

(State or Country)

Weiser Idaho

10. NAME OF FATHER

John Cochran

11. BIRTHPLACE OF FATHER

(State or Country)

Weiser

12. MAIDEN NAME OF MOTHER

Lucinda Storms

13. BIRTHPLACE OF MOTHER

(State or Country)

Chelby ev Ill

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

Chas Brady

(Address)

Glenview Ferry Ida.

15.

Filed 9-27 1913M. S. Parker

Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

September271913

(Month)

(Day)

(Year)

17. I HEREBY CERTIFY, That I attended deceased from

Sept 19, 1913, to Sep 27, 1913,that I last saw him alive on Sep. 27, 1913,and that death occurred on the date stated above, at 8 P.M.

The CAUSE OF DEATH* was as follows:

Perforative Peritonitis. (Perforation of ulcer of duodenum)(Duration) yrs. mos. 23 ds.Contributory Ulcer of duodenum
(Secondary)

(Duration) yrs. mos. ds.

(Signed) L. P. McCab, M. D.9/27/13 (Address) Bonco Idaho

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death yrs. mos. days. In the State yrs. mos. days.

Where was disease contracted if not at place of death?

Former or usual residence Glenview Ferry Ida.

19. PLACE OF BURIAL OR REMOVAL DATE OF BURIAL

St John Cemetery Sept 28, 1913

20. UNDERTAKER

ADDRESS

Schreiber & Wideman Bonco

Form V. S. No. 5 20M.1-16-12

CERTIFICATE OF DEATH

State of Idaho
 BOARD OF HEALTH
 Bureau of Vital Statistics

PLACE OF DEATH.

Registration District No. 2File No. 5705Registered No. 228County of AdaPrimary Registration District No. 1004City of Boise(No. St. Luke's Hospital St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Catherine Annie MacLean

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX Female 4. COLOR OR RACE White 5. SINGLE, MARRIED, WIDOWED, OR DIVORCED. Single
 (Write the word.)

6. DATE OF BIRTH Feb. 14 1887
 (Month) (Day) (Year)

7. AGE 26 yrs. 7 mos. 13 ds.
 IF LESS than 1 day
 how many hrs. or mins.?

8. OCCUPATION
 (a) Trade, profession or particular kind of work House work
 (b) General nature of industry, business, or establishment in which employed (or employer)

9. BIRTHPLACE Iowa
 (State or Country)

10. NAME OF FATHER Charles MacLean

11. BIRTHPLACE OF FATHER Canada
 (State or Country)

12. MAIDEN NAME OF MOTHER Catherine Bowman

13. BIRTHPLACE OF MOTHER Quebec, Canada
 (State or Country)

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Robert P. Diet(Address) Boise

15.

Filed 9-29 1913Local Registrar M. S. Parker

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH 9 28 1913
 (Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from Sept 2 1913, to Sept 29 1913, that I last saw her alive on 29th 1913, and that death occurred on the date stated above, at M.

The CAUSE OF DEATH* was as follows:

Pneumonia
(Bronchitis)

(Duration) 70 yrs. 0 mos. 0 ds.

Contributory (Secondary)

(Duration) 0 yrs. 0 mos. 0 ds.(Signed) James F. Stewart M. D.19. (Address) Boise

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death 0 yrs. 0 mos. 0 days. In the State 0 yrs. 0 mos. 0 days.

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

Morris Hill Cemetery Sept 30 1913

20. UNDERTAKER

ADDRESS

Tryg Sumner Boise Id

Form V. S. No. 5 20M.1-16-12

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

PLACE OF DEATH

Registration District No. 8County of AdaPrimary Registration District No. 2004File No. 5706City of Hamlet(No. near Hamlet St.)Registered No. 3

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Wm. A. Baxter

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX

Male

4. COLOR OR RACE

White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED.

Widower

(Write the word.)

6. DATE OF BIRTH

Feb41839

(Month)

(Day)

(Year)

7. AGE

74 yrs. 5 mos. 28 ds.IF LESS than 1 day
how many..... hrs. or
..... mins.

8. OCCUPATION

(a) Trade, profession or particular kind of work

Invalid for 5 yrs.

(b) General nature of industry, business, or establishment in which employed (or employer)

Laborer

9. BIRTHPLACE

(State or Country)

Indiana

10. NAME OF FATHER

Geo Baxter

11. BIRTHPLACE OF FATHER

(State or Country)

Ind

12. MAIDEN NAME OF MOTHER

Livina Yates

13. BIRTHPLACE OF MOTHER

(State or Country)

Ky.

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Mrs Cameron(Address) Hamlet Ada

15.

Filed 8-41913M. S. Parker

Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

Aug2nd1913

(Month)

(Day)

(Year)

17. I HEREBY CERTIFY, That I attended deceased from

Aug 2nd1913Aug 2nd1913that I last saw him alive on Aug 2nd 1913and that death occurred on the date stated above, at 11:30 A.M.

The CAUSE OF DEATH* was as follows:

Convulsions -

(Duration) yrs. mos. ds.

Contributory (Secondary)

Epilepsy & Softening of brain

(Duration) yrs. mos. ds.

(Signed)

Aug 4th 1913 (Address) Boise Ida

State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death..... yrs..... mos..... days. In the State..... yrs..... mos..... days.

Where was disease contracted if not at place of death?

Former or usual residence.....

19. PLACE OF BURIAL OR REMOVAL DATE OF BURIAL

Harris Hill Cemetery 8/5 1913

20. UNDERTAKER

ADDRESS

Schreiber & Schuyfaden Boise, Ida

-SUPPLEMENTARY DEATH CERTIFICATE-

(Please reply on this sheet to
the registrar of Vital Statistics)

Death Certificate No.

Name *Catherine Ann MacLain*

Date of Death *Sept 29 1913*

Cause of Death *Broncho Pneumonia*

Contributory Cause of death

(Sign here)

James L. Stewart

M.D.

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Form V. S. No. 5 20M.1-16-12

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics
File No. 5707
Registered No. 4

1. PLACE OF DEATH.

Registration District No. 8

County of Ada

Primary Registration District No. 2004

City of Riverside St. (No. Riverside Station St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

Emma Henriksen

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX

Female

4. COLOR OR RACE

White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED.

Married
(Write the word.)

6. DATE OF BIRTH

Oct 8 1864
(Month) (Day) (Year)

7. AGE

48 yrs. 9 mos. 2 ds.

IF LESS than 1 day
how many hrs. or
..... mins.?

8. OCCUPATION

(a) Trade, profession or particular kind of work

Housekeeper

(b) General nature of industry business, or establishment in which employed (or employer)

9. BIRTHPLACE

(State or Country)

Sweden

10. NAME OF FATHER

Bloom

11. BIRTHPLACE OF FATHER

(State or Country)

Sweden

12. MAIDEN NAME OF MOTHER

Not obtainable

13. BIRTHPLACE OF MOTHER

(State or Country)

Sweden

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

Christy Henriksen

(Address)

Boise, Ida

15.

Filed 8-12 1913 M. S. Parker
Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH

Aug 10 1913
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from May 1913, to Aug 1913, that I last saw h..... alive on..... 191.....

and that death occurred on the date stated above, at..... M.

The CAUSE OF DEATH* was as follows:

Pneumonia tubercularis

..... (Duration) yrs. mos. ds.

Contributory
(Secondary)

..... (Duration) yrs. mos. ds.

(Signed) J. W. Smith M. D.

19..... (Address).....

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death..... yrs. mos. days. In the State..... yrs. mos. days.

Where was disease contracted if not at place of death?.....

Former or usual residence.....

19. PLACE OF BURIAL OR REMOVAL DATE OF BURIAL

Worship Hill Cemetery 8/12 1913

20. UNDERTAKER

ADDRESS

Schreibers Undertaking Boise

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Form V. S. No. 5 20M.1-16-12

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH.

Registration District No. 8

County of Ada

Primary Registration District No. 2004

City of _____

(No. near Blacks Creek)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Baby Atkins

File No. 5705

Registered No. 5

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX

4. COLOR OR RACE

5. SINGLE, MARRIED, WIDOWED OR DIVORCED.

Female White

Single
(Write the word.)

6. DATE OF BIRTH

Aug 13 1913
(Month) (Day) (Year)

7. AGE

— yrs. — mos. 1 ds.

IF LESS than 1 day
how many hrs. or
..... mins.?

8. OCCUPATION

(a) Trade, profession or particular kind of work

none

(b) General nature of industry business, or establishment in which employed (or employer)

9. BIRTHPLACE

(State or Country)

Ada County Idaho

10. NAME OF FATHER

J. W. Atkins

11. BIRTHPLACE OF FATHER

(State or Country)

Idaho

12. MAIDEN NAME OF MOTHER

Alice Flemming

13. BIRTHPLACE OF MOTHER

(State or Country)

Oregon

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Mrs. Atkins

(Address) Blacks Creek Idaho

15.

Filed 8-15

1913

M. S. Parker

Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH

Aug 14 1913
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from Aug. 13 1913, to Aug. 14 1913, that I last saw him alive on Aug. 13 1913, and that death occurred on the date stated above, at _____ M.

The CAUSE OF DEATH* was as follows:

Incomplete Clipping of
Foreign Paper

(Duration) yrs. mos. 1 ds.

Contributory
(Secondary)

(Duration) yrs. mos. ds.

(Signed) M. Allen Cullen M. D.

8/15/1913 (Address) Boise Idaho

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death.....yrs.....mos.....days. In the State.....yrs.....mos.....days.

Where was disease contracted if not at place of death?.....

Former or usual residence. Near Blacks Creek Ada Co.

19. PLACE OF BURIAL OR REMOVAL DATE OF BURIAL

Morris Hill Cemetery 8/16/1913

20. UNDERTAKER

ADDRESS

Schreiber & Hidenfader Boise, Ida

Form V. S. No. 5 20M.1-16-12

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH.

Registration District No. 8County of AdaPrimary Registration District No. 10014File No. 5709City of Boise(No. Tom Davis Ranch Fairview Ave. St.)Registered No. 6

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

Louise Saffit John

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX

Male

4. COLOR OR RACE

Yellow

5. SINGLE, MARRIED, WIDOWED OR DIVORCED.

Single
(Write the word.)

6. DATE OF BIRTH

not obtainable
(Month) (Day) (Year)

7. AGE

31 yrs. — mos. — ds.IF LESS than 1 day
how many hrs. or
mins.?

8. OCCUPATION

(a) Trade, profession or particular kind of work.

(b) General nature of industry, business, or establishment in which employed (or employer)

Gardener

9. BIRTHPLACE

(State or Country)

Oregon

10. NAME OF FATHER

not obtainable

11. BIRTHPLACE OF FATHER

(State or Country)

China

12. MAIDEN NAME OF MOTHER

not obtainable

13. BIRTHPLACE OF MOTHER

(State or Country)

China

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

H. Ling Sam

(Address)

Boise, Idaho.

15.

Filed

8-201913M. S. Parker

Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH

Aug 1913
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from

Aug 5 1913, to Aug 5 1913,
that I last saw him alive on Aug 5 1913,
and that death occurred on the date stated above, at 11 A.M.

The CAUSE OF DEATH* was as follows:

Pulmonary Tuberculosisat least
(Duration) 1 yrs. — mos. — ds.Contributory
(Secondary)(Duration) — yrs. — mos. — ds.(Signed) W. M. Halverson M. D.Aug 20 1913 (Address) Boise, Ida.

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death — yrs. — mos. — days. In the State — yrs. — mos. — days.

Where was disease contracted if not at place of death?

Former or usual residence

Boise, Idaho

19. PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

Chinese Cemetery8/20 1913

20. UNDERTAKER

ADDRESS

Shriner & WidemanBoise, Ida.Dr. Halverson.

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Form V. S. No. 5 20M.1-16-12

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH.

Registration District No. 8

County of Ada
City of Boise

Primary Registration District No. 2004
(No. Boise Bench St.)

File No. 571

Registered No. 7947

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Edward Laurens Harrington

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX

Male

4. COLOR OR RACE

White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED.

Married
(Write the word.)

6. DATE OF BIRTH

Oct 1 1836
(Month) (Day) (Year)

7. AGE

76 yrs. 10 mos. 20 ds.

IF LESS than 1 day
how many hrs. or
..... mins.?

8. OCCUPATION

(a) Trade, profession or particular kind of work

Rancher

(b) General nature of industry business, or establishment in which employed (or employer)

9. BIRTHPLACE

(State or Country)

Utah.

10. NAME OF FATHER

Not obtainable

11. BIRTHPLACE OF FATHER

(State or Country)

American

12. MAIDEN NAME OF MOTHER

Not obtainable

13. BIRTHPLACE OF MOTHER

(State or Country)

American

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Mrs E. L. Harrington
(Address) Boise

15.

Filed 8-20 1913 M. S. Parker
Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH

Aug 20th 1913
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from

year 1908 to Aug 20th 1913
that I last saw him alive on Aug 19th 1913

and that death occurred on the date stated above, at 9 A.M.

The CAUSE OF DEATH* was as follows:

Grass from valvular heart lesions

(Duration) Years mos. ds.

Contributory (Secondary) Heart lesions

(Duration) yrs. mos. ds.

(Signed) John Bank M. D.

Aug 19 1913 (Address) Boise Idaho

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death.....yrs.....mos.....days. In the State.....yrs.....mos.....days.

Where was disease contracted if not at place of death?

Former or usual residence.....

19. PLACE OF BURIAL OR REMOVAL DATE OF BURIAL

Morris Hill Cemetery Aug 22 1913

20. UNDERTAKER ADDRESS

Schuba & Widenfaden Boise Ida

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Form V. S. No. 5 20M.1-16-12

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

PLACE OF DEATH

Registration District No. 8.

County of Ada
City of BoisePrimary Registration District No. 2004
(No. 6 miles west Boise St.)File No. 5711Registered No. 9

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

Clarence Adrain Hammum
If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX

Male

4. COLOR OR RACE

White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED.

Single
(Write the word.)

6. DATE OF BIRTH

Jan 8 1911
(Month) (Day) (Year)

7. AGE

1 yrs. 7 mos. 21 ds.IF LESS than 1 day
how many hrs. or
..... mins.?

8. OCCUPATION

- (a) Trade, profession or particular kind of work
- (b) General nature of industry, business, or establishment in which employed (or employer)

9. BIRTHPLACE

(State or Country) Idaho

10. NAME OF FATHER

W. G. Hammum

11. BIRTHPLACE OF FATHER

(State or Country) Iowa

12. MAIDEN NAME OF MOTHER

Ruth Carter

13. BIRTHPLACE OF MOTHER

(State or Country) Iowa

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

(Address) Boise Idaho

15.

Filed 8-30 1911Local Registrar W. O. Baker

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

Aug 29 1913
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from Aug 19 191., to Aug 29 191. 3, that I last saw him alive on " 191. 3 and that death occurred on the date stated above, at 7 P.M.

The CAUSE OF DEATH* was as follows:

Acute Enteric Colitis(Duration) yrs. mos. 10 ds.Contributory
(Secondary)(Duration) 10 mos. ds.(Signed) W. O. Baker M. D.8-30 1913 (Address) Boise

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death yrs. mos. days. In the State yrs. mos. days.

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL DATE OF BURIAL

Marion Hill Cemetery Aug 30 1913

20. UNDERTAKER ADDRESS

W. O. Baker Boise Idaho

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Form V. S. No. 5 20M.1-16-12

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics
File No. 5713

PLACE OF DEATH.

Registration District No. 2
Primary Registration District No. 1004
(No. 238, 11 7th St.)

Registered No. 175

County of Ada
City of Boise

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Anna E. Osborn

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX Female 4. COLOR OR RACE White 5. SINGLE, MARRIED, WIDOWED OR DIVORCED. Widow

6. DATE OF BIRTH

Feb 17th 1859
(Month) (Day) (Year)

7. AGE

54 yrs. 5 mos. 14 ds.

IF LESS than 1 day
how many hrs. or mins.?

8. OCCUPATION

(a) Trade, profession or particular kind of work
(b) General nature of industry, business, or establishment in which employed (or employer)

No Occupation

9. BIRTHPLACE

(State or Country)

Missouri

10. NAME OF FATHER

Sampson Neal

11. BIRTHPLACE OF FATHER

(State or Country)

Kentucky

12. MAIDEN NAME OF MOTHER

Sarah C. Carter

13. BIRTHPLACE OF MOTHER

(State or Country)

Missouri

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

W. E. Ehler

(Address)

2910 Barony

15.

Filed

8 - 2

1913

M. S. Parker
Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH

Aug 1 1913
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from

July 28 1913 to Aug 1st 1913

that I last saw him alive on Aug 1st 1913

and that death occurred on the date stated above, at 11 A.M.

The CAUSE OF DEATH* was as follows:

hepatitis, chronic.

(Duration) yrs. mos. ds.

Contributory Bronchitis with pulmonary
(Secondary) atrophy

(Duration) yrs. mos. ds.

(Signed) R. S. Gregory M. D.

19 (Address)

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death 5 yrs. 5 mos. 5 days. In the State 5 yrs. 5 mos. 5 days.

Where was disease contracted if not at place of death? 22 Years

Former or usual residence Calo Idaho

19. PLACE OF BURIAL OR REMOVAL DATE OF BURIAL

Morris Hill cemetery 7/3 1913

20. UNDERTAKER

ADDRESS

Schreiber & Sidenfaden Boise

Form V. S. No. 5 20M.1-16-12

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH

Registration District No. 2

County of Ada

Primary Registration District No. 1004

City of Boise

(No. 410 State St.)

File No. 5714

Registered No. 177

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

John Krall

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX

Male

4. COLOR OR RACE

White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED.

Married
(Write the word.)

6. DATE OF BIRTH

December 10th 1895
(Month) (Day) (Year)

7. AGE

77 yrs. 7 mos. 23 ds.

IF LESS than 1 day
how many hrs. or
mins.?

8. OCCUPATION

(a) Trade, profession or particular kind of work

Farming & Fruit Growing

(b) General nature of industry business, or establishment in which employed (or employer)

9. BIRTHPLACE

(State or Country)

Germany

10. NAME OF FATHER

Philip Krall

11. BIRTHPLACE OF FATHER

(State or Country)

Germany

12. MAIDEN NAME OF MOTHER

not obtainable

13. BIRTHPLACE OF MOTHER

(State or Country)

Germany

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

(Address)

John Krall Jr.
Boise, Idaho

15.

Filed

8 - 4

1913

M. S. Parker

Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

Aug 3rd 1913
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from

July 1 1913, to Aug 3 1913

that I last saw him alive on Aug 2 1913

and that death occurred on the date stated above, at 11:57

The CAUSE OF DEATH* was as follows:

Sepsis
Infected knee
(Duration) yrs. mos. ds.Contributory
(Secondary)

(Duration) yrs. mos. ds.

(Signed) Fred A. Pittenger M.D.

8/4 1913 (Address) Salt Lake City

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents)

At place of death 15 yrs. mos. 15 days. In the State of Idaho 15 yrs. mos. 15 days.

Where was disease contracted if not at place of death?

Former or usual residence. 209 Ave. A.

19. PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

Marion Hill Cemetery 8/5 1913

20. UNDERTAKER

ADDRESS

Schreiber & Kiefer
Boise, Idaho

MARGIN RESERVED FOR BINDING
WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY.
GIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact
ment of OCCUPATION is very important. See instructions on back of certificate.

V. S. No. 5 20M.1-16-12

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

PLACE OF DEATH

Registration District No. 2

County of Ada
City of Boise

Primary Registration District No. 1004

File No. 5715

Registered No. 178

If death occurs away from usual residence, give facts called for under special information. 2. FULL NAME

St. Alphonsus Hospital
John C. Nordby

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX male 4. COLOR OR RACE white 5. SINGLE, MARRIED, WIDOWED OR DIVORCED. Married
(Write the word.)

6. DATE OF BIRTH

July 4 1913
(Month) (Day) (Year)

7. AGE

57 yrs. 1 mos. — ds.

IF LESS than 1 day
how many hrs. or mins.?

8. OCCUPATION

(a) Trade, profession or particular kind of work Dry goods Salesman
(b) General nature of industry business, or establishment in which employed (or employer)

9. BIRTHPLACE

(State or Country) Christiania Norway

10. NAME OF FATHER

Jorgen H. Nordby

11. BIRTHPLACE OF FATHER

(State or Country) Norway

12. MAIDEN NAME OF MOTHER

not obtainable

13. BIRTHPLACE OF MOTHER

(State or Country) Norway

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Frederick J. Nordby

(Address) Denver, Colorado

15.

Filed 8-4 1913 M. S. Parker

Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

Aug 4 1913
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from

July 1st 1913, to Aug 4 1913,
that I last saw him alive on Aug 4 1913,
and that death occurred on the date stated above, at 7 A.M.

18. CAUSE OF DEATH* was as follows:

Colloid carcinoma of pylorus

(Duration) 2 yrs. mos. ds.

Contributory
(Secondary)

(Duration) yrs. mos. ds.

(Signed) M. H. Jellum M. D.

6-4 1913 (Address) Boise, Idaho

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death.....yrs.....mos.....days. In the State.....yrs.....mos.....days.

Where was disease contracted if not at place of death?.....

Former or usual residence... Boise Idaho

19. PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

Monist Hill Cem Aug 5 1913

20. UNDERTAKER

ADDRESS

Fry & Summers Co Boise Ida

MARGIN RESERVED FOR BINDING
WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Form V. S. No. 5 20M.1-16-12

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH.

Registration District No. 2

County of Ada

Primary Registration District No. 1004

City of Boise

(No. 409, Washington St.)

File No. 5716

Registered No. 179

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME no name Baby Bristow

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX

F

4. COLOR OR RACE

W

5. SINGLE, MARRIED, WID-
OWED OR DIVORCED.

single
(Write the word.)

6. DATE OF BIRTH

Aug 6 1913
(Month) (Day) (Year)

7. AGE

0 yrs. 0 mos. 0 ds. 1/2 hr.

IF LESS than 1 day
how many 1/2 hrs. or
mins.

8. OCCUPATION

(a) Trade, profession or
particular kind of work

(b) General nature of industry
business, or disestablishment in
which employed (or employer)

9. BIRTHPLACE

(State or Country)

Stalphonens, Kazakhstan
Boise, Idaho

10. NAME OF
FATHER

Paul A Bristow

11. BIRTHPLACE
OF FATHER

(State or Country)

Missouri

12. MAIDEN NAME
OF MOTHER

Ivoh E Lursher

13. BIRTHPLACE
OF MOTHER

(State or Country)

Oregon

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

Paul A Bristow

(Address)

Boise, Idaho

15.

Filed

8-6

1913

MS Parker

Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH

Aug 6 1913
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from

Aug 6 1913, to Aug 6 1913

that I last saw her alive on Aug 6 1913

and that death occurred on the date stated above, at 10:20 A.M.

The CAUSE OF DEATH* was as follows:

Cerelectasis

6 months child died 1/2 hr after birth.

(Duration) yrs. mos. 1/2 hr

Contributory
(Secondary)

(Duration) yrs. mos. ds.

(Signed) W. H. Sullivan M. D.

7/6 1913 (Address) Boise, Idaho

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death yrs. mos. days. In the State yrs. mos. days.

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

Harris Hill Cemetery
Ada County Plat

8/7 1913

20. UNDERTAKER

ADDRESS

Schreiber & Schenck Boise, Idaho

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Form V. S. No. 5 20M.1-16-12

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH.

Registration District No. 2

County of Ada

Primary Registration District No. 1004

City of Boise

(No. 919, State St.)

File No. 5717

Registered No. 180

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Elsie Elvora Woods

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX

Female

4. COLOR OR RACE

White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED.
~~Married~~ Single
(Write the word.)

6. DATE OF BIRTH

July 26 1909
(Month) (Day) (Year)

7. AGE

4 yrs. — mos. 9 ds.

IF LESS than 1 day
how many hrs. or mins.?

8. OCCUPATION

(a) Trade, profession or particular kind of work
(b) General nature of industry, business, or establishment in which employed (or employer)

None

9. BIRTHPLACE

(State or Country)

Boise

10. NAME OF FATHER

E. M. Woods

11. BIRTHPLACE OF FATHER

(State or Country)

Ark.

12. MAIDEN NAME OF MOTHER

Hollie Rinehard

13. BIRTHPLACE OF MOTHER

(State or Country)

Kas.

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

E. M. Woods

(Address)

Boise

15.

Filed 8-6 1913

M. S. Parker

Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH

Aug 4 1913
(Month) (Day) (Year)17. I HEREBY CERTIFY, That I ~~attended~~ deceased from~~see~~ saw 191...
that I last saw ~~alive~~ dead Aug 4th 1913.and that death occurred on the date stated above, at 6³⁰ P. M.

The CAUSE OF DEATH* was as follows:

Accidentally run over by Street Car.

(Duration) yrs. mos. ds.

Contributory
(Secondary)

(Duration) yrs. mos. ds.

(Signed) Adolph Schreiber, M.D.
19 (Address) Boise

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death yrs. mos. days. In the State yrs. mos. days.

Where was disease contracted if not at place of death?

Former or usual residence.

19. PLACE OF BURIAL OR REMOVAL DATE OF BURIAL

Morris Hill Cemetery 8/7 1913

20. UNDERTAKER

ADDRESS

Schreiber & Sons, Inc. Boise

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Form V. S. No. 5 20M.1-16-12

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH

Registration District No. 8

County of Ada

Primary Registration District No. 1004

File No. 571

City of Boise

(No. 530 Warm Springs St.)

Registered No. 181

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

Josephine E. Bode

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX

4. COLOR OR RACE

5. SINGLE, MARRIED, WIDOWED OR DIVORCED.

Female White

Married
(Write the word.)

6. DATE OF BIRTH

June 22 1868
(Month) (Day) (Year)

7. AGE

45 yrs. 1 mos. 17 ds.

IF LESS than 1 day
how many hrs. or
mins.?

8. OCCUPATION

(a) Trade, profession or particular kind of work

(b) General nature of industry, business, or establishment in which employed (or employer)

House Keeper

9. BIRTHPLACE

(State or Country)

Norway

10. NAME OF FATHER

Not obtainable

11. BIRTHPLACE OF FATHER

(State or Country)

Norway

12. MAIDEN NAME OF MOTHER

Not obtainable

13. BIRTHPLACE OF MOTHER

(State or Country)

Norway

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) George E. Bode

(Address) 530 Warm Springs Ave

15.

Filed 8 - 9 1913

M. S. Parker

Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH

Aug 8 1913
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from Jan 1 1913 to Aug 8 1913,

that I last saw her alive on Aug 7 1913,

and that death occurred on the date stated above, at 8 A. M.

The CAUSE OF DEATH* was as follows:

Cancer of Tongue

(Duration) 1 yr. yrs. mos. ds.

Contributory
(Secondary)

(Duration) yrs. mos. ds.

(Signed)

8/8 1913 (Address) Boise - Idaho M. D.

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death yrs. mos. days. In the State yrs. mos. days.

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL DATE OF BURIAL

Masonic Cemetery 8/10 1913

20. UNDERTAKER

ADDRESS

Schubert & Sons Boise

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Form V. S. No. 5 20M.1-16-12

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH
Registration District No. 2
County of Boise Primary Registration District No. 1004
of Boise Creek No. 633, E. Jefferson St.)

File No. 5719
Registered No. 183

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Raymond F. Sayre

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX Male 4. COLOR OR RACE White 5. SINGLE, MARRIED, WIDOWED OR DIVORCED. Married
(Write the word.)

6. DATE OF BIRTH Jan 12 1889
(Month) (Day) (Year)

7. AGE 24 yrs. 6 mos. 24 ds.
IF LESS than 1 day how many hrs. or mins.?

8. OCCUPATION
(a) Trade, profession or particular kind of work Bookkeeper & Cook
(b) General nature of industry business, or establishment in which employed (or employer)

9. BIRTHPLACE Sayre Penn
(State or Country)

10. NAME OF FATHER Fred B. Sayre

11. BIRTHPLACE OF FATHER Penn
(State or Country)

12. MAIDEN NAME OF MOTHER Florence Greenfield

13. BIRTHPLACE OF MOTHER Penn
(State or Country)

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Mrs R.T. Sayre
(Address) Boise

15. Filed 8-9 1913 M.S. Parker
Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH Aug 6 1913
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from Jan 1913 to June 4 1913
that I last saw him alive on June 8 1913
and that death occurred on the date stated above, at M.

The CAUSE OF DEATH* was as follows:

Heart trouble

(Duration) yrs. mos. ds.
Contributory (Secondary) Dropsy

(Duration) yrs. mos. ds.
(Signed) W.S. Tuttle M. D.
8-5-1913 (Address) Boise

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death Bear Valley Boise Co. Idaho yrs. mos. days State. yrs. mos. days.

Where was disease contracted if not at place of death?

Former or usual residence 633 E. Jefferson St. Boise, Id.

19. PLACE OF BURIAL OR REMOVAL Morris Hill Cemetery DATE OF BURIAL 8/10 1913

20. UNDERTAKER Schreiber & Schenck ADDRESS Boise Idaho

MARGIN RESERVED FOR BINDING
WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Form V. S. No. 5 20M.1-16-12

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH

Registration District No. 2

2

County of

Ada

Primary Registration District No. 1004

1004

File No. 5729

5729

City of

Boise

(No. Boise St Lukes St Hosp)

Registered No. 784

784

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

Franklin A. Sweet

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX

Male

4. COLOR OR RACE

white American

5. SINGLE, MARRIED, WIDOWED OR DIVORCED.

Single
(Write the word.)

6. DATE OF BIRTH

not obtainable

(Month)

(Day)

(Year)

7. AGE

73 yrs. — mos. — ds.

IF LESS than 1 day
how many hrs. or mins.?

8. OCCUPATION

(a) Trade, profession or particular kind of work
(b) General nature of industry business, or dtablissement in which employed (or employer)

Laborer.

9. BIRTHPLACE

(State or Country)

N. Y.

10. NAME OF FATHER

not obtainable

11. BIRTHPLACE OF FATHER

(State or Country)

12. MAIDEN NAME OF MOTHER

13. BIRTHPLACE OF MOTHER

(State or Country)

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

H. J. Wilson

(Address)

1509 State Ave

15.

Filed

8-9

1913

M. S. Parker

Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

Aug. 9

(Month)

(Day)

1913

(Year)

17. I HEREBY CERTIFY, That I attended deceased from

July 2, 1913, to Aug 9, 1913

that I last saw him alive on Aug 9, 1913.

and that death occurred on the date stated above, at 3 P. M.

The CAUSE OF DEATH* was as follows:

Progressive Muscular Atrophy

(Duration)

2 yrs.

mos.

ds.

Contributory
(Secondary)

Similarity

(Duration)

yrs.

mos.

ds.

(Signed)

8/9/1913 J. Earl Hice M. D.
(Address) Boise Idaho

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death.....yrs.....mos.....days.

In the

State.....yrs.....mos.....days.

Where was disease contracted if not at place of death?.....

Former or usual residence.....

19. PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

Morris Hill Cem Aug 10, 1913.

20. UNDERTAKER

ADDRESS

Fry & Summers Boise

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Form V. S. No. 5 20M.1-16-12

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH.

Registration District No. 2

County of Ada

Primary Registration District No. 1004

City of Boise

(No. 419, State St.)

File No. 5721

Registered No. 188

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Frank Bugovine

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX

Male

4. COLOR OR RACE

White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED.

Single
(Write the word.)

6. DATE OF BIRTH

Not obtainable

(Month)

(Day)

(Year)

7. AGE

57

yrs.

mos.

ds.

IF LESS than 1 day
how many hrs. or
mins.?

8. OCCUPATION

(a) Trade, profession or particular kind of work

Rancher

(b) General nature of industry, business, or establishment in which employed (or employer)

9. BIRTHPLACE

(State or Country)

France

10. NAME OF FATHER

Not obtainable

11. BIRTHPLACE OF FATHER

(State or Country)

"

"

12. MAIDEN NAME OF MOTHER

"

"

13. BIRTHPLACE OF MOTHER

(State or Country)

"

"

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

Joseph Lavelle

(Address)

Boise

15.

Filed

8-18

1913

M. S. Parker

Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH

Aug

16

1913

(Month)

(Day)

(Year)

17. I HEREBY CERTIFY, That I attended deceased from

July 26 1913, to Aug 16 1913,

that I last saw him alive on Aug 16 1913,

and that death occurred on the date stated above, at M.

The CAUSE OF DEATH* was as follows:

Cor Myocarditis

(Duration) 5 yrs. mos. ds.

Contributory
(Secondary)

(Duration) yrs. mos. ds.

(Signed) James R. Stewart M. D.

8/16 1913 (Address) Boise

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death 8 yrs. mos. days. In the State 8 yrs. mos. days.

Where was disease contracted if not at place of death?

Former or usual residence.

Parma, Idaho

19. PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

St. John's Cemetery

8/18 1913

20. UNDERTAKER

ADDRESS

Schreiber & Widener

Boise, Ida

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Form V. S. No. 5 20M.1-16-12

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH.

Registration District No. 2
Primary Registration District No. 1004
(No. *Piott Ranch Ada Co. St.*)

File No. 5722
Registered No. 189

County of *Ada*
City of *Boise*

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME *Christ Christofferson*

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX *Male* 4. COLOR OR RACE *White* 5. SINGLE, MARRIED, WIDOWED OR DIVORCED. *Widowed*
(Write the word.)

6. DATE OF BIRTH

Not obtainable
(Month) (Day) (Year)

7. AGE *about 60* yrs. — mos. — ds.

IF LESS than 1 day
how many hrs. or mins.?

8. OCCUPATION

(a) Trade, profession or particular kind of work *Mill Hand*
(b) General nature of industry business, or establishment in which employed (or employer)

9. BIRTHPLACE

(State or Country) *Norway*

10. NAME OF FATHER

Not obtainable

11. BIRTHPLACE OF FATHER

" "

(State or Country)

12. MAIDEN NAME OF MOTHER

" "

13. BIRTHPLACE OF MOTHER

" "

(State or Country)

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) *A. Schreiber*

(Address) *Boise*

15.

Filed *8-18* 1913 *M.S. Parker*
Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH

Aug 14 1913
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased *from dead* *101* to *Aug 14* 1913,
that I last saw him *alive on* *101*,
and that death occurred on the date stated above, at *4:30* M.

The CAUSE OF DEATH* was as follows:

Gunshot Wound with suicidal intent while temporarily insane

(Duration) yrs. mos. ds.

Contributory
(Secondary)

(Duration) yrs. mos. ds.

(Signed) *Adolph Schreiber M.D.*
19 (Address) *of Ada Co. corner Boise*

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place *St. Alphonsus Hospital* In the
of death... yrs. *13* mos. ... days. State... yrs. ... mos. ... days.

Where was disease contracted if not at place of death?

Former or usual residence *Boise Ida.*

19. PLACE OF BURIAL OR REMOVAL

Heilsville Wis

DATE OF BURIAL

Aug 18 1913

20. UNDERTAKER

Schreiber & Wideman

ADDRESS

Boise

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Form V. S. No. 5 20M.1-16-12

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH. Registration District No. 2
County of Ada Primary Registration District No. 1004
City of Boise (No. 442 State St. St.)

File No. 5723
Registered No. 190

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME John Blackwell

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX Male 4. COLOR OR RACE White 5. SINGLE, MARRIED, WIDOWED OR DIVORCED. Married (Write the word.)

6. DATE OF BIRTH Jan 26 1986 (Month) (Day) (Year)

7. AGE 27 yrs. 6 mos. 21 ds. IF LESS than 1 day how many hrs. or mins.?

8. OCCUPATION (a) Trade, profession or particular kind of work Laborer (b) General nature of industry business, or establishment in which employed (or employer)

9. BIRTHPLACE Shoshone Ida (State or Country)

10. NAME OF FATHER J. B. Blackwell

11. BIRTHPLACE OF FATHER Ark. (State or Country)

12. MARRIED NAME OF MOTHER Ethel

13. BIRTHPLACE OF MOTHER Iowa (State or Country)

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) J. B. Blackwell (Address) Glenns Ferry, Idaho

15. Filed 8-18 1913 M. S. Parker Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH August 18 1913 (Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from Aug 13 1913, to Aug 17 1913, that I last saw him alive on Aug 17 1913, and that death occurred on the date stated above, at 6 A. M.

The CAUSE OF DEATH* was as follows: Electric Burns from contact high tension transmission wire accidental.

(Duration) yrs. mos. ds.

Contributory (Secondary)

(Duration) yrs. mos. ds. (Signed) J. R. Numbers M. D. Aug 18 1913 (Address) Boise, Idaho

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.) St. Alphonsus Hospital

At place of death yrs. mos. 5 days. In the State yrs. mos. days.

Where was disease contracted if not at place of death?

Former or usual residence Glenns Ferry, Idaho

19. PLACE OF BURIAL OR REMOVAL Glenns Ferry, Idaho DATE OF BURIAL 8/18 1913

20. UNDERTAKER Schreiber & Sidneyfader ADDRESS Boise, Ida

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. If death occurs away from usual residence, give facts called for under special information. 2. FULL NAME
C.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. If death occurs away from usual residence, give facts called for under special information. 2. FULL NAME
D.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. If death occurs away from usual residence, give facts called for under special information. 2. FULL NAME

Form V. S. No. 5 20M-1-16-12

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

PLACE OF DEATH

Registration District No. 2

Primary Registration District No. 1004

File No. 5724

County of Ada

(No. 1702, N. 18th St.)

Registered No. 191

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME *Caroline Ramsey*

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX *F* 4. COLOR OR RACE *W.* 5. SINGLE, MARRIED, WIDOWED OR DIVORCED. *Married*
(Write the word.)

6. DATE OF BIRTH *June 10th 1849*
(Month) (Day) (Year)

7. AGE *64 yrs. 2 mos. 7 ds.*
IF LESS than 1 day how many hrs. or mins.?

8. OCCUPATION
(a) Trade, profession or particular kind of work *Housekeeper*
(b) General nature of industry, business, or establishment in which employed (or employer)

9. BIRTHPLACE *Ohio*
(State or Country)

10. NAME OF FATHER *Arthur Marshall*

11. BIRTHPLACE OF FATHER *Ohio*
(State or Country)

12. MAIDEN NAME OF MOTHER *Annie Byelles*

13. BIRTHPLACE OF MOTHER *Ohio*
(State or Country)

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) *D. Ramsey*

(Address) *Boise*

15.

Filed *8-19* 1913 *M. S. Parker*
Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH *Aug 17th 1913*
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from *Aug 14th 1913* to *Aug 17th 1913*, that I last saw her alive on *Aug 17th 1913*, and that death occurred on the date stated above, at *11:30 P.M.*

The CAUSE OF DEATH* was as follows:

Cholelithiasis

(Duration) yrs. mos. ds.

Contributory (Secondary)

(Duration) yrs. mos. ds.

(Signed) *W. F. Smith M. D.*

Aug 18 1913 (Address) *Boise, Ida*

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death yrs. mos. days. In the State yrs. mos. days.

Where was disease contracted if not at place of death?

Former or usual residence *1702 N. 18th St. Boise*

19. PLACE OF BURIAL OR REMOVAL DATE OF BURIAL

Morris Hill Cemetery *8/20* 1913

20. UNDERTAKER ADDRESS

Schreiber & Chidnapaden *Boise, Ida.*

Dr. Stewart

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICI-
CIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact state-
ment of OCCUPATION is very important. See instructions on back of certificate.

Form V. S. No. 5 20M.1-16-12

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH.

Registration District No. 2

County of Ada

Primary Registration District No. 1004

City of Boise(No. 319 N. 7th St.)File No. 572Registered No. 1923

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

Frank Williams Green

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX

Male

4. COLOR OR RACE

White5. SINGLE, MARRIED, WID-
OWED OR DIVORCED.Single
(Write the word.)

6. DATE OF BIRTH

June 1st 1913

(Month)

(Day)

(Year)

7. AGE

yrs. 2 mos. 2 ds. 18IF LESS than 1 day
how many hrs. or
..... mins.?

8. OCCUPATION

(a) Trade, profession or
particular kind of work(b) General nature of industry
business, or establishment in
which employed (or employer)No.
Boise

9. BIRTHPLACE

(State or Country)

Boise10. NAME OF
FATHERMr Frank Green.11. BIRTHPLACE
OF FATHER

(State or Country)

Canada.12. MAIDEN NAME
OF MOTHERMiss Carrie Williams13. BIRTHPLACE
OF MOTHER

(State or Country)

Burlington

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

Dr Frank Green

(Address)

319 Collier's flats

15. *

Filed

8-701913M. S. Parker

Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH

August 181913

(Month)

(Day)

(Year)

17. I HEREBY CERTIFY, That I attended deceased from

Aug 8, 1913, to Aug 18, 1913that I last saw him alive on Aug 18, 1913and that death occurred on the date stated above, at 9 A.M.

The CAUSE OF DEATH* was as follows:

Inanition

(Duration)

yrs.

mos.

ds.

Contributory
(Secondary)

(Duration)

yrs.

mos.

ds.

(Signed)

Aug 19, 1913

(Address)

Boise, IdahoState the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1)
MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.18. LENGTH OF RESIDENCE (For Hospitals, Institutions,
Transients or Recent Residents.)At place
of death

yrs.

In the

State

yrs.

mos.

days.

Where was disease contracted
if not at place of death?Former or
usual residence

19. PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

Storero Schiebo & ViduplanAug 19, 1913

20. UNDERTAKER

ADDRESS

Schiebo & ViduplanBoise, Idaho

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Form V. S. No. 5 20M.1-16-12		CERTIFICATE OF DEATH		State of Idaho BOARD OF HEALTH Bureau of Vital Statistics	
1. PLACE OF DEATH County of <u>Ada</u> City of <u>Boise</u>		Registration District No. <u>2</u> Primary Registration District No. <u>1004</u> (No. <u>618 S 17</u> St.)		File No. <u>4 942</u> Registered No. <u>5795</u>	
If death occurs away from usual residence, give facts called for under special information.		2. FULL NAME <u>Samuel J Hawkins</u>		If death occurred in a hospital, institution or camp, give its NAME instead of street and number.	
PERSONAL AND STATISTICAL PARTICULARS					
3. SEX <u>Male</u>		4. COLOR OR RACE <u>White</u>		5. SINGLE, MARRIED, WID-OWED OR DIVORCED <u>Married</u> (Write the word.)	
6. DATE OF BIRTH <u>Mar 17 1838</u> (Month) (Day) (Year)					
7. AGE <u>74 yrs 5 mos 4 ds</u>			IF LESS than 1 day how many hrs. or mins.?		
8. OCCUPATION (a) Trade, profession or particular kind of work <u>Retired Methodist Minister</u> (b) General nature of industry, business, or establishment in which employed (or employer)					
9. BIRTHPLACE (State or Country) <u>Tennessee</u>					
10. NAME OF FATHER <u>William Hawkins</u>					
11. BIRTHPLACE OF FATHER (State or Country) <u>Tennessee</u>					
12. MAIDEN NAME OF MOTHER <u>Mary Shulton</u>					
13. BIRTHPLACE OF MOTHER (State or Country) <u>Tennessee</u>					
14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE (Informant) <u>Mrs S. J. Hawkins</u> (Address) <u>Boise, Idaho</u>					
15. Filed <u>8-22-1913</u> <u>M. S. Parker</u> Local Registrar					
MEDICAL CERTIFICATE OF DEATH					
16. DATE OF DEATH <u>Aug. 22 1913</u> (Month) (Day) (Year)					
17. I HEREBY CERTIFY, That I attended deceased from <u>Aug 17 1913</u> to <u>Aug 18 1913</u> that I last saw him alive on <u>Aug 17 1913</u> and that death occurred on the date stated above, at <u>2:45 P.M.</u> The CAUSE OF DEATH* was as follows: <u>Senility with Corbion</u> <u>Senility</u> (Duration) <u>Many yrs</u> mos. ds. Contributory <u>Abscess of the neck</u> (Secondary) (Duration) <u>8</u> yrs. mos. ds. (Signed) <u>W. B. Foster M. D.</u> <u>822</u> 1913 (Address) <u>Boise</u>					
*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.					
18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.) At place of death.....yrs.mos.days. In the State.....yrs.mos.days. Where was disease contracted if not at place of death?..... Former or usual residence.....					
19. PLACE OF BURIAL OR REMOVAL <u>Morris Hill Cemetery</u> DATE OF BURIAL <u>Aug 25 1913</u>					
20. UNDERTAKER <u>Try & Summers</u> ADDRESS <u>Boise, Idaho</u>					

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Form V. S. No. 5 20M.1-16-12

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH.

Registration District No. 2

County of Ada

Primary Registration District No. 1004

City of Boise

(No. 1307, Grave St.)

File No. 572

Registered No. 196

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Mrs Alice B. Mitchell

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX

4. COLOR OR RACE

5. SINGLE, MARRIED, WIDOWED OR DIVORCED.

Female White

Married
(Write the word.)

6. DATE OF BIRTH

June (Month) 12 (Day) 1876 (Year)

7. AGE

37 yrs. 7 mos. 14 ds.

IF LESS than 1 day
how many hrs. or mins.?

8. OCCUPATION

(a) Trade, profession or particular kind of work

Housewife

(b) General nature of industry, business, or establishment in which employed (or employer)

9. BIRTHPLACE

(State or Country)

Montana

10. NAME OF FATHER

Charles Blum

11. BIRTHPLACE OF FATHER

(State or Country)

N.Y. State

12. MAIDEN NAME OF MOTHER

Sarah D Sullivan

13. BIRTHPLACE OF MOTHER

(State or Country)

Ohio

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

Clifford C Blum

(Address)

1307 Grove

15.

Filed

8-7-13

1913

M. J. Miller

Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH

Aug 25 1913
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from

Aug 18 1913, to Aug 25 1913,
that I last saw him alive on Aug 24 1913

and that death occurred on the date stated above, at 3 M.

The CAUSE OF DEATH* was as follows:

General Debility & Shock following Abdominal Operation

(Duration) yrs. mos. ds.

Contributory (Secondary)

Partial Abstinence from

(Duration) yrs. mos. ds.

(Signed)

W. J. Miller

M. D.

8-26 1913 (Address) Boise

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death St. Luke's yrs. mos. days. In the State Idaho yrs. mos. days.

Where was disease contracted if not at place of death?

Former or usual residence 1307 Grove Boise

19. PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

Marion Hill Cemetery

8/27 1913

20. UNDERTAKER

ADDRESS

Schreiber & Sidenfaden

Boise Ida

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. FAMILIAR-
CIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact state-
ment of OCCUPATION is very important. See instructions on back of certificate.

Form V. S. No. 5 20M.1-16-12

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH.

Registration District No. 2

County of Ada

Primary Registration District No. 1004

City of Boise

(No. 1607 Idaho St.)

File No. 5728

Registered No. 197

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Anna May Jones

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX

4. COLOR OR RACE

5. SINGLE, MARRIED, WID-
OWED OR DIVORCED.

Female White

(Write the word.) Single

6. DATE OF BIRTH

Sept 26 1913
(Month) (Day) (Year)

7. AGE

2 yrs. 11 mos. ds.

IF LESS than 1 day
how many hrs. or
mins.?

8. OCCUPATION

- (a) Trade, profession or particular kind of work
(b) General nature of industry business, or establishment in which employed (or employer)

9. BIRTHPLACE

(State or Country)

Idaho

10. NAME OF FATHER

R. F. Jones

11. BIRTHPLACE OF FATHER

(State or Country)

Idaho

12. MAIDEN NAME OF MOTHER

Myrtle Sizemore

13. BIRTHPLACE OF MOTHER

(State or Country)

Canada

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

R. F. Jones

(Address)

Boise Idaho

15.

Filed 8-27-1913

M. S. Parker
Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH

Aug 26 1913
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from

Aug 25 1913, to Aug 26 1913

that I last saw her alive on Aug 26 1913

and that death occurred on the date stated above, at 10:30 AM

The CAUSE OF DEATH* was as follows:

Acute Enteritis

(Duration) yrs. mos. ds.

Contributory
(Secondary)

(Duration) yrs. mos. ds.

(Signed) M. D.

19 (Address) Boise Idaho

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death yrs. mos. days. In the State yrs. mos. days.

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL DATE OF BURIAL

Morris Hill Cemetery Aug 27 1913

20. UNDERTAKER

ADDRESS

Schreiber & Sons Boise

MAR 28 1986

A stillbirth must be registered both as a birth and death. The date of death should be the date of delivery and the death certificate should further state, if known, the cause of the stillbirth and the period of utero gestation in months.

STATEMENT OF OCCUPATION.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer, Physician, Stenographer, Compositör, Architect, Locomotive engineer, Civil engineer, Stationary fireman, etc.* But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner*, (b) *Cotton mill*; (a) *Salesman*, (b) *Grocery*; (a) *Foreman*, (b) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification, as *Day laborer, Farm laborer, Laborer—Coal mine*, etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers*, who receive a definite salary), may be entered as *Housewife, Housework*, or *At home*, and children, not gainfully employed, as *At school* or *At home*. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer (retired, 6 yrs.)*. For persons who have no occupation whatever, write *None*.

STATEMENT OF CAUSE OF DEATH.—Name, first the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebro-*

spinal fever (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid Pneumonia"); *Lobar pneumonia*; *Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritoneum, etc.*, *Carcinoma, Sarcoma, etc.*, of (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles*; *Whooping cough*; *Chronic valvular heart disease*; *Chronic interstitial nephritis, etc.* The contributory (secondary or intercurrent affection need not be stated unless important. Example: *Measles* (disease causing death), 29 ds.; *Bronchopneumonia* (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "Asthenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility," "Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Haemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uraemia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify as "PUERPERAL, septicemia", "PUERPERAL peritonitis," etc., all diseases resulting from childbirth or miscarriage. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as probably such, if impossible to determine definitely. Examples: *Accidental drowning*; *Struck by railway train—accident*; *Revolver wound of head—homicide*; *Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "Contributory."

2

6

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Form V. S. No. 5 20M.1-16-12

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH.

Registration District No. 2

County of Boise

Primary Registration District No. 1004

File No. 5720

City of

(No. Boise County St.)

Registered No. 198

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Henry F. Whitney

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX

4. COLOR OR RACE

5. SINGLE, MARRIED, WID-
OWED OR DIVORCED.

Male white

married
(Write the word.)

6. DATE OF BIRTH

Not obtainable 1
(Month) (Day) (Year)

7. AGE

About

6.0 yrs. mos. ds.

IF LESS than 1 day
how many hrs. or
mins.?

8. OCCUPATION

(a) Trade, profession or
particular kind of work

Millwright

(b) General nature of industry
business, or establishment in
which employed (or employer)

9. BIRTHPLACE

(State or Country)

Idaho Not obtainable

10. NAME OF
FATHER11. BIRTHPLACE
OF FATHER

(State or Country)

Idaho Not obtainable

12. MAIDEN NAME
OF MOTHER13. BIRTHPLACE
OF MOTHER

(State or Country)

Idaho Not obtainable

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

H. M. Perry
Boise Idaho

(Address)

15.

Filed 8-26 1913

M. S. Parker
Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH

Aug 25 1913
(Month) (Day) (Year)17. I HEREBY CERTIFY, That I attended deceased from
191... to Aug 25 1913.that I last saw him alive on 25 August 1913,
and that death occurred on the date stated above, at M.

The CAUSE OF DEATH* was as follows: Deceased
been complaining for a time
fell dead on road near
Callow Station Boise Co.
Probably apoplexy
Contributed by Dr. A. S. Myer.
(Secondary) (Duration) yrs. mos. ds.
(Signed) Adolph Schreiber M.D.
19 (Address) Boise Idaho

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1)
MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.18. LENGTH OF RESIDENCE (For Hospitals, Institutions,
Transients or Recent Residents.)

At place of death yrs. mos. days. In the State yrs. mos. days.

Where was disease contracted
if not at place of death?Former or
usual residence.

19. PLACE OF BURIAL OR REMOVAL DATE OF BURIAL

Schreiber & Sidenfaden Aug 27 1913

20. UNDERTAKER

ADDRESS

Butterville Ida Boise

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Form V. S. No. 5 20M.1-16-12

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

PLACE OF DEATH

Registration District No. 2

County of Ada

Primary Registration District No. 1004

City of Boise

(No. 16 + Jefferson St.)

File No. 5730

Registered No. 199

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Martha M. Carly

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX

Female

4. COLOR OR RACE

American white

5. SINGLE, MARRIED, WIDOWED OR DIVORCED.

Married
(Write the word.)

6. DATE OF BIRTH

Mar 27 1891
(Month) (Day) (Year)

7. AGE

72 yrs. 5 mos. 1 ds.

IF LESS than 1 day
how many hrs. or mins.?

8. OCCUPATION

(a) Trade, profession or particular kind of work

House work

(b) General nature of industry, business, or establishment in which employed (or employer)

9. BIRTHPLACE

(State or Country)

Croft Co. Mo.

10. NAME OF FATHER

James H. McPherson

11. BIRTHPLACE OF FATHER

(State or Country)

not obtainable

12. MAIDEN NAME OF MOTHER

" "

13. BIRTHPLACE OF MOTHER

(State or Country)

" "

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

Joseph Sullivan

(Address)

Boise Ida

15.

Filed 8/29 1913

W. S. Parker
Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

August 28 1913
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from

July 1911, to Aug. 28 1913,
that I last saw her alive on Aug. 28 1913,
and that death occurred on the date stated above, at 12 M.

The CAUSE OF DEATH* was as follows:

Cerebral apoplexy

(Duration) yrs. mos. 1 1/2 ds.

Contributory Arterio sclerosis
(Secondary)

(Duration) yrs. mos. ds.

(Signed) Joseph R. Thompson M. D.

Aug 29 1913 (Address) Boise Idaho

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death yrs. mos. days. In the State yrs. mos. days.

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

Masonic Cem Aug 30 1913

20. UNDERTAKER

ADDRESS

Fry & Summers Boise Ida

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

PLACE OF DEATH.

Registration District No. 2

County of Ada

Primary Registration District No. 1004

City of Boise

(No. 512, South 13 $\frac{1}{2}$ St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Clarence Egland

File No. 5731

Registered No. 200

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX

Male

4. COLOR OR RACE

White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED.

Single
(Write the word.)

6. DATE OF BIRTH

Aug 15 1912
(Month) (Day) (Year)

7. AGE

1 yrs. 14 mos. 14 ds.

IF LESS than 1 day
how many hrs. or
..... mins.?

8. OCCUPATION

- (a) Trade, profession or particular kind of work
(b) General nature of industry business, or establishment in which employed (or employer)

9. BIRTHPLACE

(State or Country) Boise Ida

10. NAME OF FATHER

Thomas Egland

11. BIRTHPLACE OF FATHER

(State or Country) Norway

12. MAIDEN NAME OF MOTHER

Elizabeth Olsen

13. BIRTHPLACE OF MOTHER

(State or Country) Norway

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Thomas Egland

(Address) Boise

15.

Filed 8/30 1913

Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH

Aug 29 1913
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from

Aug 14 1913, to Aug 28 1913,

that I last saw him alive on Aug 28 1913

and that death occurred on the date stated above, at 2 P.M.

The CAUSE OF DEATH* was as follows:

Acute enteritis - white

(Duration) yrs. mos. 14 ds.

Contributory Nephritis
(Secondary)

(Duration) 1 yrs. mos. 14 ds.

(Signed) R. E. [Signature] M. D.

8/29 1913 (Address) Boise

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death yrs. mos. days. In the State yrs. mos. days.

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL DATE OF BURIAL

Woods Hill Cemetery Aug 30 1913

20. UNDERTAKER

ADDRESS

Schreiber & Hidenupaden Boise

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Form V. S. No. 5 20M.1-16-12

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

PLACE OF DEATH.

Registration District No. 2
Primary Registration District No. 1004
(No. 112 E. Bonanza St.)

File No. 5732
Registered No. 262

County of Ada
City of Boise

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Margaret Fay Ellis

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX Female 4. COLOR OR RACE White 5. SINGLE, MARRIED, WIDOWED OR DIVORCED. Single
(Write the word.)

6. DATE OF BIRTH Oct 5 1912
(Month) (Day) (Year)

7. AGE 10 yrs. 28 mos. 28 ds.
IF LESS than 1 day how many hrs. or mins.?

8. OCCUPATION
(a) Trade, profession or particular kind of work none
(b) General nature of industry business, or establishment in which employed (or employer)

9. BIRTHPLACE Boise Idaho.
(State or Country)

10. NAME OF FATHER Thos J. Ellis

11. BIRTHPLACE OF FATHER Kansas
(State or Country)

12. MAIDEN NAME OF MOTHER Margaret Mason

13. BIRTHPLACE OF MOTHER Mont
(State or Country)

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Thos J. Ellis
(Address) Ada Co.

15. Filed 8-30-1913 W. O. M. P. Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH Aug 30 1913
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from Aug. 22 1913 to Aug. 30 1913
that I last saw her alive on Aug. 30 1913
and that death occurred on the date stated above, at 12:30 P.
The CAUSE OF DEATH* was as follows:
Acute Ileo-colitis

(Duration) yrs. mos. 22 ds.
Contributory (Secondary)
(Duration) yrs. mos. ds.
(Signed) J. E. Naughton M. D.
Aug 30 1913 (Address) J. Boise.

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions Transients or Recent Residents.)
St Luke's Hospital
At place of death yrs. mos. days. State. yrs. mos. days.

Where was disease contracted if not at place of death?
Former or usual residence Ada County, Idaho.

19. PLACE OF BURIAL OR REMOVAL DATE OF BURIAL
Harris Hill Cemetery 8/31 1913

20. UNDERTAKER ADDRESS
Schreiber & Sidenfaden Boise

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Form V. S. No. 5 20M.1-16-12

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH

Registration District No. 8County of LatahPrimary Registration District No. 2004City of Near Boise Idaho(No. Near Boise Idaho St.)File No. 573Registered No. 9

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

Infant Carrico

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX

Male

4. COLOR OR RACE

White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED.

Single
(Write the word.)

6. DATE OF BIRTH

Aug 30 1913
(Month) (Day) (Year)

7. AGE

— yrs. — mos. — ds.

IF LESS than 1 day
how many ... hrs. or
... min.?

8. OCCUPATION

(a) Trade, profession or

particular kind of work

(b) General nature of industry,
business, or establishment in
which employed (or employer)

9. BIRTHPLACE

(State or Country)

Idaho

10. NAME OF FATHER

Walter Carrice

11. BIRTHPLACE OF FATHER

(State or Country)

Missouri

12. MAIDEN NAME OF MOTHER

Maudie Mason

13. BIRTHPLACE OF MOTHER

(State or Country)

Portland Oreg

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

Walter Carrico

(Address)

Boise Idaho

15.

Filed

9-101913M.S. Parker

Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

Aug. 30 1913
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from

Aug 30 1913, to Aug 30 1913,

that I last saw him alive on Aug 30 1913

and that death occurred on the date stated above, at 10:10 M.

The CAUSE OF DEATH* was as follows:

Suffocation

(Duration) — yrs. — mos. — ds.

Contributory

(Secondary)

(Duration) — yrs. — mos. — ds.

(Signed)

Mallen C. Cawley, M. D.8/30/1913

(Address)

Boise Idaho

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place

of death

— yrs. — mos. — days.

In the

State

— yrs. — mos. — days.

Where was disease contracted
if not at place of death?

Former or

usual residence

19. PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

Monistell Sunday Sep 1 1913

20. UNDERTAKER

ADDRESS

Wm. J. Summers Boise Idaho

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Form V. S. No. 5 20M.1-16-12

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH

Registration District No.

County of

Primary Registration District No.

City of

(No.

St.)

File No.

Registered No.

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

Stella May Masters

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX

4. COLOR OR RACE

5. SINGLE, MARRIED, WIDOWED OR DIVORCED.

Female White

Married
(Write the word.)

6. DATE OF BIRTH

Nov 8 1889
(Month) (Day) (Year)

7. AGE

29 yrs. 10 mos. 24 ds.

IF LESS than 1 day
how many hrs. or mins.?

8. OCCUPATION

(a) Trade, profession or particular kind of work
(b) General nature of industry, business, or establishment in which employed (or employer)

Housewife

9. BIRTHPLACE

(State or Country)

Kansas

10. NAME OF FATHER

Frank Langdon

11. BIRTHPLACE OF FATHER

(State or Country)

Austria

12. MAIDEN NAME OF MOTHER

Bertha Miller

13. BIRTHPLACE OF MOTHER

(State or Country)

Iowa

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) *A. B. Masters*

(Address) *Boise Ida*

15.

Filed *9-3* 191*3*

M. B. Parker

Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

Sept 2 1913
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from *July 1912* to *Sept 2 1913*
that I last saw her alive on *Aug. 28 1913*
and that death occurred on the date stated above, at *7 A.M.*

The CAUSE OF DEATH* was as follows:

General tuberculosis

(Duration) *2* yrs. mos. ds.

Contributory
(Secondary)

(Duration) *10* yrs. mos. ds.

(Signed) *W. B. Titus* M. D.

9-3 191*3* (Address) *Boise*

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death.....yrs.....mos.....days. In the State.....yrs.....mos.....days.

Where was disease contracted if not at place of death?.....

Former or usual residence.....

19. PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

Morris Hill Cemetery *9/3* 191*3*

20. UNDERTAKER

ADDRESS

Tracy & Summers *Boise Idaho*

Form V. S. No. 5 20M.1-16-12

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH.

Registration District No. 8County of AdaPrimary Registration District No. 2004File No. 5735City or Town near Souma Station

(No. _____ St.)

Registered No. 11

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

Frederick Douglas Brinkerhoff

If death occurred in a hospital, institution or camp, give its NAME and street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX

Male

4. COLOR OR RACE

White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED.

Single
(Write the word.)

6. DATE OF BIRTH

May 14 1897
(Month) (Day) (Year)

7. AGE

16 yrs. 3 mos. 11 ds.IF LESS than 1 day
how many hrs. or
..... mins.?

8. OCCUPATION

(a) Trade, profession or particular kind of work

Student

(b) General nature of industry business, or establishment in which employed (or employer)

9. BIRTHPLACE

(State or Country)

Ogden Utah

10. NAME OF FATHER

Garret M. Brinkerhoff

11. BIRTHPLACE OF FATHER

(State or Country)

N. J.

12. MAIDEN NAME OF MOTHER

Ellen V. Houbey

13. BIRTHPLACE OF MOTHER

(State or Country)

New York

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

Mrs. Mable Brinkerhoff

(Address)

Boise

15.

Filed 9-331913M. S. Parker

Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH

Aug 30 1913
(Month) (Day) (Year)17. I HEREBY CERTIFY, That I ~~attended~~ deceased ~~from~~ dead 1913 to Aug. 30 1913.that I last saw him alive on about 1913 and that death occurred on the date stated above, at 9 P. M.

The CAUSE OF DEATH* was as follows:

Fracture of Skull by falling under wheels of O. V. L. P. R. Co. Train coming from Hampden

(Duration) yrs. mos. ds.

Contributory Riding the Rods of(Secondary) a coach of train from Hampden

(Duration) yrs. mos. ds.

(Signed) Adolph Schreiber, M.D.19. (Address) Boise

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death yrs. mos. days. In the State yrs. mos. days.

Where was disease contracted if not at place of death?

Former or usual residence Boise Ida. Shipman

19. PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

Ogden UtahSept 4 1913

20. UNDERTAKER

ADDRESS

Schreiber & Sidenfaden Boise

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Form V. S. No. 5 20M.1-16-12

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH.

Registration District No. 8

County of Ada

Primary Registration District No. 2004

City of Barberton

(No. 1/2 mile So. Barberton St.)

File No. 5736

Registered No. 12

If death occurred away from usual residence, give name of place for under special information.

2. FULL NAME Leonard Smith

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX

Male

4. COLOR OR RACE

white
American

5. SINGLE, MARRIED, WIDOWED OR DIVORCED.

Single
(Write the word.)

6. DATE OF BIRTH

not obtainable 1913
(Month) (Day) (Year)

7. AGE

2 yrs. — mos. — ds.

IF LESS than 1 day
how many hrs. or
..... mins.?

8. OCCUPATION

(a) Trade, profession or particular kind of work

none

(b) General nature of industry business, or establishment in which employed (or employer)

9. BIRTHPLACE

(State or Country)

Boise

10. NAME OF FATHER

D. L. Smith

11. BIRTHPLACE OF FATHER

(State or Country)

not obtainable

12. MAIDEN NAME OF MOTHER

Emma Campbell

13. BIRTHPLACE OF MOTHER

(State or Country)

not obtainable

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

D. L. Smith

(Address)

Boise Ida

15.

Filed

9 - 4 1913

M. S. Parker

Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH

Sept 2 1913
(Month) Sept (Day) 2 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Aug 30 1913, to Sept 2 1913 that I last saw him alive on 2nd Sept. 1913 and that death occurred on the date stated above, at 12 M.

The CAUSE OF DEATH* was as follows:

Gastro enteritis

(Duration) yrs. mos. 5 ds.

Contributory (Secondary)

(Duration) yrs. mos. ds.

(Signed)

R. E. Shurt M. D.

19 (Address) Boise Ida

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death yrs. mos. days. In the State yrs. mos. days.

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

Morris Hill Ann

Sept 4 1913

20. UNDERTAKER

ADDRESS

Fry Summers

Boise

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Form V. S. No. 5 20M.1-16-12

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH

City of Boise
near Ada

Registration District No. 8

Primary Registration District No. 2004
(No. _____, _____ St.)

File No. 573Registered No. 13

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

Johanna Kroeger

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX

female

4. COLOR OR RACE

white

5. SINGLE, MARRIED, WIDOWED OR DIVORCED.

widowed

(Write the word.)

6. DATE OF BIRTH

June 20th 1825
(Month) (Day) (Year)

7. AGE

88 yrs. 1 mos. 14 ds.

IF LESS than 1 day
how many hrs. or
..... mins.?

8. OCCUPATION

(a) Trade, profession or particular kind of work

Retired

(b) General nature of industry business, or establishment in which employed (or employer)

9. BIRTHPLACE

(State or Country)

Germany

10. NAME OF FATHER

John Setteff

11. BIRTHPLACE OF FATHER

(State or Country)

Germany

12. MAIDEN NAME OF MOTHER

Margaretta Hansen
Johanna Setteff

13. BIRTHPLACE OF MOTHER

(State or Country)

Germany

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

Gustav Kroeger

(Address)

Boise, Idaho

15.

Filed 9-61913M. S. Parker

Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH

September 3rd 1913
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from

Sep. 2nd 1913, to Sep. 3rd 1913

that I last saw him alive on Sep. 2nd 1913

and that death occurred on the date stated above, at 5 A. M.

The CAUSE OF DEATH* was as follows:

Paralysis - due to
undiscovered epileptic
convulsions.

(Duration) yrs. mos. ds.

Contributory
(Secondary)Epilepsy

(Duration) yrs. mos. ds.

(Signed)

J. H. B. B. B. M. D.
Sept 5th 1913 (Address) Boise, Idaho

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death yrs. mos. days. In the State yrs. mos. days.

Where was disease contracted if not at place of death?

Former or usual residence.

19. PLACE OF BURIAL OR REMOVAL DATE OF BURIAL

Marion Hill Cemetery 9/6 1913

20. UNDERTAKER

ADDRESS

Schreiba & Hidenfader Boise

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Form V. S. No. 5 20M.1-16-12

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH.

Registration District No. 8

County of Ada

Primary Registration District No. 2004

City of 5 Miles So of City

(No. 5 Miles So of Boise, St.)

File No.

5738

Registered No. 14

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

John Wines

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX

Male

4. COLOR OR RACE

White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED.

Single
(Write the word.)

6. DATE OF BIRTH

Feb 10 1912
(Month) (Day) (Year)

7. AGE

1 yrs. 7 mos. 4 ds.

IF LESS than 1 day
how many hrs. or
mins.?

8. OCCUPATION

(a) Trade, profession or particular kind of work
(b) General nature of industry business, or establishment in which employed (or employer)

none

9. BIRTHPLACE

(State or Country)

Lewiston, Idaho.

10. NAME OF FATHER

A. V. Wines

11. BIRTHPLACE OF FATHER

(State or Country)

Nevada

12. MAIDEN NAME OF MOTHER

Edda Turner

13. BIRTHPLACE OF MOTHER

(State or Country)

Iowa

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

A. A. Wines

(Address)

Boise, Idaho.

15.

Filed

9-15

1913

M. S. Parker

Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH

Sept 14 1913
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from

Sept 9 - 1913, to Sept 13 1913,

that I last saw him alive on Sept 13 1913,

and that death occurred on the date stated above, at 7 A.M.

The CAUSE OF DEATH* was as follows:

Accidental - inflammation of brain
into lungs - crash by -
strangulation -

(Duration) yrs. mos. 5 ds.

Contributory
(Secondary)

Measles Colic

(Duration) yrs. mos. 6 ds.

(Signed) J. H. Brand M. D.

1913 (Address) Boise

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death yrs. mos. days. In the State yrs. mos. days.

Where was disease contracted if not at place of death?

Former or usual residence.

19. PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

Harris Hill Cemetery

9/14 1913

20. UNDERTAKER

ADDRESS

Schreiber & Sidenfaden Boise, Idaho

Dr. Brand

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Form V. S. No. 5 20M.1-16-12

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics
File No. 5739
Registered No. 6
If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

1. PLACE OF DEATH. Registration District No. 18
County of Minidoka Primary Registration District No. 2102
City of Near Eden (No. _____, St.)
If death occurs away from usual residence, give facts called for under special information. 2. FULL NAME Jennie Edna Stockeager

PERSONAL AND STATISTICAL PARTICULARS

3. SEX Female 4. COLOR OR RACE white 5. SINGLE, MARRIED, WIDOWED OR DIVORCED. Married (word-)
6. DATE OF BIRTH Aug 19 1891
(Month) (Day) (Year)

7. AGE 21 yrs. 11 mos. 27 ds.
IF LESS than 1 day how many _____ hrs. or _____ mins.?

8. OCCUPATION
(a) Trade, profession or particular kind of work Housewife
(b) General nature of industry business, or establishment in which employed (or employer)

9. BIRTHPLACE
(State or Country) Colorado

10. NAME OF FATHER Geo W. Berry

11. BIRTHPLACE OF FATHER Mo
(State or Country)

12. MAIDEN NAME OF MOTHER Eliza Jane Kline

13. BIRTHPLACE OF MOTHER Mo
(State or Country)

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Mrs Maud Vinyard
(Address) Eden Idaho

15. Filed Sept. 20 1913 J. D. Hillen
Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH Aug 15 1913
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from after death 1913, to 1913, that I last saw h alive on 1913, and that death occurred on the date stated above, at M.

The CAUSE OF DEATH* was as follows:
Gunshot Wounds

(Duration) _____ yrs. _____ mos. _____ ds.

Contributory (Secondary)

(Duration) _____ yrs. _____ mos. _____ ds.

(Signed) B. D. Barnes M.D.
19 _____ (Address) Justin & Peace

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death _____ yrs. _____ mos. _____ days. In the State _____ yrs. _____ mos. _____ days.

Where was disease contracted if not at place of death? _____

Former or usual residence _____

19. PLACE OF BURIAL OR REMOVAL Jwin Falls DATE OF BURIAL Aug 1913

20. UNDERTAKER The Crosby Co ADDRESS Jwin Falls

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Form V. S. No. 5 20M.1-16-12

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics
File No. 5741

1. PLACE OF DEATH
County of Benewah
City of Shalding

Registration District No. 99
Primary Registration District No. 21741
(No. _____, _____ St.)

Registered No. _____
If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Mary Keith

PERSONAL AND STATISTICAL PARTICULARS

3. SEX ♀ 4. COLOR OR RACE W 5. SINGLE, MARRIED, WIDOWED OR DIVORCED Single
(Write the word.)

6. DATE OF BIRTH May 1 1912
(Month) (Day) (Year)

7. AGE 1 yrs. 5 mos. ds.
IF LESS than 1 day how many _____ hrs. or _____ mins.?

8. OCCUPATION None
(a) Trade, profession or particular kind of work
(b) General nature of industry business, or establishment in which employed (or employer)

9. BIRTHPLACE I da.
(State or Country)

10. NAME OF FATHER Sam Keith

11. BIRTHPLACE OF FATHER N.C.
(State or Country)

12. MAIDEN NAME OF MOTHER Nellie Jordan

13. BIRTHPLACE OF MOTHER N.C.
(State or Country)

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) J. N. Alley
(Address) Lapwai, Ida.

15. Filed Sept 23 1913 John N. Alley
Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH Sept 20 1913
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from Sept 14 1913, to Sept 20 1913, that I last saw her alive on 14 Sept 1913, and that death occurred on the date stated above, at 5:45 M.

The CAUSE OF DEATH* was as follows:
Esophageal Cancer

(Duration) _____ yrs. _____ mos. _____ ds.
Contributory Improper eating
(Secondary)

(Duration) _____ yrs. _____ mos. _____ ds.
(Signed) Elmer H. Morris M. D.

721 1913 (Address) Lapwai, Ida.

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death _____ yrs. _____ mos. _____ days. In the State _____ yrs. _____ mos. _____ days.

Where was disease contracted if not at place of death? _____

Former or usual residence _____

19. PLACE OF BURIAL OR REMOVAL Shalding DATE OF BURIAL 9-21 1913

20. UNDERTAKER J. E. Waller ADDRESS Lapwai, Ida.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Form V. S. No. 5. 10M. 6-20-11.

CERTIFICATE OF DEATH

1. PLACE OF DEATH.
County of Blaine
City of Arco

Registration District No. 59
Primary Registration District No. 2159
(No. _____, St.)

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics
File No. 45742
Registered No. _____

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

Lab. Simmerman

If death occurred in a hospital, institution or camp give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX M. 4. COLOR OR RACE W. 5. SINGLE, MARRIED, WIDOWED OR DIVORCED. Single
(Write the word.)

6. DATE OF BIRTH Sept 27 1913
(Month) (Day) (Year)

7. AGE 45 yrs. mos. 4 ds. 45 min.
IF LESS than 1 day how many hrs. or min.?

8. OCCUPATION
(a) Trade, profession, or particular kind of work None
(b) General nature of industry business, or establishment in which employed (or employer)

9. BIRTHPLACE
(State or Country) Idaho

10. NAME OF FATHER Guy Simmerman

11. BIRTHPLACE OF FATHER
(State or Country) Iowa

12. MAIDEN NAME OF MOTHER Gallie Violet Peterson

13. BIRTHPLACE OF MOTHER
(State or Country) Iowa

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Guy Simmerman
(Address) Arco, Ida.

15. Filed Sept 27 1913 DW Matheson
Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH Sept 27 1913
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from on 10 to Sept 27 1913
that I last saw him alive on Sept 27 1913,
and that death occurred on the date stated above, at 1 P. M.

The CAUSE OF DEATH* was as follows:

Premature birth.
7 mo.
(Duration) yrs. mos. ds.

Contributory (Secondary)

(Duration) yrs. mos. ds.
(Signed) DW Matheson M. D.
Sept 27 1913 (Address) Arco

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death yrs. mos. ds. State yrs. mos. ds.
Where was Disease contracted, If not at place of death?
Former or usual residence.....

19. PLACE OF BURIAL OR REMOVAL Sept 28 1913
Arco

20. UNDERTAKER none
ADDRESS

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Form V. S. No. 5. 12½ M. 7-24-11

CERTIFICATE OF DEATH

State of Idaho

BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH.

Registration District No. 65.

County of Latah.

Primary Registration District No. 2145.

City of Princeton

(No. _____, St.)

File No. 5743

Registered No. _____

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

Clara A. Rusco

If death occurred in a hospital, institution or camp give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX

Female.

4. COLOR OR RACE

white

5. SINGLE, MARRIED, WIDOWED OR DIVORCED.

Single.
(Write the word.)

6. DATE OF BIRTH

June
(Month)15.
(Day)1875.
(Year)

7. AGE

38 yrs. 2 mos. 20 ds.IF LESS than 1 day
how many hrs. or
..... min?

8. OCCUPATION

(a) Trade, profession or particular kind of work.
(b) General nature of industry business or establishment in which employed (or employer)Housekeeper.

9. BIRTHPLACE

(State or Country)

Ohio

10. NAME OF FATHER

Benjamin Rusco

11. BIRTHPLACE OF FATHER

(State or Country)

Ohio

12. MAIDEN NAME OF MOTHER

Mary Welty.

13. BIRTHPLACE OF MOTHER

(State or Country)

Ohio

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

Benjamin Rusco
Princeton

(Address)

15.

Filed Sept. 8th 1913.D. J. Thompson
Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH

Sept.
(Month)5
(Day)1913
(Year)

17. I HEREBY CERTIFY, That I attended deceased from

Aug 10 1913, to Sept 2 1913that I last saw her alive on Sept. 2 1913and that death occurred on the date stated above, at 9 A.M.

The CAUSE OF DEATH* was as follows:

Pneumonia (lobar)(Duration) yrs. mos. 4 ds.Contributory
(Secondary)Chronic Valvular Disease of Heart(Duration) 10 yrs. mos. ds.

(Signed)

Sept. 8th 1913. (Address) Pottsville

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place

In the

of death yrs. mos. ds. State yrs. mos. ds.

Where was disease contracted,

If not at place of death?

Former or

usual residence.

19. PLACE OF BURIAL OR REMOVAL DATE OF BURIAL

Gold Creek Cemetery Sept 6 1913

20. UNDERTAKER

ADDRESS

C. L. Shaw.Palouse, Wash.

-SUPPLEMENTARY DEATH CERTIFICATE-

(Please reply on this sheet to
the registrar of Vital Statistics)

Death Certificate No.

Name Clara A. Rowe

Date of Death Sept. 5th 1913

Cause of Death Lobar pneumonia

Contributory Cause of death Chronic valvular disease of Heart

(Sign here) J. W. Thompson M.D.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Form V. S. No. 5 20M.1-16-12

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH

Registration District No. 9

County of FremontPrimary Registration District No. 2040City of Regley, R.T.D.

(No. _____, _____ St.)

File No. 5740Registered No. 5

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

Elizabeth Smith

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX

4. COLOR OR RACE

5. SINGLE, MARRIED, WIDOWED OR DIVORCED.

7W

(Write the word.)

6. DATE OF BIRTH

Aug 17 1906

(Month)

(Day)

(Year)

7. AGE

7 yrs. 1 mos. 5 ds.

IF LESS than 1 day
how many _____ hrs. or
_____ mins.

8. OCCUPATION

(a) Trade, profession or particular kind of work

(b) General nature of industry business, or establishment in which employed (or employer)

Child.

9. BIRTHPLACE

(State or Country)

Idaho.

10. NAME OF FATHER

John A. Smith.

11. BIRTHPLACE OF FATHER

(State or Country)

Utah.

12. MAIDEN NAME OF MOTHER

Clelia Williams.

13. BIRTHPLACE OF MOTHER

(State or Country)

Utah.

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

Vivian Williams.

(Address)

Rexburg.

15.

Filed

Sept. 10 1913

Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH

Aug. 22 1913

(Month)

(Day)

(Year)

17. I HEREBY CERTIFY, That I attended deceased from

191., to 191.,

that I last saw h. alive on 191.,

and that death occurred on the date stated above, at M.

The CAUSE OF DEATH* was as follows:

Ran over by wagon.
Instantly killed.
Skull fractured.

(Duration) yrs. mos. ds.

Contributory

(Secondary)

(Duration) yrs. mos. ds.

(Signed)

Ray P. Fisher M. D.Aug 22 1913 (Address) Regley, Idaho

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL OR HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death

_____ yrs. _____ mos. _____ days.

In the State

_____ yrs. _____ mos. _____ days.

Where was disease contracted if not at place of death? _____

Former or usual residence _____

19. PLACE OF BURIAL OR REMOVAL DATE OF BURIAL

Rexburg, Idaho. Rexburg, 1913.

20. UNDERTAKER

ADDRESS

John Phillips. Rexburg, Ida.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Form V. S. No. 5 20M.1-16-12

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH

Registration District No. 98County of FormontPrimary Registration District No. 2176City of Rigby

(No. _____, _____ St.)

File No. 5746Registered No. 6

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

Niles Peter Nielson Jr.

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX

M.

4. COLOR OR RACE

W.

5. SINGLE, MARRIED, WIDOWED OR DIVORCED.

Married
(Write the word.)

6. DATE OF BIRTH

Sept. 16 1913
(Month) (Day) (Year)

7. AGE

____ yrs. ____ mos. ____ ds.

IF LESS than 1 day
how many ____ hrs. or
60 mins?

8. OCCUPATION

- (a) Trade, profession or particular kind of work
(b) General nature of industry business, or establishment in which employed (or employer)

9. BIRTHPLACE

(State or Country)

Idaho

10. NAME OF FATHER

N. P. Nielson

11. BIRTHPLACE OF FATHER

(State or Country)

Dennet

12. MAIDEN NAME OF MOTHER

Olivia Petersen

13. BIRTHPLACE OF MOTHER

(State or Country)

Norway

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

N. P. Nielson

(Address)

Rigby, R.T. 1

15.

Filed

Sept. 16 1913 Ray H. H. H.
Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

Sept 16 1913
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from Sept. 16 1913 to Sept 16 1913
that I last saw him alive on Sept 16 1913

and that death occurred on the date stated above, at 12 M.

The CAUSE OF DEATH* was as follows:

lack of development
Prémature birth

(Duration) ____ yrs. ____ mos. ____ ds.

Contributory

(Secondary)

(Duration) ____ yrs. ____ mos. ____ ds.

(Signed)

G. C. Foxton M. D.
Sept 16 1913 (Address) Rigby - Idaho

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place

of death

____ yrs. ____ mos. ____ days.
Where was disease contracted if not at place of death?

In the

State

____ yrs. ____ mos. ____ days.

Former or
usual residence

19. PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

RigbySept 17 1913

20. UNDERTAKER

ADDRESS

FriendsRigby, R.T. 1

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Form V. S. No. 5 20M.1-16-12

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH.

Registration District No. 98County of TremontPrimary Registration District No. 2176City of Richy

(No. _____, _____ St.)

File No. 5741Registered No. 97

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX

M.

4. COLOR OR RACE

W

5. SINGLE, MARRIED, WIDOWED OR DIVORCED.

Infant
(Write the word.)

6. DATE OF BIRTH

Aug 201913

(Month)

(Day)

(Year)

7. AGE

12 hoursIF LESS than 1 day
how many 12 hrs. or
..... min.?

8. OCCUPATION

- (a) Trade, profession or particular kind of work
(b) General nature of industry, business, or establishment in which employed (or employer)

Infant

9. BIRTHPLACE

(State or Country)

Richy, Ida

10. NAME OF FATHER

J. H. Ward

11. BIRTHPLACE OF FATHER

(State or Country)

Utah

12. MAIDEN NAME OF MOTHER

Elsie Calk

13. BIRTHPLACE OF MOTHER

(State or Country)

Idaho

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

(Address)

J. H. Ward
Richy, Ida

15.

Filed

Sept 10 1913Ray A. Hicker
Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

Aug 201913

(Month)

(Day)

(Year)

17. I HEREBY CERTIFY, That I attended deceased from

Aug. 20 1913, to Aug 20 1913that I last saw him alive on Aug 20 1913and that death occurred on the date stated above, at 12 M.

The CAUSE OF DEATH* was as follows:

Premature7 mo utero-gestation

(Duration) yrs. mos. ds.

Contributory
(Secondary)

(Duration) yrs. mos. ds.

(Signed) A. M. Palmer M. D.Aug 20 1913 (Address) Richy, Ida

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death.....yrs.....mos.....days. In the State.....yrs.....mos.....days.

Where was disease contracted if not at place of death?.....

Former or usual residence.....

19. PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

Richy, IdaAug 21 1913

20. UNDERTAKER

ADDRESS

Mrs. Beck & Sons Richy, Ida

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Form V. S. No. 5 20M.1-16-12

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH.

Registration District No. 98County of FranklinPrimary Registration District No. 2176City of Regley

(No. _____, _____ St.)

File No. 5745Registered No. 8

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

Merwin Hill

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX

M

4. COLOR OR RACE

W

5. SINGLE, MARRIED, WIDOWED OR DIVORCED.

Single
(Write the word.)

6. DATE OF BIRTH

Aug 18

(Month)

(Day)

1911
(Year)

7. AGE

2 yrs. 1 mos. 17 ds.

IF LESS than 1 day
how many _____ hrs. or
_____ mins.?

8. OCCUPATION

- (a) Trade, profession or particular kind of work
(b) General nature of industry business, or establishment in which employed (or employer)

Chief

9. BIRTHPLACE

(State or Country)

Regley - Ida.

10. NAME OF FATHER

Chas. F. Hill

11. BIRTHPLACE OF FATHER

(State or Country)

Idaho

12. MAIDEN NAME OF MOTHER

Sarah E. Call

13. BIRTHPLACE OF MOTHER

(State or Country)

Utah

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

Chas. F. Hill

(Address)

Regley - Ida

15.

Filed Sept 10 1913Ray Pickens
Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH

Sept. 5

(Month)

(Day)

1913
(Year)

17. I HEREBY CERTIFY, That I attended deceased from Sept 1st 1913 to Sept 5th 1913,
that I last saw her alive on Sept. 5th 1913,
and that death occurred on the date stated above, at 6:55 P.M.

The CAUSE OF DEATH* was as follows:

Fasto-enteritis

(Duration) _____ yrs. _____ mos. _____ ds.

Contributory
(Secondary)(Duration) _____ yrs. _____ mos. 6 ds.

(Signed)

H. A. Anderson M. D.Sept 13 (Address) Regley Ida

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place

of death _____ yrs. _____ mos. _____ days.

In the

State _____ yrs. _____ mos. _____ days.

Where was disease contracted
if not at place of death?

Former or
usual residence

19. PLACE OF BURIAL OR REMOVAL

Regley

DATE OF BURIAL

Sept 7 1913

20. UNDERTAKER

Friends

ADDRESS

Regley

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Form V. S. No. 5 20M.1-16-12

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH.

Registration District No. 98County of ImmunPrimary Registration District No. 2176City of Rigby(No. Viola Rite St.)File No. 5741Registered No. 2

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX

F

4. COLOR OR RACE

W

5. SINGLE, MARRIED, WIDOWED OR DIVORCED.

Chief
(Write the word.)

6. DATE OF BIRTH

Nov. 51911

(Month)

(Day)

(Year)

7. AGE

1 yrs. 10 mos. 7 ds.IF LESS than 1 day
how many hrs. or
..... mins.?

8. OCCUPATION

(a) Trade, profession or particular kind of work

(b) General nature of industry, business, or establishment in which employed (or employer)

Chief

9. BIRTHPLACE

(State or Country)

Idaho

10. NAME OF FATHER

Geo. Rite

11. BIRTHPLACE OF FATHER

(State or Country)

Utah

12. MAIDEN NAME OF MOTHER

Bertha Russell

13. BIRTHPLACE OF MOTHER

(State or Country)

Utah

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

Geo. Rite

(Address)

Rigby - Ida

15.

Filed

Sept. 12 1913Ray H. H. M.
Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH

Sept. 12

(Month)

(Day)

1913
(Year)

17. I HEREBY CERTIFY, That I attended deceased from

Sept. 6 1913 to Sept. 12 1913that I last saw him alive on Sept. 12 1913and that death occurred on the date stated above, at P. M.

The CAUSE OF DEATH* was as follows:

Acute Enterocolitis

(Duration) yrs. mos. ds.

Contributory
(Secondary)(Duration) yrs. mos. 7 ds.

(Signed)

G. E. Poxton M. D.Sept. 19 13

(Address)

Rigby

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL OR HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death

..... yrs. mos. days.

In the State

..... yrs. mos. days.

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

Rigby -Sept. 18 1913

20. UNDERTAKER

ADDRESS

TrunksRigby - Ida

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Form V. S. No. 5 20M.1-16-12

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH.

Registration District No. 98County of TremontPrimary Registration District No. 2176City of Griffith

(No., St.)

File No. 575Registered No. 96.1

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

Emily Bateman

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX

Female

4. COLOR OR RACE

W

5. SINGLE, MARRIED, WIDOWED OR DIVORCED

Widowed

6. DATE OF BIRTH

Feb.
(Month)4
(Day)1898
(Year)

7. AGE

76 yrs. 6 mos. 15 ds.IF LESS than 1 day
how many hrs. or
..... mins.?

8. OCCUPATION

(a) Trade, profession or particular kind of work

(b) General nature of industry, business, or establishment in which employed (or employer)

9. BIRTHPLACE

(State or Country)

England

10. NAME OF FATHER

John Argent

11. BIRTHPLACE OF FATHER

(State or Country)

England

12. MAIDEN NAME OF MOTHER

Mary Gridley

13. BIRTHPLACE OF MOTHER

(State or Country)

England

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

C. Bateman

(Address)

Shelly, Idaho

15.

Filed

Aug 20 1913Ray S. Fisher, M.D.

Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH

Aug. 19
Aug 10 (Month) (Day) (Year) 1913

17. I HEREBY CERTIFY, That I attended deceased from

Aug 10 1913 to Aug 19 1913that I last saw h. E. alive on Aug 18 1913and that death occurred on the date stated above, at 1 P. M.

The CAUSE OF DEATH* was as follows:

General debility 74 yrs. oldIntestinal StasisSenile Dementia(Duration) 2 yrs. 4 mos. ds.

Contributory

(Secondary)

(Duration) yrs. mos. ds.

(Signed)

Ray S. Fisher, M. D.Aug 20 1913 (Address) Regley, Idaho

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death

..... yrs. mos. days.

In the

State yrs. mos. days.

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

Grout CemeteryAug 22 1913

20. UNDERTAKER.

ADDRESS

G. H. Hunt, Idaho FallsIdaho Falls

Idaho

Form V. S. No. 5 20M.1-16-12

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH.

Registration District No. 98County of BernmontPrimary Registration District No. 2176City of Regley

(No. _____ St.)

File No. 5751Registered No. 2

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

Homer S. Adams

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX

M.

4. COLOR OR RACE

White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED.

Single
(Write the word.)

6. DATE OF BIRTH

May 10

(Month)

(Day)

1893
(Year)

7. AGE

20 yrs. 2 mos. 13 ds.IF LESS than 1 day
how many hrs. or
..... mins.?

8. OCCUPATION

- (a) Trade, profession or particular kind of work
-
- (b) General nature of industry, business, or establishment in which employed (or employer)

farmer

9. BIRTHPLACE

(State or Country)

Idaho

10. NAME OF FATHER

D. H. Adams

11. BIRTHPLACE OF FATHER

(State or Country)

Utah

12. MAIDEN NAME OF MOTHER

Rebecca A. Tanner

13. BIRTHPLACE OF MOTHER

(State or Country)

Utah

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

D. H. Adams

(Address)

Regley, Idaho

15.

Filed

Aug 10 1913 Ray H. F. M.D.
Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH

July 23
(Month) (Day) (Year)17. I HEREBY CERTIFY, That I attended deceased from July 3 1913 to July 23 1913
that I last saw him alive on July 23 1913
and that death occurred on the date stated above, at 10:25 M.

The CAUSE OF DEATH* was as follows:

Typhoid fever

(Duration) yrs. mos. ds.

Contributory

(Secondary)

Acute Regurgitation

(Duration) yrs. mos. ds.

(Signed)

E. C. Porton

M. D.

July 24 1913 (Address) Regley, Idaho

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death yrs. mos. days. In the State yrs. mos. days.

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

Regley, Ida.July 26 1913

20. UNDERTAKER

ADDRESS

M. T. Peck & Sons, Regley, Ida.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Form V. S. No. 5 20M.1-16-12

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH.

Registration District No. 98County of FremontPrimary Registration District No. 2176City of Bigby

(No. _____ St.)

File No. 5752Registered No. 3

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

Riva Pearl Locker

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX

Female

4. COLOR OR RACE

W

5. SINGLE, MARRIED, WIDOWED OR DIVORCED.

Single (the word)

6. DATE OF BIRTH

July 17 1910
(Month) (Day) (Year)

7. AGE

2 yrs. 0 mos. 0 ds.IF LESS than 1 day
how many hrs. or
..... mins.?

8. OCCUPATION

(a) Trade, profession or particular kind of work

(b) General nature of industry, business, or establishment in which employed (or employer)

Child

9. BIRTHPLACE

(State or Country)

Idaho

10. NAME OF FATHER

Chas. Locker

11. BIRTHPLACE OF FATHER

(State or Country)

Utah

12. MAIDEN NAME OF MOTHER

Elsie Davis

13. BIRTHPLACE OF MOTHER

(State or Country)

Utah

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

(Address)

Chas. Locker,
Bigby, Ida

15.

Filed Aug. 10 1913Ray H. Baker
Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH

July 17 1913
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from

July 13 1913, to July 17 1913,
that I last saw him alive on July 16 1913,
and that death occurred on the date stated above, at 12 M.

The CAUSE OF DEATH* was as follows:

Broncho pneumoniaAcute nephritis(Duration) yrs. mos. 7 ds.

Contributory

(Secondary)

(Duration) yrs. mos. ds.

(Signed) H. A. Anderson M. D.July 17 1913 (Address) Bigby, Ida

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death yrs. mos. days. In the State yrs. mos. days.

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

Bigby, July 19 1913

20. UNDERTAKER

ADDRESS

Friends Bigby, Ida
Wm. Beck & Sons

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Form V. S. No. 5 20M.1-16-12

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH.

Registration District No. 98County of JeromePrimary Registration District No. 2176City of Lewisville

(No. _____, _____ St.)

File No. 5753Registered No. 4

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

Marion Peterson

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX

F.

4. COLOR OR RACE

W.

5. SINGLE, MARRIED, WIDOWED OR DIVORCED.

Widow
(Write the word.)

6. DATE OF BIRTH

Mar. 25 1830
(Month) (Day) (Year)

7. AGE

83 yrs. 5 mos. 4 ds.

IF LESS than 1 day
how many hrs. or
..... mins.?

8. OCCUPATION

(a) Trade, profession or particular kind of work

(b) General nature of industry business, or establishment in which employed (or employer)

Housewife

9. BIRTHPLACE

(State or Country)

Denmark.

10. NAME OF FATHER

Christian Larsen.

11. BIRTHPLACE OF FATHER

(State or Country)

Denmark.

12. MAIDEN NAME OF MOTHER

Marion

13. BIRTHPLACE OF MOTHER

(State or Country)

Denmark.

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Peter C. Peterson(Address) Regby, P.D. 1

15.

Filed Aug. 10 1913 Regby, Idaho
Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH

July 29 1913
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from

July 22 1913, to July 29 1913,
that I last saw her alive on July 28 1913,
and that death occurred on the date stated above, at 7 P.M.

The CAUSE OF DEATH* was as follows:

Pneumonia and Pleurisy.(Duration) yrs. mos. 7 ds.Contributory (Secondary) Old age.

(Duration) yrs. mos. ds.

(Signed) H. A. Anderson M. D.July 30 1913 (Address) Regby, Ida.

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death yrs. mos. days. In the State yrs. mos. days.

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL DATE OF BURIAL

Lewisville July 31 1913

20. UNDERTAKER

ADDRESS

McPeak & Sons Regby, Ida.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Form V. S. No. 5 20M.1-16-12

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH. Registration District No. 4
County of Adams Primary Registration District No. 2011
City of Indian Valley (No. _____, St.)
If death occurs away from usual residence, give facts called for under special information.

File No. 5751
Registered No. _____

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX 4. COLOR OR RACE 5. SINGLE, MARRIED, WIDOWED OR DIVORCED.

Female White single
(Write the word.)

6. DATE OF BIRTH

Mar 28 1898
(Month) (Day) (Year)

7. AGE

15 yrs. 7 mos. 28 ds.

IF LESS than 1 day
how many hrs. or
..... mins.?

8. OCCUPATION

(a) Trade, profession or particular kind of work not employed
(b) General nature of industry, business, or establishment in which employed (or employer)

9. BIRTHPLACE

(State or Country)

Oregon

10. NAME OF FATHER

Lewis Chalifoe

11. BIRTHPLACE OF FATHER

(State or Country)

Oregon

12. MAIDEN NAME OF MOTHER

Elizabeth Woods

13. BIRTHPLACE OF MOTHER

(State or Country)

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

Lynn Chalifoe

(Address)

Cambridge

15.

Filed

Apr 101918

Frank E. Brown
Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

July 25 1918
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from

1918, to 1918,
that I last saw h..... alive on 1918,

and that death occurred on the date stated above, at 5:30 M.

The CAUSE OF DEATH* was as follows:

accidental gun shot

(Duration) yrs. mos. ds.

Contributory
(Secondary)

(Duration) yrs. mos. ds.

(Signed)

F. A. Schmitt

M. D.

19..... (Address)

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death yrs. mos. days. In the State yrs. mos. days.

Where was disease contracted
if not at place of death?

Former or
usual residence

19. PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

CambridgeJuly 26 1918

20. UNDERTAKER

ADDRESS

MARGIN RESERVED FOR BINDING
WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Form V. S. No. 5 20M.1-16-12

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics
File No. 5755

1. PLACE OF DEATH

Registration District No. 4

County of Adams

Primary Registration District No. 2011

City of Indian Valley

(No. _____ St.)

Registered No. _____

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Tolerance E. Ware

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX

4. COLOR OR RACE

5. SINGLE, MARRIED, WIDOWED OR DIVORCED.

Female

White

Married
(Write the word.)

6. DATE OF BIRTH

May 19 1864
(Month) (Day) (Year)

7. AGE

49 yrs. 2 mos. 3 ds.

IF LESS than 1 day
how many _____ hrs. or
_____ mins.?

8. OCCUPATION

(a) Trade, profession or particular kind of work

(b) General nature of industry business, or establishment in which employed (or employer)

Nurse & House W/fe

9. BIRTHPLACE

(State or Country)

Bellevue Ohio

10. NAME OF FATHER

Engine H. Steward

11. BIRTHPLACE OF FATHER

(State or Country)

Ohio

12. MAIDEN NAME OF MOTHER

Eliza J. Taylor

13. BIRTHPLACE OF MOTHER

(State or Country)

Ohio

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

Amos E. Byers

(Address)

Indian Valley

15.

Filed

Apr 13-

1913

Frank E. Brown
Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

Aug 22 1913
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from

Aug 22 1913, to 1913,

that I last saw her alive on Aug 22 1913,

and that death occurred on the date stated above, at 4:30 PM.

The CAUSE OF DEATH* was as follows:

Strangulated Hernia

(Duration) _____ yrs. _____ mos. 1 ds.

Contributory
(Secondary)

(Duration) _____ yrs. _____ mos. _____ ds.

(Signed) Frank E. Brown M. D.

19 (Address) Council Bluffs

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death _____ yrs. _____ mos. _____ days. In the State _____ yrs. _____ mos. _____ days.

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

1913

20. UNDERTAKER

ADDRESS

Jatrudelson

Cambridge

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Form V. S. No. 5 20M.1-16-12

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics
File No. 5756
Registered No. _____

1. PLACE OF DEATH _____
County of Idaho Registration District No. 4
City of Council Primary Registration District No. 2611
(No. _____, _____ St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Larry Brooks

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX Female 4. COLOR OR RACE White 5. SINGLE, MARRIED, WIDOWED OR DIVORCED. Single
(Write the word.)

6. DATE OF BIRTH March 26 1908
(Month) (Day) (Year)

7. AGE 10 yrs. 1 mos. 17 ds.
IF LESS than 1 day how many _____ hrs. or _____ mins.?

8. OCCUPATION
(a) Trade, profession or particular kind of work _____
(b) General nature of industry business, or establishment in which employed (or employer) _____

9. BIRTHPLACE W. Y.
(State or Country)

10. NAME OF FATHER Fred Brooks

11. BIRTHPLACE OF FATHER W. Y.
(State or Country)

12. MAIDEN NAME OF MOTHER Lillian McGwire

13. BIRTHPLACE OF MOTHER Iowa
(State or Country)

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Fred Brooks
(Address) Council, Idaho.

15. Filed June 1 1913 Frank E. Brown
Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH May 13 1913
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from _____ 1913, to _____ 1913,
that I last saw h. _____ alive on _____ 1913,
and that death occurred on the date stated above, at _____ M.

The CAUSE OF DEATH* was as follows:

Scarlet Fever

(Duration) _____ yrs. _____ mos. 36 hrs. ds.
Contributory _____
(Secondary) _____

(Duration) _____ yrs. _____ mos. _____ ds.
(Signed) Frank E. Brown M. D.
19 _____ (Address)

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death _____ yrs. _____ mos. _____ days. In the State _____ yrs. _____ mos. _____ days.

Where was disease contracted if not at place of death? _____
Former or usual residence _____

19. PLACE OF BURIAL OR REMOVAL Council DATE OF BURIAL May 14 1913

20. UNDERTAKER Robt. Young ADDRESS Council

MARGIN RESERVED FOR BINDING
WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Form V. S. No. 5 20M.1-16-12

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH.

Registration District No. 2

County of Adams

Primary Registration District No. 2011

City of Council

(No. St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Martha Alice Haines

File No. 575

Registered No. 33

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX

F

4. COLOR OR RACE

W

5. SINGLE, MARRIED, WIDOWED OR DIVORCED.

(Write the word.)

6. DATE OF BIRTH

Sept 3 1892
(Month) (Day) (Year)

7. AGE

16 yrs. 8 mos. 10 ds.

IF LESS than 1 day
how many hrs. or
 mins.?

8. OCCUPATION

- (a) Trade, profession or particular kind of work
(b) General nature of industry business, or establishment in which employed (or employer)

9. BIRTHPLACE

(State or Country) Idaho

10. NAME OF FATHER

William R. Haines

11. BIRTHPLACE OF FATHER

(State or Country) Idaho

12. MAIDEN NAME OF MOTHER

William

13. BIRTHPLACE OF MOTHER

(State or Country) Oregon

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) W R Haines

(Address) Council Idaho

15.

Filed 5-1 1913 Robt Young

Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH

May 13 1913
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from Apr. 10 1913, to May 13 1913, that I last saw her alive on May 8 1913, and that death occurred on the date stated above, at 12 M.

The CAUSE OF DEATH* was as follows:

Inflammatory Rheumatism

(Duration) yrs. mos. ds.

Contributory mitral heart disease
(Secondary)

(Duration) yrs. mos. ds.

(Signed) Robt Young M. D.

5-17-1913 (Address) Council

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death yrs. mos. days. In the State yrs. mos. days.

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL

Council

DATE OF BURIAL

May 14 1913

20. UNDERTAKER

Robt Young

ADDRESS

Council

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Form V S. No. 5 20M.1-16-12

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH. Registration District No. 4
County of Adams Primary Registration District No. 2011
City of Trutvale (No. _____, St.)

File No. 575-

Registered No. _____
If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME unnamed

PERSONAL AND STATISTICAL PARTICULARS

3. SEX Male 4. COLOR OR RACE white 5. SINGLE, MARRIED, WIDOWED OR DIVORCED.
(Write the word.)

6. DATE OF BIRTH Jan 27 1913
(Month) (Day) (Year)

7. AGE _____ yrs. _____ mos. 17 ds.
IF LESS than 1 day
how many _____ hrs. or
_____ mins.?

8. OCCUPATION
(a) Trade, profession or particular kind of work _____
(b) General nature of industry business, or establishment in which employed (or employer) _____

9. BIRTHPLACE
(State or Country) Idaho

10. NAME OF FATHER Fred. C. Jackson

11. BIRTHPLACE OF FATHER
(State or Country) Oregon

12. MAIDEN NAME OF MOTHER L. Riddle

13. BIRTHPLACE OF MOTHER
(State or Country) Idaho

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Fred C Jackson
(Address) Trutvale

15. Filed 7-1-37 1913 Frank E. Brown
Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH July 8th 1913
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from July 6 1913, to July 8 1913,
that I last saw him alive on July 6 1913
and that death occurred on the date stated above, at 9 P M.
The CAUSE OF DEATH* was as follows:
Insanition

(Duration) _____ yrs. _____ mos. _____ ds.

Contributory
(Secondary) _____

(Duration) _____ yrs. _____ mos. _____ ds.

(Signed) Frank Brown M. D.
7-11-13 (Address) Council Idaho

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death _____ yrs. _____ mos. _____ days. In the State _____ yrs. _____ mos. _____ days.

Where was disease contracted if not at place of death? _____

Former or usual residence _____

19. PLACE OF BURIAL OR REMOVAL Trutvale DATE OF BURIAL July 9 1913

20. UNDERTAKER Neighbors - ADDRESS Trutvale

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital StatisticsFile No. 5751

Registered No. _____

If death occurred in a hospital, institution or camp give its NAME instead of street and number.

1. PLACE OF DEATH.
County of Adams
City of CuprumRegistration District No. 4Primary Registration District No. 2811

(No. _____, _____ St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME S. Curtis Road

PERSONAL AND STATISTICAL PARTICULARS

3. SEX 4. COLOR OR RACE 5. SINGLE, MARRIED, WIDOWED OR DIVORCED.

Male White Single
(Write the word.)6. DATE OF BIRTH
Not known
(Month) (Day) (Year)7. AGE
64 yrs. + 0 mos. 0 ds.
IF LESS than 1 day
how many hrs. or
..... min.?

8. OCCUPATION

(a) Trade, profession, or particular kind of work Carpenter
(b) General nature of industry business, or establishment in which employed (or employer) Past 12 yrs. prospecting and mining.

9. BIRTHPLACE

(State or Country) New York

10. NAME OF FATHER

Porter Road

11. BIRTHPLACE OF FATHER

(State or Country) - N. Y.

12. MAIDEN NAME OF MOTHER

- Curtis

13. BIRTHPLACE OF MOTHER

(State or Country) N. Y.

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) R. C. Watt(Address) Council

15.

Filed Sept 15 - 1913 Frank E. Brewer
Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

July 19 1913
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from

May 20 1911, to July 17 1913
that I last saw him alive on July 17 1913,
and that death occurred on the date stated above, at 9:30 A.M.

The CAUSE OF DEATH* was as follows:

Chronic Subcutaneous HydatidNot known
(Duration) yrs. mos. ds.Contributory Pulmonary Tuberculosis
(Secondary)

(Duration) yrs. mos. ds.

(Signed) H. M. Brown M. D.July 20 1913 (Address) London

State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place In the
of death yrs. mos. ds. State yrs. mos. ds.Where was Disease contracted,
If not at place of death?Former or
usual residence.

19. PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

Cuprum July 20 1913

20. UNDERTAKER

ADDRESS

noneR. C. Watt, Council, may be able to give more complete information

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
N. B.—Every item of information should be carefully supplied. AGE should be state EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Form V. S. No. 5. 10M. 6-20-11.

CERTIFICATE OF DEATH

 State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

 1. PLACE OF DEATH.
County of Adams
City of Mesa

 Registration District No. 4
Primary Registration District No. 2011
(No. _____, _____ St.)

 File No. 5760
Registered No. _____

If death occurs away from usual residence, give facts called for under special information.

 2. FULL NAME Mary E Bacon

If death occurred in a hospital, institution or camp give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

 3. SEX Female 4. COLOR OR RACE Wh 5. SINGLE, MARRIED, WID-
OWED OR DIVORCED. married
(Write the word.)

 6. DATE OF BIRTH March 20 1847
(Month) (Day) (Year)

 7. AGE 65 yrs. 11 mos. 26 ds. IF LESS than 1 day
how many hrs. or
..... min.?

8. OCCUPATION

 (a) Trade, profession or particular kind of work
(b) General nature of industry business or establishment in which employed (or employer)

Housewife

 9. BIRTHPLACE
(State or Country)

Ky.

10. NAME OF FATHER

J. M. King

 11. BIRTHPLACE OF FATHER
(State or Country)

unknown

12. MAIDEN NAME OF MOTHER

Pernecy J. Hodges

 13. BIRTHPLACE OF MOTHER
(State or Country)

unknown

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

G. H. Bacon

(Address)

Mesa Idaho

15.

 Filed 9-15
1913
Frank E Bacon

Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

March 16 1913
(Month) (Day) (Year)

 17. I HEREBY CERTIFY, That I attended deceased from
..... 191....., to..... 191.....

 that I last saw h..... alive on..... 191.....
and that death occurred on the date stated above, at..... M.

The CAUSE OF DEATH* was as follows:

Chronic Nephritis

 (Duration) 1 yrs. mos. ds.

 Contributory
(Secondary)

Scarlet Fever

(Duration) yrs. mos. ds.

 (Signed) Frank E Bacon M. D.

19 (Address)

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and 2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death yrs. mos. ds. State yrs. mos. ds.

Where was disease contracted,

If not at place of death?

Former or

usual residence.

19. PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

Indian Valley
3-17-9 1913

20. UNDERTAKER

ADDRESS

J. A. Huddleson
Cambridge

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Form V. S. No. 5 20M.1-16-12

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH.....*Washington Adams* Registration District No. *26 4*
County of *Washington* Primary Registration District No. *21142011*
City of *Indian Valley* (No., St.)

File No. *5761*
Registered No. *45*

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME *William P McChute*

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX *Male* 4. COLOR OR RACE *white* 5. SINGLE, MARRIED, WIDOWED OR DIVORCED. *married*
(Write the word.)

6. DATE OF BIRTH *June 10 1862*
(Month) (Day) (Year)

7. AGE *49 yrs. 11 mos. 26 ds.*
IF LESS than 1 day how many hrs. or mins.?

8. OCCUPATION
(a) Trade, profession or particular kind of work *Ranching*
(b) General nature of industry business, or establishment in which employed (or employer) *California*

9. BIRTHPLACE *California*
(State or Country)

10. NAME OF FATHER *Eschel M McChute*

11. BIRTHPLACE OF FATHER *Mo*
(State or Country)

12. MAIDEN NAME OF MOTHER *Mary M Clair*

13. BIRTHPLACE OF MOTHER *Mo*
(State or Country)

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) *Mary M McChute*
(Address) *Moscow Ida*

15. Filed *June 5 1913* *C E Schunk*
Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH *June 4 1913*
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from *Aug 15 1912*, to *June 4 1913*, that I last saw him alive on *June 1 1913*, and that death occurred on the date stated above, at *2:50 AM*.

The CAUSE OF DEATH* was as follows:

I.B. Necrosis of Hip

(Duration) yrs. *9* mos. *6* ds.
Contributory *dislocation of hip joint*
(Secondary)

(Duration) yrs. *9* mos. *6* ds.
(Signed) *C E Schunk* M. D.
Jan 5 1913 (Address) *Cambridge*

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death yrs. mos. days. In the State yrs. mos. days.

Where was disease contracted if not at place of death?

Former or usual residence.....

19. PLACE OF BURIAL OR REMOVAL *Moscow* DATE OF BURIAL *June 7 1913*

20. UNDERTAKER *R W Bowen* ADDRESS *Idaho*

Form V. S. No. 5 20M.1-16-12

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH.

Registration District No. 4County of AdamsPrimary Registration District No. 2218City of Council

(No. _____ St.)

Registered No. _____

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME G. L. Perdue

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX

4. COLOR OR RACE

5. SINGLE, MARRIED, WIDOWED OR DIVORCED.

malewhitesingle
(Write the word.)

6. DATE OF BIRTH

1891
(Month) (Day) (Year)

7. AGE

42 yrs. — mos. — ds.IF LESS than 1 day
how many hrs. or
..... mins.?

8. OCCUPATION

(a) Trade, profession or particular kind of work

(b) General nature of industry business, or establishment in which employed (or employer)

miner

9. BIRTHPLACE

(State or Country)

10. NAME OF FATHER

11. BIRTHPLACE OF FATHER

(State or Country)

12. MAIDEN NAME OF MOTHER

13. BIRTHPLACE OF MOTHER

(State or Country)

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Fred Hancock(Address) New Meadows Idaho

15.

Filed Aug 10 1913 Frank E. Dan
Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH

Aug 3 1913
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from

Aug 3 1913 to 1913that I last saw him alive on Aug 3 1913,and that death occurred on the date stated above, at M.

The CAUSE OF DEATH* was as follows:

Nephritis

(Duration) yrs. mos. ds.

Contributory
(Secondary)

(Duration) yrs. mos. ds.

(Signed)

Frank E. Dan M. D.Aug 3 1913 (Address) Council

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death yrs. mos. days. In the State yrs. mos. days.

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

Council IdahoAug 4 1913

20. UNDERTAKER

ADDRESS

Robt YoungCouncil

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Form V. S. No. 5. 10M. 6-20-11.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH.

Registration District No. 4.County of AdamsPrimary Registration District No. 2012City of Meadows

(No. _____, _____ St.)

Registered No. _____

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

Carl Braughan

If death occurred in a hospital, institution or camp give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX

Male

4. COLOR OR RACE 5. SINGLE, MARRIED, WIDOWED OR DIVORCED.

whiteSingle
(Write the word.)

6. DATE OF BIRTH

Mo.
(Month)14
(Day)1829
(Year)

7. AGE

84 yrs. 2 mos. 11 ds.

IF LESS than 1 day
how many _____ hrs. or
_____ min.?

8. OCCUPATION

- (a) Trade, profession, or particular kind of work
(b) General nature of industry, business, or establishment in which employed (or employer)

Miner

9. BIRTHPLACE

(State or Country)

Germany

10. NAME OF FATHER

Braughan

11. BIRTHPLACE OF FATHER

(State or Country)

Germany

12. MAIDEN NAME OF MOTHER

13. BIRTHPLACE OF MOTHER

(State or Country)

Germany

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

John E. Brown

(Address)

Meadows

15.

Filed

Sept 12 - 1913Frank E. Brown

Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

May
(Month)25th
(Day)1913
(Year)

17. I HEREBY CERTIFY, That I attended deceased from

May 71913

to

May 241913that I last saw him alive on May 23d 1913and that death occurred on the date stated above, at 6:15 p.m.

The CAUSE OF DEATH* was as follows:

Senility(Duration) 5 yrs. _____ mos. _____ ds.Contributory
(Secondary)Bright's Disease(Duration) 1 yrs. _____ mos. _____ ds.

(Signed)

T. E. Martin

M. D.

May 26th 1913 (Address) New Meadows, Ida.

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place _____ yrs. _____ mos. _____ ds. In the
of death _____ yrs. _____ mos. _____ ds. State _____ yrs. _____ mos. _____ ds.

Where was Disease contracted,

If not at place of death?

Former or

usual residence.

19. PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

MeadowsMay 27th 1913

20. UNDERTAKER

ADDRESS

John E. BrownMeadows, Ida.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Form V. S. No. 5 20M.1-16-12

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics
File No. 5764
Registered No. 4

1. PLACE OF DEATH. Registration District No. 86
County of Washington Primary Registration District No. 2163
City of Wenatchee (No. , St.)

If death occurs away from usual residence, give facts called for under special information. 2. FULL NAME Frank M. Johnson
If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX Male 4. COLOR OR RACE Wht 5. SINGLE, MARRIED, WID-OWED OR DIVORCED. Single
(Write the word.)

6. DATE OF BIRTH
_____. _____. _____.
(Month) (Day) (Year)

7. AGE
_____. yrs. _____. mos. _____. ds.
IF LESS than 1 day how many _____. hrs. or _____. mins.?

8. OCCUPATION Lineman
(a) Trade, profession or particular kind of work
(b) General nature of industry, business, or establishment in which employed (or employer)

9. BIRTHPLACE Miles City Mont.
(State or Country)

10. NAME OF FATHER J. H. Johnson

11. BIRTHPLACE OF FATHER
(State or Country)

12. MAIDEN NAME OF MOTHER Lizzie Bieman

13. BIRTHPLACE OF MOTHER Mont.
(State or Country)

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) J. H. Redman
(Address) Boise

15. Filed Aug. 28 1913 W. P. Hamilton
Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH
Aug 27 1913
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from
191 , to 191 ,
that I last saw h. alive on 191 ,
and that death occurred on the date stated above, at M.

The CAUSE OF DEATH* was as follows:
Accidentally electrocuted

(Duration) _____. yrs. _____. mos. _____. ds.
Contributory
(Secondary)

(Duration) _____. yrs. _____. mos. _____. ds.
(Signed) James J. McCombs
19 (Address) _____

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death _____. yrs. _____. mos. _____. days. In the State _____. yrs. _____. mos. _____. days.

Where was disease contracted if not at place of death? _____

Former or usual residence _____

19. PLACE OF BURIAL OR REMOVAL Kallispel Mont. DATE OF BURIAL 191

20. UNDERTAKER L. B. Northman ADDRESS Wenatchee, Ida.

77X

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Form V. S. No. 5 20M.1-16-12

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH.

Registration District No.

26 86

County of

Washington

Primary Registration District No.

2110 2163

City of

Weiser

(No. 5 miles east of Weiser St.)

File No.

5765

Registered No.

3

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

Mrs Feater

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX

Female

4. COLOR OR RACE

White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED.

(Write the word.)

6. DATE OF BIRTH

Sept - 19 - 1836
(Month) (Day) (Year)

7. AGE

76 yrs. 10 mos. 22 ds.

IF LESS than 1 day
how many hrs. or
..... mins.?

8. OCCUPATION

(a) Trade, profession or particular kind of work
(b) General nature of industry, business, or establishment in which employed (or employer)

Housewife

9. BIRTHPLACE

(State or Country)

State of Ohio

10. NAME OF FATHER

David Grimes

11. BIRTHPLACE OF FATHER

(State or Country)

State Maryland

12. MAIDEN NAME OF MOTHER

Rebecca Cagle

13. BIRTHPLACE OF MOTHER

(State or Country)

State of Maryland

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

(Address)

J. E. Feater
Weiser Idaho

15.

Filed

Aug. 12 1913

W. R. Hamilton
Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH

August - 11 - 1913
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from

July 21 1913, to Aug. 11 1913
that I last saw him alive on Aug. 10 1913

and that death occurred on the date stated above, at 6 A.M.

The CAUSE OF DEATH* was as follows:

mitral insufficiency

(Duration) yrs. mos. ds.

Contributory
(Secondary)

(Duration) yrs. mos. ds.

(Signed)

J. M. Watson M. D.

Aug. 11 1913 (Address) Weiser Idaho

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death yrs. mos. days. In the State yrs. mos. days.

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

Weiser, Idaho

8/12 1913

20. UNDERTAKER

ADDRESS

R. W. Bowen

Weiser, Ida.

Form V. S. No. 5 20M.1-16-12

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics
File No. 5761. PLACE OF DEATH. Registration District No. 86
County of Washington Primary Registration District No. 1010
City of Wia (No. St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME James Greenleaf

Registered No. 2

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX Male 4. COLOR OR RACE whr 5. SINGLE, MARRIED, WIDOWED OR DIVORCED. unknown (Write the word.)

6. DATE OF BIRTH

(Month) (Day) (Year)

7. AGE

About 65 yrs. mos. ds.

IF LESS than 1 day
how many hrs. or
mins.?

8. OCCUPATION

(a) Trade, profession or particular kind of work
(b) General nature of industry, business, or establishment in which employed (or employer)

Laborer

9. BIRTHPLACE

(State or Country)

unknown

10. NAME OF FATHER

unknown

11. BIRTHPLACE OF FATHER

(State or Country)

unknown

12. MAIDEN NAME OF MOTHER

unknown

13. BIRTHPLACE OF MOTHER

(State or Country)

unknown

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

L.B. North

(Address)

Wesley, Ida

15.

Filed Aug 4 1913

W.R. Hamilton
Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH

Aug 4 1913
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from July 3 1913, to Aug 4 1913, that I last saw him alive on Aug 4 1913,

and that death occurred on the date stated above, at 2 P.M.

The CAUSE OF DEATH* was as follows:

Encephalomalacia

(Duration) yrs. 2 mos. ds.

Contributory
(Secondary)

(Duration) yrs. mos. ds.

(Signed) M. D.

19 (Address)

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL OR HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death yrs. mos. days. In the State yrs. mos. days.

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL

Wesley, Ida

DATE OF BURIAL

Aug 4 1913

20. UNDERTAKER

L.B. North

ADDRESS

Wesley, Ida

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Form V. S. No. 5 20M.1-16-12

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH.

Registration District No. 86County of WashingtonPrimary Registration District No. 1010City of Weiser

(No. _____ St.)

File No. 5767

Registered No. _____

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Fred R. Harlow

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX

Male

4. COLOR OR RACE

Wbr

5. SINGLE, MARRIED, WIDOWED OR DIVORCED.

(Write the word.)

6. DATE OF BIRTH

Jan111912

(Month)

(Day)

(Year)

7. AGE

1 yrs. 6 mos. 22 ds.IF LESS than 1 day
how many _____ hrs. or
_____ mins.?

8. OCCUPATION

(a) Trade, profession or particular kind of work
(b) General nature of industry, business, or establishment in which employed (or employer)

9. BIRTHPLACE

(State or Country)

Missouri

10. NAME OF FATHER

H W Harlow

11. BIRTHPLACE OF FATHER

(State or Country)

Missouri

12. MAIDEN NAME OF MOTHER

Fannie Hinkle

13. BIRTHPLACE OF MOTHER

(State or Country)

Missouri

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

H W Harlow

(Address)

Weiser Ida

15.

Filed Aug 4 1913W. R. Hamilton
Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH

August3rd1913

(Month)

(Day)

(Year)

17. I HEREBY CERTIFY, That I attended deceased from

June 11913,August1913,that I last saw him alive on August 2 1913,and that death occurred on the date stated above, at 6 A. M.

The CAUSE OF DEATH* was as follows:

malnutrition

(Duration)

since birth

yrs.

mos.

ds.

Contributory

(Secondary)

(Duration)

yrs.

mos.

ds.

(Signed)

James A Young

M. D.

Aug 4 1913

(Address)

Weiser Ida

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL OR HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place

of death _____ yrs. _____ mos. _____ days.

In the

State _____ yrs. _____ mos. _____ days.

Where was disease contracted if not at place of death?

Former or usual residence _____

19. PLACE OF BURIAL OR REMOVAL

Weiser

DATE OF BURIAL

Aug 4 1913

20. UNDERTAKER

L. E. Northman

ADDRESS

Weiser

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Form V. S. No. 5. 12½M.7-24-11

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH. Registration District No. 26
County of Washington Primary Registration District No. 5114
City of Cambridge (No. _____, St.)

File No. 5768Registered No. 54

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

Premature Lake

If death occurred in a hospital, institution or camp give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX FM 4. COLOR OR RACE W 5. SINGLE, MARRIED, WIDOWED OR DIVORCED. Single
(Write the word.)

6. DATE OF BIRTH July 18 1913
(Month) (Day) (Year)

7. AGE _____ yrs. _____ mos. _____ ds. IF LESS than 1 day
how many 4 hrs. or _____ min?

8. OCCUPATION

(a) Trade, profession or particular kind of work _____
(b) General nature of industry business or establishment in which employed (or employer) _____

9. BIRTHPLACE

(State or Country)

Cambridge Ida

10. NAME OF FATHER

Henry J. Cleverley

11. BIRTHPLACE OF FATHER

(State or Country)

Minnesota

12. MAIDEN NAME OF MOTHER

Edyth McDonald

13. BIRTHPLACE OF MOTHER

(State or Country)

Ida

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

(Address)

J. Hopper
Cambridge

15.

Filed July 20 1913C. E. Schmitt
Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH

July 18 1913
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from

7/18 1913, to 7/18 1913

that I last saw h. e. alive on 7/18 1913

and that death occurred on the date stated above, at 11 30 A.M.

The CAUSE OF DEATH* was as follows:

Premature - about 7 mo

(Duration) _____ yrs. _____ mos. _____ ds.

Contributory
(Secondary)

(Duration) _____ yrs. _____ mos. _____ ds.

(Signed) J. Hopper M. D.

19 (Address) Cambridge

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; (2) whether ACCIDENTAL, SUICIDAL OR HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place _____ In the _____
of death _____ yrs. _____ mos. _____ ds. State _____ yrs. _____ mos. _____ ds.

Where was disease contracted,

If not at place of death?

Former or
usual residence.

19. PLACE OF BURIAL OR REMOVAL DATE OF BURIAL

Cambridge Ida July 18 1913

20. UNDERTAKER ADDRESS

J. H. H. H. H. Cambridge

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Form V. S. No. 5 20M.1-16-12

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH

Registration District No. 27

County of Washington

Primary Registration District No. 2114

City of Cambridge

(No. _____, _____ St.)

File No. 5769

Registered No. 53

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Anna May Crabtree

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX

Female

4. COLOR OR RACE

Caucasian

5. SINGLE, MARRIED, WIDOWED OR DIVORCED.

Single
(Write the word.)

6. DATE OF BIRTH

June 6 1909
(Month) (Day) (Year)

7. AGE

4 yrs. 15 mos. ds.

IF LESS than 1 day
how many _____ hrs. or
_____ mins.?

8. OCCUPATION

- (a) Trade, profession or particular kind of work
(b) General nature of industry, business, or establishment in which employed (or employer)

9. BIRTHPLACE

(State or Country) Seattle Washington

10. NAME OF FATHER

David W Crabtree

11. BIRTHPLACE OF FATHER

(State or Country) Hillbous Idhar

12. MAIDEN NAME OF MOTHER

Anna O Steal

13. BIRTHPLACE OF MOTHER

(State or Country) Portsmouth England

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) D W Crabtree

(Address) _____

15.

Filed June 22 1913

C E Schumtz
Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH

June 21 1913
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from

June 8 1913, to June 21 1913,

that I last saw her alive on June 21 1913,

and that death occurred on the date stated above, at 6 AM.

The CAUSE OF DEATH* was as follows:

acute suppurative sealdery followed by sealdery pneumonia

(Duration) yrs. mos. 12 hours

Contributory (Secondary)

(Duration) yrs. mos. ds.

(Signed) C E Schumtz M. D.

June 22 1913 (Address) Cambridge Idhar

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death _____ yrs. _____ mos. _____ days. In the State _____ yrs. _____ mos. _____ days.

Where was disease contracted if not at place of death?

Former or usual residence _____

19. PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

Cambridge Idhar

June 22 1913

20. UNDERTAKER

ADDRESS

J A Anderson

Cambridge

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Form V. S. No. 5 20M.1-16-12

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH

Registration District No. 26

County of Washington

Primary Registration District No. 2117

City of Cambridge

(No. , St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

Grace Ann Childers

File No. 5771

Registered No. 54

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX

4. COLOR OR RACE

5. SINGLE, MARRIED, WIDOWED OR DIVORCED.

Female

Caucasian

Single
(Write the word.)

6. DATE OF BIRTH

Dec 25 1899
(Month) (Day) (Year)

7. AGE

13 yrs. 5 mos. 26 ds.

IF LESS than 1 day
how many hrs. or mins.?

8. OCCUPATION

- (a) Trade, profession or particular kind of work
(b) General nature of industry, business, or establishment in which employed (or employer)

9. BIRTHPLACE

(State or Country)

Fort Clatsop Oregon

10. NAME OF FATHER

Geo Childers

11. BIRTHPLACE OF FATHER

(State or Country)

Jackson Co Oregon

12. MAIDEN NAME OF MOTHER

Dora E Norton

13. BIRTHPLACE OF MOTHER

(State or Country)

Jackson Co Oregon

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

Geo Childers
Cambridge Idaho

(Address)

15.

Filed

June 19 1913

1913

C E Schmitz
Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH

June 19 1913
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from

June 1 1913, to June 19 1913,

that I last saw her alive on June 19 1913,

and that death occurred on the date stated above, at 1 M.

The CAUSE OF DEATH* was as follows:

Septic Paracenter

(Duration) yrs. mos. 19 ds.

Contributory
(Secondary)

Rheumatism

(Duration) yrs. mos. ds.

(Signed)

C E Schmitz
June 19 1913 (Address) Cambridge

M. D.

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death yrs. mos. days. In the State yrs. mos. days.

Where was disease contracted if not at place of death?

Former or usual residence.

19. PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

Cambridge Ida.

June 20 1913

20. UNDERTAKER

ADDRESS

J A Davidson

Cambridge

1. PLACE OF DEATH. Registration District No. 26
County of Washington Primary Registration District No. 2114
City of Cambridge (No. _____, _____ St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Nancy Marilla Squires

If death occurred in a hospital, institution or camp give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX Female	4. COLOR OR RACE White	5. SINGLE, MARRIED, WIDOWED OR DIVORCED. Widowed (Write the word.)
------------------	---------------------------	--

6. DATE OF BIRTH June 21 1832
(Month) (Day) (Year)

7. AGE 82 yrs. 11 mos. 21 ds. IF LESS than 1 day
how many.....hrs. or
min?

8. OCCUPATION

(a) Trade, profession or particular kind of work... *House wife*

(b) General nature of industry business or establishment in which employed (or employer) ... *house*

9. BIRTHPLACE
(State or Country)

10. NAME OF FATHER

**11. BIRTHPLACE
OF FATHER**
(State or Country)

12. MAIDEN NAME
OF MOTHER

**13. BIRTHPLACE
OF MOTHER**
(State or Country)

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) John A. Harlan
(Address) Painville, Ohio

15. *June 14* 1913

Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH
June 12 1915
(Month) (Day) (Year)

17 I HEREBY CERTIFY, That I attended deceased from June 17 1913, to June 11 1913
that I last saw her alive on June 11 1913
and that death occurred on the date stated above, at 59 M.

The CAUSE OF DEATH* was as follows:

Lagrippe & acute gastro-enteritis

..... (Duration) yrs. mos, 6 ds.

Contributory (Secondary) metrol resurgitation

(Duration) unknown yrs. 0 mos. 0 ds.

(Signed) Lincoln Fokker M. D.
6/13/13 (Address) Cambridge, Mass.

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place				In the			
of death	hrs	mos	ds	State	hrs	mos	ds

Where was disease contracted,
If not at place of death?

Former or
usual residence.....

19. PLACE OF BURIAL OR REMOVAL		DATE OF BURIAL

Cambridge Isle June 22, 1913.

20. UNDERTAKER	ADDRESS

Al Hudson	Lee, bridge
-----------	-------------

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Form V. S. No. 20M.1-16-12

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH

Registration District No. 84

County of Blaine

Primary Registration District No. 2161

City of Pocatello

(No. 1027 N. Main St.)

File No. 2 5771

Registered No. 10976

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

Mr. Wm. Liddle

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX

Female

4. COLOR OR RACE

White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED.

Married

6. DATE OF BIRTH

May

12

1851

(Month)

(Day)

(Year)

7. AGE

62

2

mos.

25

ds.

IF LESS than 1 day how many hrs. or mins.?

8. OCCUPATION

(a) Trade, profession or particular kind of work

Housewife

(b) General nature of industry business, or establishment in which employed (or employed)

9. BIRTHPLACE

(State or Country)

Prince Edward Island, Canada

10. NAME OF FATHER

Henry Simpson

11. BIRTHPLACE OF FATHER

(State or Country)

Scotland

12. MAIDEN NAME OF MOTHER

Eliza Simpson

13. BIRTHPLACE OF MOTHER

(State or Country)

Scotland

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

Wm. Liddle

(Address)

1027 N. Main St.

15.

Filed

Aug 7

1913

O. J. Seelye
Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

Aug

6

1913

(Month)

(Day)

(Year)

17. I HEREBY CERTIFY, That I attended deceased from

May 27 1913, to Aug 6 1913,

that I last saw her alive on Aug 6 1913,

and that death occurred on the date stated above, at 1:00 P. M.

The CAUSE OF DEATH was as follows:

Cerebral Haemorrhage

(Duration) yrs. 1 mos. ds.

Contributory (Secondary)

Arterio sclerosis

(Duration) few yrs. mos. ds.

(Signed)

W. J. Howard M. D.

8/6/1913

(Address)

Pocatello Idaho

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death yrs. mos. days. In the State yrs. mos. days.

Where was disease contracted if not at place of death?

Former or usual residence.

19. PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

St. Leo Cemetery

1913

20. UNDERTAKER

W. H. Walker

ADDRESS

Pocatello Idaho

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Form V. S. No. 5 20M.1-16-12

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH.

Registration District No. 28 84

County of Bannock

Primary Registration District No. 2161

City of Pocatello

(No. 604, N. Arthur St.)

File No. A 5774

Registered No. 78

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Winifred Clara Miller

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX

Female

4. COLOR OR RACE

White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED.

Single (Write the word)

6. DATE OF BIRTH

June (Month)

27 (Day)

1913 (Year)

7. AGE

1 yrs. 18 mos. 18 ds.

IF LESS than 1 day
how many hrs. or
..... mins.?

8. OCCUPATION

(a) Trade, profession or particular kind of work
(b) General nature of industry, business, or establishment in which employed (or employer)

Housewife

9. BIRTHPLACE

(State or Country)

Bannock, Ida

10. NAME OF FATHER

C. W. Miller

11. BIRTHPLACE OF FATHER

(State or Country)

Utah

12. MAIDEN NAME OF MOTHER

England

13. BIRTHPLACE OF MOTHER

(State or Country)

Emma Harris

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

C. W. Miller

(Address)

604 N. Arthur

15.

Filed

Aug 14

191 3

O. B. Seeley

Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH

Aug 14

14th

191 3

(Month)

(Day)

(Year)

17. I HEREBY CERTIFY, That I attended deceased from

July 25 1913, to Aug 10 1913,

that I last saw him alive on Aug 10 1913,

and that death occurred on the date stated above, at 7:00 AM.

The CAUSE OF DEATH* was as follows:

Cholera Infantum

(Duration)

yrs.

mos.

21 ds.

Contributory
(Secondary)

Imperfect nutrition

(Duration)

yrs.

mos.

21 ds.

(Signed)

W. A. Wright, M. D.
8/19 1913 - (Address) Pocatello, Idaho

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place

of death.....yrs.....mos.....days.

In the

State.....yrs.....mos.....days.

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

Mountain View

Aug 17 191 3

20. UNDERTAKER

ADDRESS

Ray Russell Pocatello

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Form V. S. No 5 20M.1-16-12

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH.

Registration District No.

84

County of *Sanmark*

Primary Registration District No.

2161

City of *Pocatello*

(No. *315* *St. Nalleyday* St.)

File No. *II 577*

Registered No. *79*

If death occurs away from usual residence, give facts about for under special information.

2. FULL NAME

Miss Eliza Scott

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX

4. COLOR OR RACE

5. SINGLE, MARRIED, WIDOWED OR DIVORCED.

Female

White

Single (Write the word.)

6. DATE OF BIRTH

Sept 29

1912

(Month) (Day) (Year)

7. AGE

10 yrs. *23* mos. *23* ds.

IF LESS than 1 day how many hrs. or mins.?

8. OCCUPATION

(a) Trade, profession or particular kind of work
(b) General nature of industry business, or establishment in which employed (or employer)

None

9. BIRTHPLACE

(State or Country)

Idaho Falls, Idaho

10. NAME OF FATHER

Orin Elwood Scott

11. BIRTHPLACE OF FATHER

(State or Country)

Ohio

12. MAIDEN NAME OF MOTHER

Betty E. Heller

13. BIRTHPLACE OF MOTHER

(State or Country)

Illinois

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

Orin E. Scott

(Address)

Pocatello Idaho

15.

Filed

8/21

1913

W. Steacy

Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH

Aug 21

21

1913

(Month)

(Day)

(Year)

17. I HEREBY CERTIFY, That I attended deceased from

Aug 21

1913

to *Aug 21*

1913

that I last saw her alive on *Aug 21*

1913

and that death occurred on the date stated above, at *8:30* M.

The CAUSE OF DEATH* was as follows:

Acute Toxic enteritis

(Duration)

yrs.

mos.

ds.

Contributory (Secondary)

Exhaustion

(Duration)

yrs.

mos.

ds.

(Signed)

8/21/13

J. M. Ray, M.D.

(Address) *Pocatello, Idaho*

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death

.....yrs.....mos.....days.

In the State

.....yrs.....mos.....days.

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

Newbury

Aug 23

1913

20. UNDERTAKER

ADDRESS

P. H. Walker

Pocatello Idaho

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Form V. S. No. 5 20M.1-16-12

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH

Registration District No. *84*County of *Blaine*Primary Registration District No. *2161*City of *Pocatello*(No. *Gen Hospital* St.)File No. *II*Registered No. *81577*

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME *Louis Schifano*

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX

Male

4. COLOR OR RACE

Italian

5. SINGLE, MARRIED, WIDOWED OR DIVORCED.

(Write the word.)

6. DATE OF BIRTH

1878
(Month) (Day) (Year)

7. AGE

35 yrs. *1* mos. *1* ds.

IF LESS than 1 day
how many hrs. or
..... mins.?

8. OCCUPATION

(a) Trade, profession or particular kind of work
(b) General nature of industry, business, or establishment in which employed (or employer)

Laborer

9. BIRTHPLACE

(State or Country)

Italy

10. NAME OF FATHER

11. BIRTHPLACE OF FATHER

(State or Country)

12. MAIDEN NAME OF MOTHER

13. BIRTHPLACE OF MOTHER

(State or Country)

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) *M. Maeker*(Address) *Pocatello Idaho*

15.

Filed *Aug 29*191 *3*Local Registrar *O. B. Moody*

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

Aug 27 191 *3*
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from

191 *3*, to *Aug 27* 191 *3*

that I last saw him alive on *Aug 27* 191 *3*and that death occurred on the date stated above, at *8 P. M.*

The CAUSE OF DEATH* was as follows:

Gun shot wound - homicide.

(Duration) yrs. mos. ds.

Contributory (Secondary)

(Duration) yrs. mos. ds.

(Signed) *O. B. Moody**8-29-1913* (Address) *Coroner*

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death yrs. mos. days. In the State yrs. mos. days.

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL DATE OF BURIAL

Mt View Cemetery 191 *3*

20. UNDERTAKER

ADDRESS

M. Maeker *Pocatello*

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Form V. S. No. 5 20M.1-16-12

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH.

Registration District No.

28 84

County of

Primary Registration District No.

2161

City of

(No.)

1042, N. Lincoln

St.)

File No.

H 577

Registered No.

82

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

Olive Marie Johnston

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

MEDICAL CERTIFICATE OF DEATH.

3. SEX

4. COLOR OR RACE

5. SINGLE, MARRIED, WIDOWED OR DIVORCED.

Male

White

Single
(Write the word.)

6. DATE OF BIRTH

Nov.

26

1910

(Month)

(Day)

(Year)

7. AGE

2

yrs.

10

mos.

4

ds.

IF LESS than 1 day
how many hrs. or
..... mins.?

8. OCCUPATION

(a) Trade, profession or particular kind of work
(b) General nature of industry, business, or establishment in which employed (or employer)

None.

9. BIRTHPLACE

(State or Country)

Deer Lodge Mont

10. NAME OF FATHER

J. C. Johnston

11. BIRTHPLACE OF FATHER

(State or Country)

Springfield Mo

12. MAIDEN NAME OF MOTHER

Lea. Hutchins

13. BIRTHPLACE OF MOTHER

(State or Country)

Missouri

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

J. C. Johnston

(Address)

Procatello Idaho

15.

Filed

Aug 30

1913

O. B. Seery

Local Registrar

16. DATE OF DEATH

Aug

30

1913

(Month)

(Day)

(Year)

17. I HEREBY CERTIFY, That I attended deceased from

Jan 14 1913, to Aug 20 1913,
that I last saw her alive on Aug 20 1913,
and that death occurred on the date stated above, at 3 A.M.

The CAUSE OF DEATH* was as follows:

Tuberculosis of Bowels

(Duration)

yrs.

mos.

ds.

Contributory
(Secondary)

(Duration)

yrs.

mos.

ds.

(Signed)

(Address)

Procatello Idaho

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place

of death.....yrs.....mos.....days.

In the

State.....yrs.....mos.....days.

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

Mountain View

Sept 1 1913

20. UNDERTAKER

ADDRESS

H. H. Walker

Procatello

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Form V. S. No. 5 20M.1-16-12

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH. Registration District No. _____
County of Shoshone Primary Registration District No. _____
City of Kallegg (No. Upper Klamath St.) _____
File No. 5749
Registered No. _____
If death occurs away from usual residence, give facts called for under special information. 2. FULL NAME Herence Dunham
If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX female 4. COLOR OR RACE white 5. SINGLE, MARRIED, WIDOWED OR DIVORCED. married
(Write the word.)

6. DATE OF BIRTH XX XX 1890
(Month) (Day) (Year)

7. AGE 23 yrs. mos. ds.
IF LESS than 1 day how many hrs. or mins.?

8. OCCUPATION
(a) Trade, profession or particular kind of work Nurse
(b) General nature of industry business, or establishment in which employed (or employer) _____

9. BIRTHPLACE
(State or Country) Texas

10. NAME OF FATHER No information

11. BIRTHPLACE OF FATHER No information
(State or Country)

12. MAIDEN NAME OF MOTHER No information

13. BIRTHPLACE OF MOTHER No information
(State or Country)

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Flores Mills
(Address) ardner, Idaho.

15. Filed Oct 7th 1913 G. S. Leshner
Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH October 7 1913
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from 191, to 191, that I last saw h alive on 191, and that death occurred on the date stated above, at M. The CAUSE OF DEATH* was as follows:
Suicide---Corrosive
sublimate poisoning
(Duration) yrs. mos. ds.
Contributory (Secondary)
(Duration) yrs. mos. ds.
(Signed) G. S. Leshner M. D.
19 (Address) Atty. General

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death yrs. mos. days. In the State yrs. mos. days.
Where was disease contracted if not at place of death?
Former or usual residence

19. PLACE OF BURIAL OR REMOVAL Spokane, Wash. DATE OF BURIAL Oct 10 1913

20. UNDERTAKER Bruce J. Mottet Wallace ADDRESS

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Form V. S. No. 5 20M.1-16-12

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH.

Registration District No.

County of Shoshone

Primary Registration District No.

City of Kellogg

(No. St.)

File No. 578

Registered No.

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Daniel Hughes

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX

M

4. COLOR OR RACE

W

5. SINGLE, MARRIED, WIDOWED OR DIVORCED.

Married
(Write the word.)

6. DATE OF BIRTH

Jan 1 1884
(Month) (Day) (Year)

7. AGE

29 yrs. 10 mos. 7 ds.

IF LESS than 1 day
how many hrs. or
..... mins.?

8. OCCUPATION

(a) Trade, profession or particular kind of work

Miner

(b) General nature of industry business, or establishment in which employed (or employer)

9. BIRTHPLACE

(State or Country)

Wales

10. NAME OF FATHER

Dan Hughes

11. BIRTHPLACE OF FATHER

(State or Country)

Wales

12. MAIDEN NAME OF MOTHER

Mary Howard

13. BIRTHPLACE OF MOTHER

(State or Country)

Wales

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

Mrs. Hughes

(Address)

Wardner,

15.

Filed

Oct 7th 1913 Geo. S. Leshner,
Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH

Oct 7 1913
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from

Oct 5th 1913, to Oct 7th 1913

that I last saw him alive on Oct 7th 1913

and that death occurred on the date stated above, at 3 P.M.

The CAUSE OF DEATH* was as follows:

Dysphoid fever(Duration) 2 yrs. 20 mos. 20 ds.

Contributory

(Secondary)

(Duration) 2 yrs. 20 mos. 20 ds.

(Signed)

Geo. S. Leshner M. D.

Oct 9 1913 (Address) Kellogg, Ida.

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death yrs. mos. days. In the State yrs. mos. days.

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

Greenwood, Kellogg Oct. 17 1913

20. UNDERTAKER

ADDRESS

E. B. Hankins Kellogg, Ida.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Form V. S. No. 5 20M.1-16-12

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH.

Registration District No. 15

County of Baine

Primary Registration District No.

City of Rosbury

(No. St.)

File No. 5781

Registered No. 2

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Laura Agness Long

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX

Female

4. COLOR OR RACE

White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED.

Single
(Write the word.)

6. DATE OF BIRTH

Feb. 20 1905-
(Month) (Day) (Year)

7. AGE

8 yrs. 8 mos. 20 ds.

IF LESS than 1 day
how many hrs. or mins.?

8. OCCUPATION

- (a) Trade, profession or particular kind of work
(b) General nature of industry, business, or establishment in which employed (or employer)

School Child

9. BIRTHPLACE

(State or Country)

Baine Idaho

10. NAME OF FATHER

Otis A. Long

11. BIRTHPLACE OF FATHER

(State or Country)

Michigan

12. MAIDEN NAME OF MOTHER

Lusie R. Swamy

13. BIRTHPLACE OF MOTHER

(State or Country)

Mo.

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

Otis A. Long

(Address)

Rosbury Idaho

15.

Filed

Sept. 14 1913

D. H. Compton
Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH

Sept. 14 1913
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from

11 A.M. Sept. 13 1913, to 6 P.M. Sept. 13 1913

that I last saw her alive on Sept. 13 at 6 P.M. 1913,

and that death occurred on the date stated above, at 8 A.M.

The CAUSE OF DEATH* was as follows:

Peritonitis following a ruptured appendix Vermiformis.

(Duration) yrs. mos. 10 ds.

Contributory
(Secondary)

(Duration) yrs. mos. ds.

(Signed) D. H. Compton M. D.

Sept. 14 1913 (Address) Rosbury Idaho

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death.....yrs.....mos.....days. In the State.....yrs.....mos.....days.

Where was disease contracted if not at place of death?

Former or usual residence.

19. PLACE OF BURIAL OR REMOVAL DATE OF BURIAL

Willcox Cemetery Sept. 15 1913

20. UNDERTAKER

ADDRESS

Robert Halfer, Jr. Spirit Idaho

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Form V. S. No. 5 20M.1-16-12

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH.

Registration District No. 96

County of Myer

Primary Registration District No. 1009

City of Lewiston

(No. _____ St.)

File No. 5782

Registered No. 18

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Electa S. Fargo

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX

4. COLOR OR RACE

5. SINGLE, MARRIED, WIDOWED OR DIVORCED.

Female white

Single (use word.)

6. DATE OF BIRTH

December 5 1881
(Month) (Day) (Year)

7. AGE

32 yrs. 6 mos. 28 ds.

IF LESS than 1 day
how many _____ hrs. or
_____ mins.

8. OCCUPATION

(a) Trade, profession or particular kind of work

at home

(b) General nature of industry business, or dtablissement in which employed (or employer)

9. BIRTHPLACE

(State or Country)

Russell Kans.

10. NAME OF FATHER

J. S. Fargo

11. BIRTHPLACE OF FATHER

(State or Country)

York State

12. MAIDEN NAME OF MOTHER

Jennie Riley

13. BIRTHPLACE OF MOTHER

(State or Country)

Iowa

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

Miss Grace Fargo

(Address)

Lewiston Idaho

15.

Filed

Sept 8 1913
Oct 10 1913

L. W. K. K.

Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH

Sept 5 1913
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from

191 to 191

that I last saw h. _____ alive on _____ 191

and that death occurred on the date stated above, at _____ M.

The CAUSE OF DEATH* was as follows:

Accidental Drowning

_____ (Duration) _____ yrs. _____ mos. _____ ds.

Contributory

(Secondary)

_____ (Duration) _____ yrs. _____ mos. _____ ds.

(Signed)

W. Vassar

19

(Address)

Lewiston Ida.

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place

of death _____ yrs. _____ mos. _____ days.

In the

State _____ yrs. _____ mos. _____ days.

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

Lewiston

Sept 5-1913

20. UNDERTAKER

ADDRESS

C. J. Vassar

Lewiston

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Form V, S. No. 5. 12½ M. 7-24-11

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics
File No. 5753
Registered No. 19

1. PLACE OF DEATH. Registration District No. 96
County of Nez Perce Primary Registration District No. 1009
City of Lewiston Idaho (No. St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

George Allen Hart

If death occurred in a hospital, institution or camp give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX Male 4. COLOR OR RACE White 5. SINGLE, MARRIED, WIDOWED OR DIVORCED. Married (Write the word.)

6. DATE OF BIRTH May 3 1873 (Month) (Day) (Year)

7. AGE 40 yrs. 5 mos. 7 ds. IF LESS than 1 day how many hrs. or min?

8. OCCUPATION

(a) Trade, profession or particular kind of work. Laborer
(b) General nature of industry business or establishment in which employed (or employer)

9. BIRTHPLACE

(State or Country)

Washington

10. NAME OF FATHER

Frank Hart

11. BIRTHPLACE OF FATHER

(State or Country)

Missouri

12. MAIDEN NAME OF MOTHER

X X

13. BIRTHPLACE OF MOTHER

(State or Country)

X X

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

(Address)

Mrs. George A. Hart
Clarkston Wash.

15.

Filed

Oct 10 1913 P. H. Weber
Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

September 10 1913 (Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from August 5 1913, to September 10 1913, that I last saw him alive on September 10 1913, and that death occurred on the date stated above, at 1 P. M.

The CAUSE OF DEATH* was as follows:

Tuberculosis of the Bronchi
and Chronic Suppurative
Osteomyelitis

(Duration) 2 yrs. 2 mos. 2 ds.
Contributory (Secondary) Anterior Peritonitis
(Duration) yrs. mos. ds.
(Signed) Paul J. Sawyer M. D.
Sept 12 1913 (Address) Astoria, Wash.

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death... yrs. mos. ds. State... yrs. mos. ds.
Where was disease contracted, If not at place of death?
Former or usual residence...

19. PLACE OF BURIAL OR REMOVAL DATE OF BURIAL

Clarkston Wash Oct 12 1913

20. UNDERTAKER ADDRESS

H R Merchant Astoria Wash

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Form V. S. No. 5 20M.1-16-12

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH.

Registration District No. 76County of Naz. PercePrimary Registration District No. 1009File No. 578+City of Lewiston(No. 764, 6 St.)Registered No. 20

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

Christine Jane Nasmund

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX

Female

4. COLOR OR RACE

White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED.

Single (Use the word.)

6. DATE OF BIRTH

January 19th 1892
(Month) (Day) (Year)

7. AGE

21 yrs. 7 mos. 23 ds.IF LESS than 1 day
how many _____ hrs. or
_____ mins.?

8. OCCUPATION

(a) Trade, profession or particular kind of work

Nursing -

(b) General nature of industry business, or establishment in which employed (or employer)

St. Luke's Hospital Spokane, Wash.

9. BIRTHPLACE

(State or Country)

Pattee Creek, Ida Co., Iowa.

10. NAME OF FATHER

John Nasmund

11. BIRTHPLACE OF FATHER

(State or Country)

Germany

12. MAIDEN NAME OF MOTHER

Jessie Mohler

13. BIRTHPLACE OF MOTHER

(State or Country)

Iowa

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

Blanche Nasmund

(Address)

Grangeville Idaho

15.

Filed

Oct 10 19188L. J. Perkins

Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH

September 11th 1913
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from

191, to 191,that I last saw him alive on Aug. 13 1913,and that death occurred on the date stated above, at 9⁴⁵ AM.

The CAUSE OF DEATH* was as follows:

Valvular Heart TroubleDr. Stickton of Grangeville, Ida was last Dr. to see deceased.(Duration) Between 2 & 3 years ds.Contributory
(Secondary)

(Duration) _____ yrs. _____ mos. _____ ds.

(Signed) Blanche Nasmund M. D.19 _____ (Address) Grangeville, Ida.

*State the DISEASE CAUSING DEATH; or in death from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death _____ yrs. _____ mos. 21 days. In the State _____ yrs. _____ mos. _____ days.

Where was disease contracted if not at place of death?

Former or usual residence

Grangeville Idaho

19. PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

Green IdahoSept-13 1913

20. UNDERTAKER

ADDRESS

C. J. VassarLewiston

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Form V. S. No. 5 20M.1-16-12		CERTIFICATE OF DEATH		State of Idaho BOARD OF HEALTH Bureau of Vital Statistics	
1. PLACE OF DEATH		Registration District No. 96		File No. 578	
County of Neg. Pierce		Primary Registration District No. 1007		Registered No. 21	
City of Leuciston (No. , St.)		FULL NAME Alice E. Chamberlin		If death occurred in a hospital, institution or camp, give its NAME instead of street and number.	
If death occurs away from usual residence, give facts called for under special information.					
PERSONAL AND STATISTICAL PARTICULARS					
3. SEX		4. COLOR OR RACE		5. SINGLE, MARRIED, WIDOWED OR DIVORCED.	
F		W.		Widow (Write the word.)	
6. DATE OF BIRTH					
Nov. 17 1827 (Month) (Day) (Year)					
7. AGE				IF LESS than 1 day	
85 yrs. 9 mos. 28 ds.				how many hrs. or mins.	
8. OCCUPATION					
(a) Trade, profession or particular kind of work none					
(b) General nature of industry business, or establishment in which employed (or employer)					
9. BIRTHPLACE					
(State or Country) Canada					
10. NAME OF FATHER					
Abbott.					
11. BIRTHPLACE OF FATHER					
(State or Country) not known					
12. MAIDEN NAME OF MOTHER					
"					
13. BIRTHPLACE OF MOTHER					
(State or Country) "					
14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE					
(Informant) Ira Small					
(Address) Leuciston, Ida					
15. Filed Oct. 10 1913 L. J. Perkins Local Registrar					
MEDICAL CERTIFICATE OF DEATH.					
16. DATE OF DEATH.					
Sep 15 1913 (Month) (Day) (Year)					
17. I HEREBY CERTIFY, That I attended deceased from Sep 15 1913, to Sep 16 1913, that I last saw her alive on Sep 16 1913, and that death occurred on the date stated above, at 8.30 P. M.					
The CAUSE OF DEATH* was as follows:					
Cerebral hemorrhage					
(Duration) yrs. mos. 20 min. ds.					
Contributory (Secondary) old age					
(Duration) yrs. mos. ds.					
(Signed) M. D.					
19 (Address) J. B. Thurman					
*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.					
18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)					
At place of death yrs. mos. days. In the State yrs. mos. days.					
Where was disease contracted if not at place of death?					
Former or usual residence					
19. PLACE OF BURIAL OR REMOVAL DATE OF BURIAL					
Halla Walla Wash. Leuciston, Ida					
20. UNDERTAKER ADDRESS					
O. J. Vassar. Leuciston.					

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Form V. S. No. 5 20M.1-16-12

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH
County of Adams
City of Leicester

Registration District No. 96
Primary Registration District No. 1009
(No. Hospital St.)

File No. 5786
Registered No. 22

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME August Anderson

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX M 4. COLOR OR RACE W 5. SINGLE, MARRIED, WID-
OWED OR DIVORCED. Single
(Write the word.)

6. DATE OF BIRTH Not known
(Month) (Day) (Year)

7. AGE 41 yrs. mos. ds.
IF LESS than 1 day
how many hrs. or
 mins?

8. OCCUPATION
(a) Trade, profession or particular kind of work Carpenter
(b) General nature of industry, business, or establishment in which employed (or employer)

9. BIRTHPLACE
(State or Country) Sweden

10. NAME OF FATHER Not known

11. BIRTHPLACE OF FATHER
(State or Country) "

12. MAIDEN NAME OF MOTHER "

13. BIRTHPLACE OF MOTHER
(State or Country) "

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) J. J. Vassar
(Address) Leicester

15. Filed Oct 20 1913 L. G. Verlin
Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH
Apr 20 1913
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from
Apr 14 1913, to Apr 20 1913,
that I last saw him alive on Apr 20 1913
and that death occurred on the date stated above, at 4 P.M.

The CAUSE OF DEATH* was as follows:

Acute blacking of femoral artery as result of gunshot wound

(Duration) 7 yrs. mos. ds.
Contributory gunshot
(Secondary)

(Duration) 7 yrs. mos. ds.
(Signed) J. J. Vassar M. D.
19 Leicester (Address)

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death yrs. mos. days. In the State yrs. mos. days.

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL Cabrera - Id. DATE OF BURIAL Sept 22 1913

20. UNDERTAKER C. J. Vassar ADDRESS Leicester

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Form V. S. No. 5 20M.1-16-12

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH

Registration District No. 96

County of *Boise*

Primary Registration District No. 1009

City of *Lewiston*

(No. 602, 9th Ave St.)

File No. 5787

Registered No. 23

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME *Willton Edward Loon*

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX

4. COLOR OR RACE

5. SINGLE, MARRIED, WIDOWED OR DIVORCED.

M

W

Single
(Write the word.)

6. DATE OF BIRTH

May 30 1913
(Month) (Day) (Year)

7. AGE

.....yrs.mos.ds. *20*

IF LESS than 1 day
how manyhrs. or
.....mins?

8. OCCUPATION

(a) Trade, profession or particular kind of work

None

(b) General nature of industry business, or establishment in which employed (or employer)

9. BIRTHPLACE

(State or Country)

Lewiston

10. NAME OF FATHER

W. S. Coon

11. BIRTHPLACE OF FATHER

(State or Country)

Wis.

12. MAIDEN NAME OF MOTHER

Mary Louie

13. BIRTHPLACE OF MOTHER

(State or Country)

Idaho

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

C. J. Coon

(Address)

Lewiston

15.

Filed

Oct. 10 1913
C. J. Coon
Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH

Sept 20 1913
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from

Sept 20 1913, to *Sept 20 1913*,

that I last saw him alive on *Sept 20 1913*,

and that death occurred on the date stated above, at *11:00 AM*.

The CAUSE OF DEATH* was as follows:

Starvation

(Duration)yrs.mos.ds.

Contributory (Secondary)

marasmus

(Duration)yrs.mos.ds.

(Signed)

J. H. Hurler

M. D.

19. (Address) *Lewiston*

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of deathyrs.mos.days. In the Stateyrs.mos.days.

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

Lewiston

Sept 21 1913

20. UNDERTAKER

ADDRESS

C. J. Coon

Lewiston

MARGIN RESERVED FOR BINDING

WHITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Form V. S. No. 5 20M.1-16-12

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH.

Registration District No. 92

County of Nez Perce

Primary Registration District No. 1009

City of Lewiston

(No. 63, Snake river valley St.)

File No. 5785

Registered No. 24

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

Stewart David Hilton

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX

M.

4. COLOR OR RACE

W.

5. SINGLE, MARRIED, WIDOWED OR DIVORCED.

Single
(Write the word.)

6. DATE OF BIRTH

June 21 1913
(Month) (Day) (Year)

7. AGE

3 yrs. 3 mos. 3 ds.

IF LESS than 1 day
how many hrs. or mins.?

8. OCCUPATION

(a) Trade, profession or particular kind of work

None

(b) General nature of industry business, or establishment in which employed (or employer)

9. BIRTHPLACE

(State or Country)

10. NAME OF FATHER

Mr. P. Hilton

11. BIRTHPLACE OF FATHER

(State or Country)

Idaho Ida

12. MAIDEN NAME OF MOTHER

Laura E. Stewart

13. BIRTHPLACE OF MOTHER

(State or Country)

Oregon

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

(Address)

Lewiston

15.

Filed

Oct. 10

191 3

L. J. Perkins

Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH

Sept 22 1913
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from

Sept 22 1913, to Sept 22 1913

that I last saw him alive on Sept 22 1913

and that death occurred on the date stated above, at 8:30 PM

The CAUSE OF DEATH* was as follows:

Plumaine Poisoning

(Duration) 2 yrs. 2 mos. 2 ds.

Contributory (Secondary)

(Duration) 2 yrs. 2 mos. 2 ds.

(Signed)

Edgar H. White M. D.

Sept 22, 1913 (Address) Lewiston Ida

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death. 2 yrs. 2 mos. 2 days. In the State 2 yrs. 2 mos. 2 days.

Where was disease contracted if not at place of death?

Former or usual residence.

19. PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

Pullman Sept - 23 1913

20. UNDERTAKER

ADDRESS

C. J. Vassar Lewiston

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Form V. S. No. 5. 12½ M. 7-24-11

CERTIFICATE OF DEATH

1. PLACE OF DEATH.
County of My Peru
City of Lewiston

Registration District No. 96
Primary Registration District No. 1089
(No. _____, _____ St.)

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics
File No. 5789
Registered No. 26

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Jane Towanda

If death occurred in a hospital, institution or camp give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX Female 4. COLOR OR RACE White 5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.)

6. DATE OF BIRTH 29 May 1913
(Month) (Day) (Year)

7. AGE 3 mos. 30 ds. IF LESS than 1 day how many _____ hrs. or _____ min?

8. OCCUPATION
(a) Trade, profession or particular kind of work.
(b) General nature of industry business or establishment in which employed (or employer)

9. BIRTHPLACE Lewiston Idaho
(State or Country)

10. NAME OF FATHER Geo. Towanda

11. BIRTHPLACE OF FATHER Id.
(State or Country)

12. MAIDEN NAME OF MOTHER Olivia Lewis

13. BIRTHPLACE OF MOTHER Kan
(State or Country)

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Geo. Towanda
(Address) Lewiston Idaho

15. Filed Oct. 10 1913 L. G. Perkins
Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH Sept. 28 1913
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from June 1913, to Sept 28 1913 that I last saw her alive on Sept 28 1913 and that death occurred on the date stated above, at 4 P. M.

THE CAUSE OF DEATH* was as follows:
Quarantine

(Duration) _____ yrs. 4 mos. _____ ds.
Contributory Quarantine - interesting case
(Secondary)

(Duration) _____ yrs. _____ mos. _____ ds.
(Signed) L. G. Perkins M. D.
Sept 29 1913 (Address) Lewiston, Ida

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place _____ yrs. _____ mos. _____ ds. In the _____ State _____ yrs. _____ mos. _____ ds.
of death. _____
Where was disease contracted, _____
If not at place of death? _____
Former or _____
usual residence. _____

19. PLACE OF BURIAL OR REMOVAL Green, Idaho DATE OF BURIAL Sept 29 1913

20. UNDERTAKER H. P. Merchant ADDRESS Perkins Wn.

Form V. S. No. 5 20M.1-16-12

CERTIFICATE OF DEATH

 State of Idaho
 BOARD OF HEALTH
 Bureau of Vital Statistics

1. PLACE OF DEATH.

Registration District No. 96County of BozemanPrimary Registration District No. 1009City of Leaverton(No. 7315, Main St.)File No. 57911Registered No. 26

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

Geo. A. Manning

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX

M

4. COLOR OR RACE

W

5. SINGLE, MARRIED, WIDOWED OR DIVORCED.

married
(Write the word.)

6. DATE OF BIRTH

Nov. 21 1936
 (Month) (Day) (Year)

7. AGE

76 yrs. 10 mos. 9 ds.
 IF LESS than 1 day
 how many hrs. or
 mins.?

8. OCCUPATION

(a) Trade, profession or particular kind of work

retired

(b) General nature of industry business, or establishment in which employed (or employer)

9. BIRTHPLACE

(State or Country)

Maine

10. NAME OF FATHER

not known

11. BIRTHPLACE OF FATHER

(State or Country)

" "

12. MAIDEN NAME OF MOTHER

" "

13. BIRTHPLACE OF MOTHER

(State or Country)

" "

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

Nathan Branch

(Address)

Leaverton Idaho

15.

Filed

Oct 101913P. J. Berken

Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH

Sept 25 1913
 (Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from

Sept 10 1913, to Sept 25 1913,
 that I last saw him alive on Sept 25 1913,
and that death occurred on the date stated above, at 4 P.M.

The CAUSE OF DEATH* was as follows:

barren of stomach(Duration) yrs. six mos. ds.Contributory
(Secondary)

(Duration) yrs. mos. ds.

(Signed)

M. D.
19 (Address) Leaverton Idaho

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death yrs. mos. days. In the State yrs. mos. days.

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

Leaverton IdaSept 30 1913

20. UNDERTAKER

ADDRESS

J. D. Dassar

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Form V. S. No. 5 20M.1-16-12

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH

Registration District No. 96

County of Nez Perce

Primary Registration District No. 1009

City of Lewiston

(No. 1528, 15th Ave St.)

File No. 5791

Registered No. 27

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

Violet Skelton

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX

F

4. COLOR OR RACE

W

5. SINGLE, MARRIED, WIDOWED OR DIVORCED.

Widow
(Write the word.)

6. DATE OF BIRTH

Sept 29 1 47
(Month) (Day) (Year)

7. AGE

46 yrs. 11 mos. 20 ds.

IF LESS than 1 day
how many hrs. or
..... mins.?

8. OCCUPATION

(a) Trade, profession or particular kind of work

none

(b) General nature of industry business, or establishment in which employed (or employer)

9. BIRTHPLACE

(State or Country)

not known

10. NAME OF FATHER

Henry Killen

11. BIRTHPLACE OF FATHER

(State or Country)

not known

12. MAIDEN NAME OF MOTHER

Francis Henry

13. BIRTHPLACE OF MOTHER

(State or Country)

not known

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

J. H. Hasser

(Address)

Lewiston

15.

Filed

Oct 10

1913

R. G. Perkins

Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH

Sept 21st 1913
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from

Sept 18th 1913, to Sept 21st 1913

that I last saw her alive on Sept 21st 1913

and that death occurred on the date stated above, at 1:30 P.M.

The CAUSE OF DEATH* was as follows:

Pleuro Pneumonia

(Duration) yrs. mos. 4 ds.

Contributory
(Secondary)

Chronic Bronchitis

(Duration) 2 yrs. mos. ds.

(Signed)

Edgar L. White M. D.

Sept 21/1913 (Address) Lewiston Ida

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death yrs. mos. days. In the State yrs. mos. days.

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

Lewiston Ida

Sept 23 1913

20. UNDERTAKER

ADDRESS

J. H. Hasser

143-9th St

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Form V. S. No. 5. 12½ M. 7-24-11

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH. Registration District No.
County of Canyon Primary Registration District No.
City of New Plymouth (No., St.)

File No. 5793
Registered No.

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

unnamed

If death occurred in a hospital, institution or camp give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX Girl 4. COLOR OR RACE White 5. SINGLE, MARRIED, WIDOWED OR DIVORCED. Infant
(Write the word.)

6. DATE OF BIRTH September 2 1913
(Month) (Day) (Year)

7. AGE ½ hour IF LESS than 1 day
how many... hrs. or min?
yrs. mos. ds. 30 min?

8. OCCUPATION

- (a) Trade, profession or particular kind of work
(b) General nature of industry business or establishment in which employed (or employer)

Infant

9. BIRTHPLACE

(State or Country)

New Plymouth Ida.

10. NAME OF FATHER

John A. Whittier

11. BIRTHPLACE OF FATHER

(State or Country)

Minnesota

12. MAIDEN NAME OF MOTHER

Ruth Lucile Ballou

13. BIRTHPLACE OF MOTHER

(State or Country)

Nebraska

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

(Address)

Crispin Wright
Fruitland, Ida.

15.

Filed 191

Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH

September 2nd 1913
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from Arrived 2 hours after child was dead 1913
that I last saw h. alive on September 2nd 1913

and that death occurred on the date stated above, at 2:30 a.m.

The CAUSE OF DEATH* was as follows:

Asphyxia, or Congenital deformity - Failure of Forebrain vessels of Heart to close

(Duration) yrs. mos. ds.

Contributory (Secondary)

Chf. Palate & Hair Lip 30 minutes

(Duration) yrs. mos. ds.

(Signed)

Crispin Wright M. D.

9/2 1913 (Address) Fruitland, Ida.

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place

In the

of death... yrs. mos. ds. State... yrs. mos. ds.

Where was disease contracted,

If not at place of death?

Former or

usual residence.

19. PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

Sept 3 1913

20. UNDERTAKER

ADDRESS

Had none.

Form V. S. No. 5 20M.1-16-12

CERTIFICATE OF DEATH

State of Idaho
BUREAU OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH.

Registration District No.

County of *Canyon*

Primary Registration District No.

City of *New Plymouth* (No. St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

*Emily Dorothy*File No. *579*Registered No.
If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX

Female

4. COLOR OR RACE

White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED.

Married
(Write the word.)

6. DATE OF BIRTH

June 27 1841
(Month) (Day) (Year)

7. AGE

*72 yrs. 2 mos. 8 ds.*IF LESS than 1 day
how many hrs. or
..... mins.?

8. OCCUPATION

(a) Trade, profession or particular kind of work

(b) General nature of industry, business, or establishment in which employed (or employer)

Housewife

9. BIRTHPLACE

(State or Country)

His cousin

10. NAME OF FATHER

Dayton

11. BIRTHPLACE OF FATHER

(State or Country)

His cousin

12. MAIDEN NAME OF MOTHER

Not known

13. BIRTHPLACE OF MOTHER

(State or Country)

Not known

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) *Mrs. Will Hurre*(Address) *New Plymouth Ida.*

15.

Filed *191**Wm. J. Dupdale*
Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH

Sept 5 1913
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from

*Aug 23 1913, to Sept 5 1913,*that I last saw him alive on *Sept 5 1913,*and that death occurred on the date stated above, at *9:00 P.M.*

The CAUSE OF DEATH* was as follows:

Broncho pneumonia

(Duration) yrs. mos. ds.

Contributory (Secondary)

(Duration) yrs. mos. ds.

(Signed)

*Wm. J. Dupdale M.D.**Sept 5 1913 (Address) New Plymouth Ida.*

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death yrs. mos. days. In the State yrs. mos. days.

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL DATE OF BURIAL

New Plymouth Ida Sept 8 1913

20. UNDERTAKER

ADDRESS

Wm. J. Dupdale

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Form V. S. No. 5 20M.1-16-12

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics
File No. **579+**

1. PLACE OF DEATH.

Registration District No. **77**

County of **Freemont**

Primary Registration District No. **2176**

City of **Chapin**

(No. _____)

(St. _____)

Registered No. **6**

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME **Elfonso Penfold**

PERSONAL AND STATISTICAL PARTICULARS

3. SEX **Male**

4. COLOR OR RACE **White**

5. SINGLE, MARRIED, WIDOWED OR DIVORCED **Married**

6. DATE OF BIRTH **Jan 14 1898**

(Month)

(Day)

(Year)

7. AGE **15 yrs 5 mos 22 ds**

IF LESS than 1 day
how many _____ hrs. or
_____ mins.

8. OCCUPATION

(a) Trade, profession or particular kind of work

(b) General nature of industry, business, or establishment in which employed (or employer)

9. BIRTHPLACE

(State or Country) **Chapin Idaho**

10. NAME OF FATHER **Farley Penfold**

11. BIRTHPLACE OF FATHER **Idaho**

(State or Country)

12. MAIDEN NAME OF MOTHER **Phoebe Nelson**

13. BIRTHPLACE OF MOTHER **Idaho**

(State or Country)

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) **x Farley Penfold**

(Address) **Chapin Idaho**

15. Filed **July 9 - 1913**

1913

M. P. Crisler
Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH **July 6 1913**

(Month)

(Day)

(Year)

17. I HEREBY CERTIFY, That I attended deceased from **May 10 1913**, to **July 2 1913**

that I last saw him alive on **July 2 1913**

and that death occurred on the date stated above, at **5 p.m.**

The CAUSE OF DEATH* was as follows:

Rheumatic infection complicated by leakage of the heart

(Duration) **2 yrs 2 mos** ds.

Contributory **Failure of compensation**
(Secondary) **of action of heart**

(Duration) **2 yrs 2 mos** ds.

(Signed) **David L. Redding M. D.**

19 **357 W. 3rd St. Boise City** (Address)

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death _____ yrs _____ mos _____ days. In the State _____ yrs _____ mos _____ days.

Where was disease contracted if not at place of death?

Former or usual residence _____

19. PLACE OF BURIAL OR REMOVAL **Victor Idaho**

DATE OF BURIAL **7 8 1913**

20. UNDERTAKER **Chapin Idaho**

ADDRESS **Dr 1990**

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Form V. S. No. 5 20M.1-16-12

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH.

Registration District No. 77

County of Sevier

Primary Registration District No. 2176

City of Ellettsville

(No. St.)

File No. 5795

Registered No. 2

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Lovell Ramdell

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX

4. COLOR OR RACE

5. SINGLE, MARRIED, WIDOWED OR DIVORCED.

Male White Single (Write the words)

6. DATE OF BIRTH

July 8 1892
(Month) (Day) (Year)

7. AGE

21 yrs. 3 mos. 28 ds.

IF LESS than 1 day
how many hrs. or
..... mins.?

8. OCCUPATION

(a) Trade, profession or particular kind of work
(b) General nature of industry, business, or establishment in which employed (or employer)

9. BIRTHPLACE

(State or Country)

Utah

10. NAME OF FATHER

George J. Ramdell

11. BIRTHPLACE OF FATHER

(State or Country)

Utah

12. MAIDEN NAME OF MOTHER

Josephine Nickerson

13. BIRTHPLACE OF MOTHER

(State or Country)

Utah

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

(Address)

George J. Ramdell
Ellettsville

15.

Filed

June 6 - 1913 M. P. Crisler

Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

June 6 1913
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from

191, to 191,
that I last saw h alive on 191,
and that death occurred on the date stated above, at M.
The CAUSE OF DEATH* was as follows:

Stroke
(Duration) yrs. mos. ds.
Contributory (Secondary)
(Duration) yrs. mos. ds.
(Signed) M. D.
19 (Address)

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death yrs. mos. days. In the State yrs. mos. days.

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

Ellettsville, Idaho June 8 1913

20. UNDERTAKER

ADDRESS

Telepherrington Triggo

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Form V. S. No. 5 20M.1-16-12

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH.

Registration District No. 77

County of Franklin

Primary Registration District No. 2176

City of Idaho

(No. _____ St.)

File No. 5796

Registered No. 3

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Robert Leroy Fulmer

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX

4. COLOR OR RACE

5. SINGLE, MARRIED, WIDOWED OR DIVORCED.

Male

White

Married
(Write the word.)

6. DATE OF BIRTH

October
(Month)

14
(Day)

1870
(Year)

7. AGE

41 yrs. 8 mos. 2 ds.

IF LESS than 1 day
how many _____ hrs. or
_____ mins.?

8. OCCUPATION

(a) Trade, profession or particular kind of work

(b) General nature of industry business, or establishment in which employed (or employer)

Farmer

9. BIRTHPLACE

(State or Country)

Utah

10. NAME OF FATHER

Shelby Lewis Fulmer

11. BIRTHPLACE OF FATHER

(State or Country)

Illinois

12. MAIDEN NAME OF MOTHER

Jane E. Griffiths

13. BIRTHPLACE OF MOTHER

(State or Country)

England

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Jane E. Horchotrasser

(Address) Idaho

15.

Filed June 6 1913

M. P. Crisler

Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH

June
(Month)

6
(Day)

1913
(Year)

17. I HEREBY CERTIFY, That I attended deceased from

1913, to

1913,

that I last saw him alive on 1913,

and that death occurred on the date stated above, at M.

The CAUSE OF DEATH* was as follows:

Struck by Automobile

(Duration) _____ yrs. _____ mos. _____ ds.

Contributory (Secondary)

(Duration) _____ yrs. _____ mos. _____ ds.

(Signed)

M. D.

19 _____ (Address)

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL OR HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death _____ yrs. _____ mos. _____ days. In the State _____ yrs. _____ mos. _____ days.

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

June 8 1913

20. UNDERTAKER

ADDRESS

McKerningston

Idaho

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Form V. S. No. 5 20M.1-16-12

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH.

Registration District No. 77

County of Blaine

Primary Registration District No. 2176

City of Briggs

(No. St.)

File No. 579

Registered No. 4

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Arthur Lincoln Hansen

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX Male

4. COLOR OR RACE White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED. Single
(Write the word.)

6. DATE OF BIRTH April 22 1908
(Month) (Day) (Year)

7. AGE 5 yrs. 5 mos. 03 ds.

IF LESS than 1 day
how many hrs. or
 mins.?

8. OCCUPATION

- (a) Trade, profession or particular kind of work
(b) General nature of industry business, or establishment in which employed (or employer)

9. BIRTHPLACE Idaho
(State or Country)

10. NAME OF FATHER Alma Hansen

11. BIRTHPLACE OF FATHER Utah
(State or Country)

12. MAIDEN NAME OF MOTHER Maria S. Hagensen

13. BIRTHPLACE OF MOTHER Norway
(State or Country)

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

(Address) Idaho

15.

Filed Sept. 26- 1913

M. P. Crisler
Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH Sept 25 1913
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from July 19 1913, to July 20 1913, that I last saw him alive on July 20 1913, and that death occurred on the date stated above, at M.

The CAUSE OF DEATH* was as follows:

mitral insufficiency and nephritis

(Duration) 6 yrs. 6 mos. ds.

Contributory (Secondary)

(Duration) yrs. mos. ds.

(Signed) Wm. A. Keist M. D.

Sept 26 1913 (Address) Briggs

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death yrs. mos. days. In the State yrs. mos. days.

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL Idaho

DATE OF BURIAL Sept 26 1913

20. UNDERTAKER Cherrington

ADDRESS Briggs

Form V. S. No. 5 20M.1-16-12

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH.

Registration District No. 77County of ShoshonePrimary Registration District No. 2176City of Idaho

(No. _____ St.)

File No. 5795Registered No. 5

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

Ellen Peradalla Rato

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX

Female

4. COLOR OR RACE

White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED

Widow

6. DATE OF BIRTH

March 18 1892
(Month) (Day) (Year)

7. AGE

21 yrs. 6 mos. 7 ds.IF LESS than 1 day
how many hrs. or
..... mins.?

8. OCCUPATION

(a) Trade, profession or particular kind of work

Housewife

(b) General nature of industry business, or establishment in which employed (or employer)

9. BIRTHPLACE

(State or Country)

Idaho

10. NAME OF FATHER

Charles Josephson

11. BIRTHPLACE OF FATHER

(State or Country)

Sweden

12. MAIDEN NAME OF MOTHER

Anna Isaacson

13. BIRTHPLACE OF MOTHER

(State or Country)

Sweden

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

Ellen Peradalla Rato

(Address)

Idaho

15.

Filed Sept. 26 - 1913M. P. Crisler

Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH

Sept 25 1913
(Month) (Day) (Year)17. I HEREBY CERTIFY, That I attended deceased from Sept. 25 1913, to Sept. 25 1913, that I last saw her alive on Sept. 25 1913, and that death occurred on the date stated above, at 9 P. M.

The CAUSE OF DEATH* was as follows:

puerperal eclampsia(Duration) yrs. mos. one ds.Contributory
(Secondary)

(Duration) yrs. mos. ds.

(Signed) Chas. D. Smith M. D.Sept. 26 1913 (Address) Driggs

*State the DISEASE CAUSING DEATH; or in deaths from VICIOUS CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death yrs. mos. days. In the State yrs. mos. days.

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

Idaho Sept 28 1913

20. UNDERTAKER

ADDRESS

Cherrington Driggs

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Form V. S. No. 5 20M.1-16-12

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH.

Registration District No. 4County of CanyonPrimary Registration District No. 1008City of Taiyette(No. Charles Fredrick Shouz St.)File No. 580Registered No. 99

If death occurs away from usual residence, give facts called for under special instruction.

2. FULL NAME

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX

4. COLOR OR RACE

5. SINGLE, MARRIED, WIDOWED OR DIVORCED.

6. DATE OF BIRTH

7. AGE

IF LESS than 1 day
how many hrs. or
..... mins.?

8. OCCUPATION

(a) Trade, profession or particular kind of work
(b) General nature of industry, business, or establishment in which employed (or employer)

9. BIRTHPLACE

(State or Country)

10. NAME OF FATHER

11. BIRTHPLACE OF FATHER

(State or Country)

12. MAIDEN NAME OF MOTHER

13. BIRTHPLACE OF MOTHER

(State or Country)

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

(Address)

15.

Filed

1913

Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH

17. I HEREBY CERTIFY, That I attended deceased from

Sept 10 1913, to Sept 13 1913,

that I last saw him alive on Sept 13 1913,

and that death occurred on the date stated above, at 8 P. M.

The CAUSE OF DEATH* was as follows:

Enterocolitis

(Duration) yrs. mos. 7 ds.

Contributory

(Secondary)

(Duration) yrs. mos. ds.

(Signed)

9/14/1913 (Address) Payette Ida.

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death yrs. mos. days. In the State yrs. mos. days.

Where was disease contracted if not at place of death?

Former or usual residence.

19. PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

Payette Ida Sept 14 1913

20. UNDERTAKER

ADDRESS

H. Adair Payette Ida

1. PLACE OF DEATH.

Registration District No.

County of Guster

Primary Registration District No.

City of Challis

(No., St.)

File No. 5801Registered No. 38

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

Baby Cee

If death occurred in a hospital, institution or camp give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX

4. COLOR OR RACE

5. SINGLE, MARRIED, WIDOWED OR DIVORCED.

male white Single
(Write the word.)

6. DATE OF BIRTH

Aug 7 1913
(Month) (Day) (Year)

7. AGE

IF LESS than 1 day
how many hrs. or
..... min?

8. OCCUPATION

- (a) Trade, profession or particular kind of work
-
- (b) General nature of industry business or establishment in which employed (or employer)

None

9. BIRTHPLACE

(State or Country)

Ida.

10. NAME OF FATHER

11. BIRTHPLACE OF FATHER

(State or Country)

Jno. Carr
Ida.

12. MAIDEN NAME OF MOTHER

13. BIRTHPLACE OF MOTHER

(State or Country)

Minne Blume
Ida.

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

(Address)

Jno. Carr
Challis

15.

Filed Oct 10th 1913

Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH

Aug 7 1913
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from

191 to 191
that I last saw him alive on Aug 7 1913
and that death occurred on the date stated above, at 10:10 AM.

The CAUSE OF DEATH* was as follows:

Malformation of
neck & throat.(Duration) yrs. mos. ds. 10 min.Contributory
(Secondary)

(Duration) yrs. mos. ds.

(Signed) J. W. Kelley M. D.Aug 7 1913 (Address) Challis

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place yrs. mos. ds. In the
of death. yrs. mos. ds. State. yrs. mos. ds.

Where was disease contracted,

If not at place of death?

Former or

usual residence.

19. PLACE OF BURIAL OR REMOVAL DATE OF BURIAL

Challis, IdaAug 8th 1913

20. UNDERTAKER

ADDRESS

familyChallis

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH

Registration District No. 11

County of Tannock

Primary Registration District No. 2048

City of Bancroft

(No. _____)

St. _____

Registered No. 44

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

George Washington McPhellan

If death occurred in a hospital, institution or camp give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX

M

4. COLOR OR RACE

W

5. SINGLE, MARRIED, WIDOWED OR DIVORCED.

Single
(Write the word.)

6. DATE OF BIRTH

Feb

24

1901

(Month)

(Day)

(Year)

7. AGE

12 yrs. 5 mos. 23 ds.

IF LESS than 1 day
how many hrs. or
..... min.?

8. OCCUPATION

- (a) Trade, profession or particular kind of work none
- (b) General nature of industry business or establishment in which employed (or employer)

9. BIRTHPLACE

(State or Country)

Bancroft

10. NAME OF FATHER

Washington McPhellan

11. BIRTHPLACE OF FATHER

(State or Country)

England

12. MAIDEN NAME OF MOTHER

Sarah M.

13. BIRTHPLACE OF MOTHER

(State or Country)

Utah

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

Washington McPhellan

(Address)

Bancroft.

15.

Filed Aug 16, 1913

Elias Kasey

Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

Aug 16

1913

(Month)

(Day)

(Year)

17. I HEREBY CERTIFY, That I attended deceased from

Aug 15 1913, to Aug 15 1913

that I last saw him alive on Aug 15 1913

and that death occurred on the date stated above, at 7 A. M.

The CAUSE OF DEATH* was as follows:

Vedema Glottidis

(Duration)

yrs.

mos.

ds.

Contributory (Secondary)

Suppurative tonsillitis

(Duration)

yrs.

mos.

ds.

(Signed)

J. R. Smith

Aug 16, 1913

(Address)

Bancroft

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place

In the

of death yrs. mos. ds. State yrs. mos. ds.

Where was disease contracted,

If not at place of death?

Former or

usual residence.

19. PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

Bancroft

Aug 16 1913

20. UNDERTAKER

ADDRESS

Bancroft

Bancroft

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. PH. N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PH. CIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Form V. S. No. 5 20M.1-16-12

CERTIFICATE OF DEATH

 State of Idaho
 BOARD OF HEALTH
 Bureau of Vital Statistics

1. PLACE OF DEATH.

Registration District No. 11

County of Blaine

Primary Registration District No. 2048

City of Lund

(No. 11, St.)

File No. 580

Registered No. 43

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

Lawney Helch

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX

M

4. COLOR OR RACE

W

5. SINGLE, MARRIED, WIDOWED OR DIVORCED.

(Write the word.)

6. DATE OF BIRTH

 Sept 28 1913
 (Month) (Day) (Year)

7. AGE

yrs. mos. 2 ds.

 IF LESS than 1 day
 how many hrs. or mins.

8. OCCUPATION

- (a) Trade, profession or particular kind of work
 (b) General nature of industry business, or establishment in which employed (or employer)

9. BIRTHPLACE

(State or Country) Idaho

10. NAME OF FATHER

Judson C. Welch

11. BIRTHPLACE OF FATHER

(State or Country) Utah

12. MAIDEN NAME OF MOTHER

Emma Hansen

13. BIRTHPLACE OF MOTHER

(State or Country) Utah

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

Judson C. Welch

(Address)

Lund, Ida

15.

Filed

Oct 10, 1913

1913

O. K. Karg

Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH

 Sept 30 1913
 (Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from Sept 28 1913, to Sept 30 1913,

that I last saw him alive on Sept 29 1913,

and that death occurred on the date stated above, at 9:30 P.M.

The CAUSE OF DEATH* was as follows:

Convulsions

(Duration) yrs. mos. ds.

Contributory (Secondary) Instrumental delivery

(Duration) yrs. mos. ds.

(Signed) M. D.

Oct 2, 1913 (Address) Blaine, Ida.

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death. yrs. mos. days. In the State. yrs. mos. days.

Where was disease contracted if not at place of death?

Former or usual residence.

19. PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

Lund

Oct 1, 1913

20. UNDERTAKER

ADDRESS

Hans Johnson

Blaine

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Form V. S. No. 5 20M.1-16-12

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH

Registration District No. 2085County of Twin Falls

Primary Registration District No. _____

City of (No. St.)File No. 5807

Registered No. _____

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

Eldon Mullins

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX

4. COLOR OR RACE

5. SINGLE, MARRIED, WIDOWED OR DIVORCED.

MWSingle

6. DATE OF BIRTH

Sept 22 1911
(Month) (Day) (Year)

7. AGE

1 yrs. 4 mos. 27 ds.IF LESS than 1 day
how many hrs. or mins.?

8. OCCUPATION

(a) Trade, profession or particular kind of work

farmer's son

(b) General nature of industry business, or establishment in which employed (or employer)

9. BIRTHPLACE

(State or Country)

Idaho

10. NAME OF FATHER

Chas. H. Mullins

11. BIRTHPLACE OF FATHER

(State or Country)

Ark.

12. MAIDEN NAME OF MOTHER

Tranny Logsdon

13. BIRTHPLACE OF MOTHER

(State or Country)

Wash.

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

(Address)

Chas. H. Mullins
Twin Falls R.R.D. 1

15.

Filed

9-201913John H. Brigham
Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH

9 19 1913
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from

9/15/1913 to 9/18/1913that I last saw him alive on 9/18/1913and that death occurred on the date stated above, at 9 A. M.

The CAUSE OF DEATH* was as follows:

acute gastritis(Duration) yrs. mos. 5 1/2 ds.Contributory
(Secondary)

(Duration) yrs. mos. ds.

(Signed) C. D. Weaver M. D.7/29/1913 (Address) Twin Falls, Ida.

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death yrs. mos. days. In the State yrs. mos. days.

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

Twin FallsSept 20 1913

20. UNDERTAKER

ADDRESS

J. J. GrosvanTwin Falls

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Form V. S. No. 5 20M.1-16-12

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH _____ Registration District No. 1085
County of Twins Falls Primary Registration District No. _____
City of Idaho Falls (No. _____, St.)

File No. 5805

Registered No. _____

If death occurs away from usual residence, give facts called for under special information.

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Maxwell P Davis

PERSONAL AND STATISTICAL PARTICULARS

3. SEX M 4. COLOR OR RACE W 5. SINGLE, MARRIED, WIDOWED OR DIVORCED. Single

6. DATE OF BIRTH March 14 1915
(Month) (Day) (Year)

7. AGE 8 yrs. 5 mos. 27 ds. IF LESS than 1 day how many hrs. or mins.?

8. OCCUPATION

(a) Trade, profession or particular kind of work Farm
(b) General nature of industry, business, or establishment in which employed (or employer)

9. BIRTHPLACE

(State or Country) Washington10. NAME OF FATHER Fred E Davis11. BIRTHPLACE OF FATHER Wisconsin

(State or Country)

12. MAIDEN NAME OF MOTHER Rosa B Bales13. BIRTHPLACE OF MOTHER Mo.

(State or Country)

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Fred E Davis(Address) Burley

15.

Filed 9-11 1913Local Registrar Arthur Hughes

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH Sept 11 1913
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from Sept 7 1913 to Sept 11 1913
that I last saw him alive on Sept 11 1913

and that death occurred on the date stated above, at Idaho Falls

The CAUSE OF DEATH* was as follows:

fracture base of skull
result of horse kick

(Duration) _____ yrs. _____ mos. _____ ds.

Contributory (Secondary)

(Duration) _____ yrs. _____ mos. _____ ds.

(Signed) W. J. G. Smith M. D.19 _____ (Address) Idaho Falls Idaho

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death _____ yrs. _____ mos. _____ days. In the State _____ yrs. _____ mos. _____ days.

Where was disease contracted if not at place of death?

Former or usual residence _____

19. PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

Burley Ida Sept 13 1913

20. UNDERTAKER

ADDRESS

J. J. Groenman Twins Falls

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Form V. S. No. 5 20M.1-16-12

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH. Registration District No. 1085
County of Twins Falls Primary Registration District No. _____
City of Idaho Falls (No. _____ St.)

File No. 5806

Registered No. _____

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Lula S Myers

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX Female 4. COLOR OR RACE White 5. SINGLE, MARRIED, WIDOWED OR DIVORCED Married
(Make the words.)

6. DATE OF BIRTH Jan 7 1880
(Month) (Day) (Year)

7. AGE 33 yrs. 8 mos. 8 ds.
IF LESS than 1 day how many hrs. or mins.?

8. OCCUPATION
(a) Trade, profession or particular kind of work House wife
(b) General nature of industry, business, or establishment in which employed (or employer)

9. BIRTHPLACE Missouri
(State or Country)

10. NAME OF FATHER Jacob D Miller

11. BIRTHPLACE OF FATHER Missouri
(State or Country)

12. MAIDEN NAME OF MOTHER Eliza Sloop

13. BIRTHPLACE OF MOTHER Missouri
(State or Country)

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Joseph E Myers

(Address) Idaho Falls

15. John E. Hughes

Filed 9-15 1913 Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH Sept 15 1913
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from Sept 6 1913, to Sept 15 1913, that I last saw him alive on Sept 15 1913, and that death occurred on the date stated above, at 3 P M.

The CAUSE OF DEATH* was as follows:

Splenic mar

(Duration) _____ yrs. _____ mos. 20 ds.

Contributory (Secondary)

(Duration) _____ yrs. _____ mos. _____ ds.

(Signed) John E. Hughes M. D.

Sept 17 1913 (Address) Idaho Falls

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death _____ yrs. _____ mos. _____ days. In the State _____ yrs. _____ mos. _____ days.

Where was disease contracted if not at place of death?

Former or usual residence _____

19. PLACE OF BURIAL OR REMOVAL DATE OF BURIAL

Idaho Falls Sept 16 1913

20. UNDERTAKER ADDRESS

J. P. Grossman Idaho Falls

TRUMAN O. BOYD, M.D.
TWIN FALLS, IDAHO

Twin Falls, Idaho, Nov. 22, 1913

Ralph J. Falk,
Boise, Idaho.

Dear Sir:

Replying to your favor of November 21st.

Death of David Bear, September 29th, 1913. Cause of his death was
Lobar pneumonia.

Lula S. Meyers died September 15th, 1913, cause streptococcus ^{*Infection*} which
entered the system through an abrasion in the upper jaw, which ~~was~~ caused
from a bad fitting plate.

Abraham Bledsoe died May 23th, 1913, cause streptococcus infection
which entered the system through a small gash in the index finger of the
right hand.

Yours very truly,

Truman O. Boyd

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Form V. S. No. 5 20M.1-16-12

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH. Registration District No. 1085
County of Twin Falls Primary Registration District No. _____
City of Holister (No. _____ St.)

File No. 5807

Registered No. _____

If death occurs away from usual residence, give facts called for under special information.

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Rustine E. Gross

PERSONAL AND STATISTICAL PARTICULARS

3. SEX M 4. COLOR OR RACE W 5. SINGLE, MARRIED, WIDOWED OR DIVORCED. Married

6. DATE OF BIRTH

Feb. 16 1898
(Month) (Day) (Year)

7. AGE

62 yrs. 6 mos. 20 ds.

IF LESS than 1 day
how many _____ hrs. or
_____ mins.?

8. OCCUPATION

(a) Trade, profession or particular kind of work

Farmer

(b) General nature of industry business, or establishment in which employed (or employer)

9. BIRTHPLACE

(State or Country)

Illinois

10. NAME OF FATHER

John C. Gross

11. BIRTHPLACE OF FATHER

(State or Country)

Pa.

12. MAIDEN NAME OF MOTHER

Elizabeth Eberly

13. BIRTHPLACE OF MOTHER

(State or Country)

Pa.

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

Mrs. R. E. Gross

(Address)

Holister

15.

Filed

9-12

1913

John C. Gross
Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH

Sept. 11th 1913
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from

May 1913 to Sept. 1913

that I last saw him alive on Sept. 9 1913

and that death occurred on the date stated above, at 6:30 AM

The CAUSE OF DEATH* was as follows:

Rheumatic Carditis

not known
(Duration) _____ yrs. _____ mos. _____ ds.

Contributory
(Secondary)

not known
(Duration) _____ yrs. _____ mos. _____ ds.

(Signed)

Sept. 11 1913 (Address) Holister, Idaho

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death _____ yrs. _____ mos. _____ days. In the State _____ yrs. _____ mos. _____ days.

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

Twin Falls Sept 14 1913

20. UNDERTAKER

ADDRESS

J. J. Grossman Twin Falls
Idaho

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Form V. S. No. 5 20M.1-16-12

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH Registration District No. 1085
County of Twin Falls Primary Registration District No. _____
City of " " (No. _____ St.)

File No. 5808
Registered No. _____

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Mrs M. J. Wicker

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX Female 4. COLOR OR RACE White 5. SINGLE, MARRIED, WIDOWED OR DIVORCED. Widowed

6. DATE OF BIRTH Sept 22nd 1825
(Month) (Day) (Year)

7. AGE 87 yrs. 11 mos. 14 ds. IF LESS than 1 day how many _____ hrs. or _____ mins.?

8. OCCUPATION
(a) Trade, profession or particular kind of work None
(b) General nature of industry business, or establishment in which employed (or employer) _____

9. BIRTHPLACE (State or Country) Kentucky

10. NAME OF FATHER M. C. Dineen

11. BIRTHPLACE OF FATHER (State or Country) Unknown and no record

12. MAIDEN NAME OF MOTHER Unknown and no record

13. BIRTHPLACE OF MOTHER (State or Country) Unknown and no record

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) H. W. Eggleston
(Address) Twin Falls, Ida

15. Filed 9-2 1913 John B. Fisher Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH Sept. 1 1913
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from Aug 1 1913, to Sept 1 1913, that I last saw him alive on Aug. 15 1913 and that death occurred on the date stated above, at 2 pm M.

The CAUSE OF DEATH* was as follows:
Bronchopneumonia

(Duration) _____ yrs. _____ mos. 10 ds.

Contributory (Secondary) _____

(Duration) _____ yrs. _____ mos. _____ ds.

(Signed) H. W. Eggleston M. D.

Sept 2 1913 (Address) Twin Falls, Ida

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death _____ yrs. _____ mos. _____ days. In the State _____ yrs. _____ mos. _____ days.

Where was disease contracted if not at place of death? _____

Former or usual residence _____

19. PLACE OF BURIAL OR REMOVAL DATE OF BURIAL

Twin Falls Sept 2 1913

20. UNDERTAKER ADDRESS

E. J. Crosby Twin Falls

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
 N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Form V. S. No. 5 20M.1-16-12

CERTIFICATE OF DEATH

 State of Idaho
 BOARD OF HEALTH
 Bureau of Vital Statistics

File No. 5809

Registered No.

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

1. PLACE OF DEATH

Registration District No.

County of

Primary Registration District No.

City of

(No.)

St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

PERSONAL AND STATISTICAL PARTICULARS

3. SEX

4. COLOR OR RACE

5. SINGLE, MARRIED, WIDOWED OR DIVORCED

6. DATE OF BIRTH

7. AGE

53 yrs. mos. ds.

 IF LESS than 1 day
 how many hrs. or mins.

8. OCCUPATION

(a) Trade, profession or particular kind of work

(b) General nature of industry business, or establishment in which employed (or employer)

9. BIRTHPLACE

(State or Country)

10. NAME OF FATHER

11. BIRTHPLACE OF FATHER

(State or Country)

12. MAIDEN NAME OF MOTHER

13. BIRTHPLACE OF MOTHER

(State or Country)

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

(Address)

15.

Filed 4-30 1913

Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

(Month)

(Day)

1913

17. I HEREBY CERTIFY, That I attended deceased from

Sept 26 1913, to Sept 29 1913,

that I last saw him alive on Sept 29 1913,

and that death occurred on the date stated above, at P. M.

The CAUSE OF DEATH* was as follows:

 Pneumonia
 (Cholera)

(Duration) yrs. mos. 7 ds.

Contributory

(Secondary)

(Duration) yrs. mos. ds.

(Signed)

M. D.

9-29 1913 (Address) Twin Falls

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death yrs. mos. days. In the State yrs. mos. days.

Where was disease contracted if not at place of death?

Former or usual residence.

19. PLACE OF BURIAL OR REMOVAL DATE OF BURIAL

Bad Axe Mich. 1913

20. UNDERTAKER ADDRESS

J. J. Grossman Twin Falls

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Form V. S. No. 5 20M.1-16-12

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH Registration District No. 1085
County of Twin Falls Primary Registration District No. _____
City of " " (No. _____ St.)

File No. 5810
Registered No. _____

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

Joe Wolfe

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX Female 4. COLOR OR RACE White 5. SINGLE, MARRIED, WIDOWED OR DIVORCED. _____
(Write the word.)

6. DATE OF BIRTH May 6 1913
(Month) (Day) (Year)

7. AGE 4 yrs. 1 mos. 1 ds. IF LESS than 1 day how many hrs. or mins.?

8. OCCUPATION

- (a) Trade, profession or particular kind of work _____
(b) General nature of industry business, or establishment in which employed (or employer) _____

9. BIRTHPLACE

(State or Country)

Twin Falls

10. NAME OF FATHER

John H. Wolfe

11. BIRTHPLACE OF FATHER

(State or Country)

Ill

12. MAIDEN NAME OF MOTHER

Jennie Miller

13. BIRTHPLACE OF MOTHER

(State or Country)

Ill

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

John H. Wolfe

(Address)

Twin Falls

15.

Filed

9-211913

Robert Brighten
Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH

9 20 1913
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from 9/20/1913 to 9/20/1913, that I last saw her alive on 9/20/1913, and that death occurred on the date stated above, at 8 P.M.

The CAUSE OF DEATH* was as follows:

Cholera Infantum(Duration) yrs. mos. 2 ds.Contributory
(Secondary)

(Duration) yrs. mos. ds.

(Signed)

H. O. Parker

M. D.

9/24/1913 (Address) Twin Falls, Ida

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death yrs. mos. days. In the State yrs. mos. days.

Where was disease contracted if not at place of death?

Former or usual residence.

19. PLACE OF BURIAL OR REMOVAL DATE OF BURIAL

Twin Falls Cemetery Sept 21 1913

20. UNDERTAKER

ADDRESS

Grosby Twin Falls

Form V. S. No. 5 20M.1-16-12

CERTIFICATE OF DEATH

 State of Idaho
 BOARD OF HEALTH
 Bureau of Vital Statistics

1. PLACE OF DEATH.

Registration District No. 1085

County of Twin Falls

Primary Registration District No.

City of

(No. St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

Thomas B. Cross

Registered No.

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX

4. COLOR OR RACE

5. SINGLE, MARRIED, WIDOWED OR DIVORCED.

6. DATE OF BIRTH

7. AGE

 IF LESS than 1 day
 how many hrs. or
 mins.?

8. OCCUPATION

(a) Trade, profession or particular kind of work

(b) General nature of industry business, or establishment in which employed (or employer)

9. BIRTHPLACE

(State or Country)

10. NAME OF FATHER

11. BIRTHPLACE OF FATHER

(State or Country)

12. MAIDEN NAME OF MOTHER

13. BIRTHPLACE OF MOTHER

(State or Country)

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

(Address)

15.

Filed

9-27

1913

Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH

 9 26 1913
 (Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from

9/6/ 1913, to 9/26/ 1913

that I last saw him alive on 9/26/ 1913

and that death occurred on the date stated above, at 12 M.

The CAUSE OF DEATH* was as follows:

Chronic interstitial nephritis

(Duration) 7 yrs. mos. ds.

Contributory (Secondary)

(Duration) yrs. mos. ds.

(Signed) J. D. Weaver M. D.

19 (Address) Twin Falls, Ida.

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death. yrs. mos. days. In the State. yrs. mos. days.

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

Twin Falls

Sept 27 1913

20. UNDERTAKER

ADDRESS

J. D. Grossman Twin Falls

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Form V. S. No. 5 20M.1-16-12

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH
County of Idaho Falls
City of Idaho Falls

Registration District No. 1055
Primary Registration District No. _____
(No. _____ St.)

File No. 5812
Registered No. _____

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME E. C. Trebley

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX male 4. COLOR OR RACE White 5. SINGLE, MARRIED, WIDOWED OR DIVORCED. single
(Write the word.)

6. DATE OF BIRTH January 8th 1871
(Month) (Day) (Year)

7. AGE 42 yrs. 8 mos. 9 ds.
IF LESS than 1 day how many _____ hrs. or _____ mins.?

8. OCCUPATION
(a) Trade, profession or particular kind of work Farming
(b) General nature of industry business, or establishment in which employed (or employer) _____

9. BIRTHPLACE Ohio
(State or Country)

10. NAME OF FATHER Andrew H. Trebley

11. BIRTHPLACE OF FATHER Pennsylvania
(State or Country)

12. MAIDEN NAME OF MOTHER Elizabeth Kern

13. BIRTHPLACE OF MOTHER Ohio
(State or Country)

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) E. Kern

(Address) Burlington Junction Mo.

15. Filed 9-18 1913 Joseph C. Hughes
Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH Sept 17 1913
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from Sept 17 1913, to Sept 17 1913, that I last saw him alive on Sept 17 1913 and that death occurred on the date stated above, at 1 P. M.

The CAUSE OF DEATH* was as follows:

tuberculosis
(Duration) _____ yrs. _____ mos. _____ ds.

Contributory (Secondary) _____
(Duration) _____ yrs. _____ mos. _____ ds.
(Signed) H. W. Douchett M. D.
19 _____ (Address) Idaho Falls, Idaho

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death _____ yrs. _____ mos. _____ days. In the State _____ yrs. _____ mos. _____ days.
Where was disease contracted if not at place of death? _____

Former or usual residence _____

19. PLACE OF BURIAL OR REMOVAL Burlington Mo. DATE OF BURIAL 1913

20. UNDERTAKER G. Crosby ADDRESS Idaho Falls

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Form V. S. No. 5 20M.1-16-12

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH.

Registration District No. 10County of AdaPrimary Registration District No. 2002File No. 5813City of Eagle

(No. _____, St.)

Registered No. _____

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME George Russell Brashars

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX

4. COLOR OR RACE

5. SINGLE, MARRIED, WID-
OWED OR DIVORCED.Male WhiteSingle
(Write the word.)

6. DATE OF BIRTH

Oct
(Month)25
(Day)1913
(Year)

7. AGE

10 yrs. 19 mos. 19 ds.IF LESS than 1 day
how many hrs. or
..... mins.?

8. OCCUPATION

(a) Trade, profession or
particular kind of work(b) General nature of industry
business, or establishment in
which employed (or employer)

9. BIRTHPLACE

(State or Country)

Idaho10. NAME OF
FATHERGeorge Brashars11. BIRTHPLACE
OF FATHER

(State or Country)

Arkansas12. MAIDEN NAME
OF MOTHERMabel Atkins13. BIRTHPLACE
OF MOTHER

(State or Country)

Idaho

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

(Address)

G R Brashars
Eagle Idaho

15.

Filed

Sept 151913C R Bloom
Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH

9
(Month)14
(Day)1913
(Year)

17. I HEREBY CERTIFY, That I attended deceased from

9/8 1913, to 9/14 1913that I last saw him alive on 9/13 1913and that death occurred on the date stated above, at 12:30 A.M.

The CAUSE OF DEATH* was as follows:

Gastro Enteritis

(Duration) yrs. mos. ds.

Contributory
(Secondary)

(Duration) yrs. mos. ds.

(Signed) Fred A. Pittenger M. D.9/15 1913 (Address) Eagle Idaho

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death yrs. mos. days. In the State yrs. mos. days.

Where was disease contracted
if not at place of death?Former or
usual residence.

19. PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

Dry Creek Cemetery Sept 15 1913

20. UNDERTAKER

ADDRESS

Try & Sumner Bowling

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Form V. S. No. 5. 12½ M. 7-24-11

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH.

Registration District No. 47

County of Lewis

Primary Registration District No. 2124

City of Nezperce

(No. St.)

File No. 5814

Registered No. 3

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

Olga Eunice Clara Johnson

If death occurred in a hospital, institution or camp give its NAME instead of street and number.

PERSONAL AND STATISTICAL PART

3. SEX

4. COLOR OR RACE

5. SINGLE, MARRIED, WIDOWED OR DIVORCED.

Female White

Single
(Write the word.)

6. DATE OF BIRTH

October 29 1910
(Month) (Day) (Year)

7. AGE

2 yrs. 10 mos. 24 ds.

IF LESS than 1 day
how many hrs. or min?

8. OCCUPATION

- (a) Trade, profession or particular kind of work.
(b) General nature of industry business or establishment in which employed (or employer)

None

9. BIRTHPLACE

(State or Country)

Lewis Co. Idaho

10. NAME OF FATHER

Arthur Johnson

11. BIRTHPLACE OF FATHER

(State or Country)

Sweden

12. MAIDEN NAME OF MOTHER

Josephina Swanson

13. BIRTHPLACE OF MOTHER

(State or Country)

Sweden

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

(Address)

Arthur Johnson
Nezperce, Idaho

15.

Filed

Oct 3 1913

J. M. Jones

Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH

September 23 1913
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from 9/22 1913, to 9/23 1913

that I last saw her alive on 9/23 1913 and that death occurred on the date stated above, at 5 P.M.

The CAUSE OF DEATH* was as follows:

Heart attack

(Duration) yrs. mos. 7 ds.

Contributory (Secondary)

(Duration) yrs. mos. ds.

(Signed) P. G. Jeffers M. D.

Oct 5 1913 (Address) Nezperce

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; (2) whether ACCIDENTAL, SUICIDAL OR HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place In the of death yrs. mos. ds. State yrs. mos. ds.

Where was disease contracted,

If not at place of death?

Former or

usual residence.

19. PLACE OF BURIAL OR REMOVAL DATE OF BURIAL

Nezperce

9/24 1913

20. UNDERTAKER

ADDRESS

P. E. McLean

Nezperce

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Form V. S. No. 5 20M.1-16-12

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics
File No. 5815
Registered No. 4

1. PLACE OF DEATH. Registration District No. 47
County of Lewis Primary Registration District No. 2124
City of Keyport (No. _____, St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME James Duggett

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX M 4. COLOR OR RACE W 5. SINGLE, MARRIED, WIDOWED OR DIVORCED. Single
(Write the word.)

6. DATE OF BIRTH July 28 1913
(Month) (Day) (Year)

7. AGE 1 yrs. 2 mos. — ds.
IF LESS than 1 day how many _____ hrs. or _____ mins.?

8. OCCUPATION
(a) Trade, profession or particular kind of work _____
(b) General nature of industry business, or establishment in which employed (or employer) _____

9. BIRTHPLACE
(State or Country) Mohler Idaho

10. NAME OF FATHER A. J. Duggett

11. BIRTHPLACE OF FATHER
(State or Country) California

12. MAIDEN NAME OF MOTHER Edna A. Woodward

13. BIRTHPLACE OF MOTHER
(State or Country) Missouri

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) A. J. Duggett
(Address) Mohler Idaho

15. Filed Oct 3 1913 2 M Jones
Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH Sept 27 1913
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from Sept 24 1913, to Sept 27 1913, that I last saw him alive on Sept 27 1913, and that death occurred on the date stated above, at 7 P. M.
The CAUSE OF DEATH* was as follows:

Manuscript
(Duration) — yrs. 2 mos. — ds.
Contributory (Secondary) _____
(Duration) _____ yrs. _____ mos. _____ ds.
(Signed) 2 M Jones M. D.
7-28-1913 (Address) Keyport

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death _____ yrs. _____ mos. _____ days. In the State _____ yrs. _____ mos. _____ days.
Where was disease contracted if not at place of death? _____
Former or usual residence _____

19. PLACE OF BURIAL OR REMOVAL Keyport DATE OF BURIAL Aug 28 1913

20. UNDERTAKER P. E. Miller ADDRESS Keyport Idaho

Form V. S. No. 5. 12½ M. 7-24-11

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH.

Registration District No. 62County of BlainePrimary Registration District No. 2/42City of Genesee

(No. _____, St.)

File No. 511Registered No. 3

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

New born Infant

If death occurred in a hospital, institution or camp give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX

4

4. COLOR OR RACE

W

5. SINGLE, MARRIED, WIDOWED OR DIVORCED.

Single
(Write the word.)

6. DATE OF BIRTH

Sept 16

(Month)

16

(Day)

1913

(Year)

7. AGE

7 yrs. 1 mos. 1 ds.IF LESS than 1 day
how many 7 hrs. or
min?

8. OCCUPATION

- (a) Trade, profession or particular kind of work.
-
- (b) General nature of industry business or establishment in which employed (or employer)

9. BIRTHPLACE

(State or Country)

Idaho Co

10. NAME OF FATHER

Mr Duval

11. BIRTHPLACE OF FATHER

(State or Country)

unknown

12. MAIDEN NAME OF MOTHER

Josephine Eglad

13. BIRTHPLACE OF MOTHER

(State or Country)

Idaho

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

(Address)

Mr. J. A. Bell, E. land
Genesee, Idaho

15.

Filed

Sept 7 1913W. H. Egan
Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH

Sept 16

(Month)

16

(Day)

1913

(Year)

17. I HEREBY CERTIFY, That I attended deceased from

Sept 16 1913 to Sept 16 1913that I last saw him alive on Sept 16 1913
and that death occurred on the date stated above, at 9 P. M.

The CAUSE OF DEATH* was as follows:

Pulmonary Congestion(Duration) 4 yrs. 4 mos. 4 ds.Contributory (Secondary) hypertension
coronary atherosclerosis(Duration) 4 yrs. 4 mos. 4 ds.(Signed) W. H. Egan M. D.9-17 1913 Address Genesee

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death 4 yrs. 4 mos. 4 ds. State Idaho yrs. 4 mos. 4 ds.

Where was disease contracted, If not at place of death?

Former or usual residence.

19. PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

Idaho Co.Sept 19 1913

20. UNDERTAKER

ADDRESS

Nov EgladGeneseeWRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY.
CLANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Form V. S. No. 5 20M.1-16-12

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH

Registration District No. 61County of LatahPrimary Registration District No. 1011City of Moscow(No. Premature St.)File No. 5819Registered No. 110

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Little Rosa Ann named

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX

Female

4. COLOR OR RACE

White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED.

Single
(Write the word.)

6. DATE OF BIRTH

Oct 3 1913
(Month) (Day) (Year)

7. AGE

.....yrs.....mos.....ds.

IF LESS than 1 day
how many 10 hrs. or
.....mins.?

8. OCCUPATION

(a) Trade, profession or particular kind of work

(b) General nature of industry business, or establishment in which employed (or employer)

None

9. BIRTHPLACE

(State or Country)

Moscow Ida

10. NAME OF FATHER

G. P. Nix

11. BIRTHPLACE OF FATHER

(State or Country)

Idaho

12. MAIDEN NAME OF MOTHER

Maiden Gale

13. BIRTHPLACE OF MOTHER

(State or Country)

Wis

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

G. P. Nix

(Address)

Moscow

15.

Filed Oct 4 1913D. F. Rae

Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH

October 4 1913
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from

Oct. 3 - 4 P.M. 1913, to Oct. 4 - 2 A.M. 1913,that I last saw him alive on Oct. 4 - 10 P.M. 1913,and that death occurred on the date stated above, at 2:00 A.M.

The CAUSE OF DEATH* was as follows:

Premature birth(Duration)yrs.....mos. 10 ds.Contributory
(Secondary)(Duration)yrs.....mos. 10 ds.

(Signed)

Chas. R. Eitzen M. D.10-4-1913 (Address) Moscow Idaho

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL OR HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of deathyrs.....mos.....days. In the Stateyrs.....mos.....days.

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL

Moscow

DATE OF BURIAL

Oct 4 1913

20. UNDERTAKER

Geo. Stetly

ADDRESS

Moscow

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Form V. S. No. 5 20M.1-16-12

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH.

Registration District No. 61

County of Blaine

Primary Registration District No. 2141

City of Moscow

(No. _____ St.)

File No. 5820

Registered No. 108

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Chas A. Nobast

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX M. 4. COLOR OR RACE white 5. SINGLE, MARRIED, WIDOWED OR DIVORCED. married
(Write the word.)

6. DATE OF BIRTH Nov 17 1845
(Month) (Day) (Year)

7. AGE 67 yrs 9 mos 19 ds
IF LESS than 1 day how many _____ hrs. _____ mins.

8. OCCUPATION
(a) Trade, profession or particular kind of work Farmer
(b) General nature of industry, business, or establishment in which employed (or employer)

9. BIRTHPLACE Ohio
(State or Country)

10. NAME OF FATHER Johannathan P. Nobast

11. BIRTHPLACE OF FATHER Ohio
(State or Country)

12. MAIDEN NAME OF MOTHER _____

13. BIRTHPLACE OF MOTHER Ohio
(State or Country)

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) J. A. B. B. B.

(Address) Moscow Ida

15. Filed Aug 6 1913 S F Rae
Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH Sept - 5 - 1913
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from May 31 1913, to Sept 5 1913, that I last saw him alive on August 17 1913, and that death occurred on the date stated above, at 5:15 P.M.
The CAUSE OF DEATH* was as follows:
Mitral Insufficiency
(Duration) 1 yrs 6 mos ds.
Contributory (Secondary) _____
(Duration) _____ yrs _____ mos _____ ds.
(Signed) Chas. L. Kristman M. D.
9-6-1913 (Address) Moscow, Ida

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death _____ yrs _____ mos _____ days. In the State _____ yrs _____ mos _____ days.

Where was disease contracted if not at place of death? _____

Former or usual residence _____

19. PLACE OF BURIAL OR REMOVAL Moscow DATE OF BURIAL Sept 7 1913

20. UNDERTAKER Geo. Stoff ADDRESS Moscow

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Form V. S. No. 5 20M.1-16-12

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics
File No. 5821
Registered No. 109

1. PLACE OF DEATH *Moos Lake* Registration District No. *61*
County of *Moos Lake* Primary Registration District No. *2141*
City of *Moos Lake* (No. _____ St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME *Ben. Lissone*

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX *Male* 4. COLOR OR RACE *White* 5. SINGLE, MARRIED, WIDOWED OR DIVORCED. *Single*
(Write the word.)

6. DATE OF BIRTH *Aug 5* 1913
(Month) (Day) (Year)

7. AGE *83* yrs. *1* mos. *20* ds. IF LESS than 1 day how many hrs. or mins.?

8. OCCUPATION
(a) Trade, profession or particular kind of work *Retired farmer*
(b) General nature of industry, business, or establishment in which employed (or employer)

9. BIRTHPLACE *Illinois*
(State or Country)

10. NAME OF FATHER *Don't know*

11. BIRTHPLACE OF FATHER *"* *"*
(State or Country)

12. MAIDEN NAME OF MOTHER *"* *"*

13. BIRTHPLACE OF MOTHER *"* *"*
(State or Country)

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) *J. B. Hissinger*
(Address) *Viola Idaho*

15. Filed *Sept 26* 1913 *J. F. Re*
Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH *Sept 25* 1913
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from *Aug 15* 1913, to *Sept 25* 1913, that I last saw him alive on *Sept 21* 1913, and that death occurred on the date stated above, at *10 P.M.*

The CAUSE OF DEATH* was as follows:

Gen. Debility

(Duration) *83* yrs. *7* mos. ds.
Contributory (Secondary) *patent heart*
leion

(Duration) *7* yrs. *7* mos. ds.
(Signed) *J. N. Clarke* M. D.
19 (Address)

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death. yrs. mos. days. In the State. yrs. mos. days.

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL *Viola* DATE OF BURIAL *Sept 27* 1913

20. UNDERTAKER *Geo. Stutz* ADDRESS *Moos Lake*

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Form V. S. No. 5 20M.1-16-12

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics
File No. **5822**

1. PLACE OF DEATH _____ Registration District No. **87**
County of **Washington** Primary Registration District No. **2804**
City of **Medvale** (No. _____, _____ St.)

Registered No. _____

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME **James Cooper**

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX **male** 4. COLOR OR RACE **white** 5. SINGLE, MARRIED, WIDOWED OR DIVORCED. **single**
(Write the word.)

6. DATE OF BIRTH **Dec. 10 1901**
(Month) (Day) (Year)

7. AGE **11 yrs. 4 mos. 10 ds.** IF LESS than 1 day how many _____ hrs. or _____ mins.?

8. OCCUPATION
(a) Trade, profession or particular kind of work **not employed**
(b) General nature of industry business, or establishment in which employed (or employer) _____

9. BIRTHPLACE (State or Country) **Idaho**

10. NAME OF FATHER **Chris Cooper**

11. BIRTHPLACE OF FATHER (State or Country) **Nebraska**

12. MAIDEN NAME OF MOTHER **Willie Garner**

13. BIRTHPLACE OF MOTHER (State or Country) **Nebraska**

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) **Harry Garner**
(Address) **Medvale Ida**

15. Filed **Sept 16 1913** **Falschmidt**
Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH **Sept 16 1913**
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from **Sept. 16 1913**, to **Sept 16 1913**, that I last saw him alive on **Sept. 13 1913**, and that death occurred on the date stated above, at **10 A.M.**

The CAUSE OF DEATH* was as follows:

Rheumatism
(Duration) _____ yrs. _____ mos. **7** ds.

Contributory **Endocarditis**
(Secondary)
(Duration) _____ yrs. _____ mos. **2** ds.

(Signed) **Falschmidt** M. D.
Sept 16 1913 (Address) **Medvale Ida**

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death _____ yrs. _____ mos. _____ days. In the State _____ yrs. _____ mos. _____ days.

Where was disease contracted if not at place of death? _____

Former or usual residence _____

19. PLACE OF BURIAL OR REMOVAL **Medvale** DATE OF BURIAL **Sept 17 1913**

20. UNDERTAKER **W. H. Boy** ADDRESS **Medvale**

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Form V. S. No. 5 20M.1-16-12

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics
File No. 5824
Registered No. 22
If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

1. PLACE OF DEATH.
County of Tremont
City of Rushburg
Registration District No. 100
Primary Registration District No. 2178
(No. _____ St.)
If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME John Wm Byrnes

PERSONAL AND STATISTICAL PARTICULARS

3. SEX M 4. COLOR OR RACE W 5. SINGLE, MARRIED, WIDOWED OR DIVORCED.
(Write the word.)

6. DATE OF BIRTH
9 19 1913
(Month) (Day) (Year)

7. AGE
____ yrs. ____ mos. ____ ds.
IF LESS than 1 day how many 12 hrs. or ____ mins.

8. OCCUPATION
(a) Trade, profession or particular kind of work
(b) General nature of industry business, or establishment in which employed (or employer)

9. BIRTHPLACE
(State or Country) Ida

10. NAME OF FATHER Clarence C Byrnes

11. BIRTHPLACE OF FATHER
(State or Country) Ida

12. MAIDEN NAME OF MOTHER Alzada Furniss

13. BIRTHPLACE OF MOTHER
(State or Country) W. Va.

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Clarence C Byrnes
(Address) Woodsy Creek

15. Filed 9-20 1913 G. G. Espe
Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH
9 19 1913
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from
1913, to 1913,
that I last saw h. alive on 1913,
and that death occurred on the date stated above, at M.
The CAUSE OF DEATH* was as follows:
Atlectosis

(Duration) ____ yrs. ____ mos. ____ ds.
Contributory
(Secondary)
(Duration) ____ yrs. ____ mos. ____ ds.
(Signed) none M. D.
19 ____ (Address) _____

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death ____ yrs. ____ mos. ____ days. In the State ____ yrs. ____ mos. ____ days.
Where was disease contracted if not at place of death?
Former or usual residence _____

19. PLACE OF BURIAL OR REMOVAL Burton DATE OF BURIAL 9-20 1913

20. UNDERTAKER John Phillips ADDRESS Rushburg

CERTIFICATE OF DEATH

State of Idaho

BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH

Registration District No.

County of Franklin

Primary Registration District No.

City of Suzan

(No., St.)

File No. 5825Registered No. 23

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

Hans J. Hansen

If death occurred in a hospital, institution or camp give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX

Male

4. COLOR OR RACE

White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED.

Single
(Write the word.)

6. DATE OF BIRTH

June13 - 1882
(Month) (Day) (Year)

7. AGE

31 yrs. 3 mos. 6 ds.IF LESS than 1 day
how many hrs. or
min?

8. OCCUPATION

(a) Trade, profession or particular kind of work
(b) General nature of industry business or establishment in which employed (or employer)Blacksmith

9. BIRTHPLACE

(State or Country)

Danma

10. NAME OF FATHER

Hans Hansen

11. BIRTHPLACE OF FATHER

(State or Country)

Danma

12. MAIDEN NAME OF MOTHER

Northa Polson

13. BIRTHPLACE OF MOTHER

(State or Country)

Danma

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

Paul Hansen

(Address)

South Danma

15.

Filed 9-22 1913L. G. Espe

Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH

Dec191913

(Month)

(Day)

(Year)

17. I HEREBY CERTIFY, That I attended deceased from

Adelphi 1911, to Arrived 1911that I last saw h. — alive on — 1911and that death occurred on the date stated above, at — M.

The CAUSE OF DEATH* was as follows:

Killed instantly
neck broken

(Duration) yrs. mos. ds.

Contributory (Secondary)

(Duration) yrs. mos. ds.

(Signed) J. P. Hughes M. D.

19..... (Address)

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place In the

of death yrs. mos. ds. State yrs. mos. ds.

Where was disease contracted,

If not at place of death?

Former or

usual residence.

19. PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

Suzan9/23 1913

20. UNDERTAKER

ADDRESS

J. YoungRedkey

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Form V. S. No. 5. 12% M. 7-24-11

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH

Registration District No. 100

County of *Lincoln*

Primary Registration District No. 2178

City of *Salmon*

(No. _____)

St.)

File No. 5826

Registered No. 24

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

Orson A. Larson

If death occurred in a hospital, institution or camp give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX

Male

4. COLOR OR RACE

white

5. SINGLE, MARRIED, WIDOWED OR DIVORCED.

married
(Write the word.)

6. DATE OF BIRTH

Oct
(Month)*30*
(Day)*1913*
(Year)

7. AGE

42 yrs.*10* mos.*22* ds.

IF LESS than 1 day
how many hrs. or
..... min?

8. OCCUPATION

(a) Trade, profession or particular kind of work.....
(b) General nature of industry business or establishment in which employed (or employer).....

Famer

9. BIRTHPLACE

(State or Country)

Utah

10. NAME OF FATHER

Saunders O. Larson

11. BIRTHPLACE OF FATHER

(State or Country)

Norway

12. MAIDEN NAME OF MOTHER

Caroline Larson

13. BIRTHPLACE OF MOTHER

(State or Country)

Norway

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

(Address)

Orson A. Larson
Reiley

15.

Filed *9-22* 191*3**L. L. Cooper*

Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH

9

(Month)

21

(Day)

1913

(Year)

17. I HEREBY CERTIFY, That I attended deceased from

Apr. 9 191*3*, to *Apr. 21* 191*3*that I last saw him alive on *Sept. 20* 191*3*and that death occurred on the date stated above, at *9* A. M.

The CAUSE OF DEATH* was as follows:

*Lympho Sarcoma Post.
the carcinoma*(Duration) *3* yrs. *3* mos. *1* ds.Contributory
(Secondary)(Duration) *3* yrs. *3* mos. *1* ds.(Signed) *John R. Reiley* M. D.*19* (Address) *Reiley*

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted,

If not at place of death?

Former or

usual residence.

19. PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

*Reiley**9-22* 191*3*

20. UNDERTAKER

ADDRESS

*J. R. Young**Reiley*

A stillbirth must be registered both as a birth and death. The date of death should be the date of delivery and the death certificate should further state, if known, the cause of the stillbirth and the period of utero gestation in months.

STATEMENT OF OCCUPATION.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer, Physician, Stenographer, Compositor, Architect, Locomotive engineer, Civil engineer, Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner*, (b) *Cotton mill*; (a) *Salesman*, (b) *Grocery*; (a) *Foreman*, (b) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification, as *Day laborer, Farm laborer, Laborer—Coal mine*, etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers*, who receive a definite salary), may be entered as *Housewife, Housework*, or *At home*, and children, not gainfully employed, as *At school* or *At home*. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer (retired, 6 yrs.)*. For persons who have no occupation whatever, write *None*.

STATEMENT OF CAUSE OF DEATH.—Name, first the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebro-*

spinal fever (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid Pneumonia") *Lobar pneumonia; Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritoneum*, etc., *Carcinoma, Sarcoma*, etc., of (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent affection need not be stated unless important. Example: *Measles* (disease causing death), 29 ds.; *Bronchopneumonia* (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "Asthenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility, (Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Haemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uraemia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify as "PUERPERAL, septicemia", "PUERPERAL peritonitis," etc., all diseases resulting from childbirth or miscarriage. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning; Struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "Contributory."

2 # 6

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Form V. S. No. 5 20M.1-16-12

CERTIFICATE OF DEATH

1. PLACE OF DEATH

County of Fremont
City of SugarRegistration District No. 100Primary Registration District No. 2178

(No. _____, _____ St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Belva M. WilliamsState of Idaho
BOARD OF HEALTH
Bureau of Vital StatisticsFile No. 5827Registered No. 235

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX

Female

4. COLOR OR RACE

White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED.

(Write the word.)

6. DATE OF BIRTH

Apr. 11 1913
(Month) (Day) (Year)

7. AGE

5 yrs. 10 mos. 10 ds.IF LESS than 1 day
how many _____ hrs. or
_____ mins.?

8. OCCUPATION

(a) Trade, profession or particular kind of work

Sugar City

(b) General nature of industry business, or establishment in which employed (or employer)

Idaho.

9. BIRTHPLACE

(State or Country)

Idaho.

10. NAME OF FATHER

Leslie W. Williams

11. BIRTHPLACE OF FATHER

(State or Country)

Utah

12. MAIDEN NAME OF MOTHER

Ruby Blake

13. BIRTHPLACE OF MOTHER

(State or Country)

Utah

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

Leslie W. Williams

(Address)

Sugar City

15.

Filed 9-21 1913G. G. Espe

Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH

Sept. 21 1913
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from

Apr. 1913, to Sept. 1913,that I last saw him alive on Sept 21 1913,

and that death occurred on the date stated above, at _____ M.

The CAUSE OF DEATH* was as follows:

Beholera Infantum

(Duration) _____ yrs. _____ mos. _____ ds.

Contributory
(Secondary)(Duration) _____ yrs. 5 mos. _____ ds.(Signed) J. P. Sprague M. D.19. (Address) Sugar City

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death _____ yrs. _____ mos. _____ days. In the State _____ yrs. _____ mos. _____ days.

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

1913

20. UNDERTAKER

ADDRESS

John PhillipsRexburg

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Form V. S. No. 5 20M.1-16-12

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH.

Registration District No. 200County of FremontPrimary Registration District No. 2178City of Salem(No.)

St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Chas. H. BallFile No. 5829Registered No. 30

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX

4. COLOR OR RACE

5. SINGLE, MARRIED, WIDOWED OR DIVORCED.

maleWhite

(Write the word.)

6. DATE OF BIRTH

Oct.
(Month)3
(Day)1899
(Year)

7. AGE

14 yrs.

mos.

2 ds.IF LESS than 1 day
how many hrs. or
..... mins.?

8. OCCUPATION

- (a) Trade, profession or particular kind of work
(b) General nature of industry, business, or establishment in which employed (or employer)

9. BIRTHPLACE

(State or Country)

Fremont Co. Ida.

10. NAME OF FATHER

James Ball

11. BIRTHPLACE OF FATHER

(State or Country)

Wales

12. MAIDEN NAME OF MOTHER

Harriet M. Hixley

13. BIRTHPLACE OF MOTHER

(State or Country)

Utah

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

James Ball

(Address)

Salem

15.

Filed 10-71913E. H. Eise

Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH

Oct.
(Month)5
(Day)1913
(Year)

17. I HEREBY CERTIFY, That I attended deceased from

191 to 191191that I last saw h. alive on 191and that death occurred on the date stated above, at M.

The CAUSE OF DEATH* was as follows:

Endocarditis(Duration) yrs. mos. ds.Contributory
(Secondary)Rheumatism(Duration) yrs. mos. ds.

(Signed)

J. R. Shuple

M. D.

Oct. 6 1913 (Address) Sugar City

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death yrs. mos. days. In the State yrs. mos. days.

Where was disease contracted if not at place of death?

Former or usual residence.

19. PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

RephurcyOct. 7 1913

20. UNDERTAKER

ADDRESS

John PhillipsRephurcy

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Extra state-ment of OCCUPATION is very important. See instructions on back of certificate.

1. PLACE OF DEATH
County of Freemont
City of Sugar
Registration District No. 100
Primary Registration District No. 2178
(No. _____, St.)
2. FULL NAME Caroline Anetta Larsen

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX Female 4. COLOR OR RACE White 5. SINGLE, MARRIED, WIDOWED OR DIVORCED. married
(Write the word.)

6. DATE OF BIRTH Dec 29 1869
(Month) (Day) (Year)

7. AGE 43 yrs. 9 mos. 3 ds.
IF LESS than 1 day how many hrs. or mins.?

8. OCCUPATION
(a) Trade, profession or particular kind of work Housewife
(b) General nature of industry business, or establishment in which employed (or employer) _____

9. BIRTHPLACE Utah
(State or Country)

10. NAME OF FATHER Samuel Ware

11. BIRTHPLACE OF FATHER England
(State or Country)

12. MAIDEN NAME OF MOTHER Caroline Christensen

13. BIRTHPLACE OF MOTHER Denmark
(State or Country)

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) H. A. Larsen
(Address) Sugar City

15. Filed 1 1913 G. G. Espe
Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH Oct 2 1913
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from Oct 1 1913, to Oct 2 1913, that I last saw him alive on Oct 1 1913, and that death occurred on the date stated above, at 7 A.M.
The CAUSE OF DEATH* was as follows:
Lobar Pneumonia

(Duration) _____ yrs. _____ mos. _____ ds.
Contributory (Secondary) _____
(Duration) _____ yrs. _____ mos. _____ ds.
(Signed) J. P. Shupe M. D.
19. (Address) Sugar City

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death _____ yrs. _____ mos. _____ days. In the State _____ yrs. _____ mos. _____ days.
Where was disease contracted if not at place of death? _____
Former or usual residence _____

19. PLACE OF BURIAL OR REMOVAL Sugar City DATE OF BURIAL Oct 5 1913

20. UNDERTAKER John Phillips ADDRESS Reynolds

-SUPPLEMENTARY DEATH CERTIFICATE-

(Please reply on this sheet to
the registrar of Vital Statistics)

Death Certificate No.

Name

Cecilia Evelyn Larson

Date of Death

Oct 2nd 1913 7 am.

Cause of Death

Labor Pneumonia

Contributory Cause of death

Leukemia

(Sign here)

J. R. [Signature]

M.D.

Dear Doctor.

I am unable to give
you the positive cause
of death in this case
She died without medical
aid. did not see Dr untill
after death judged from the
symptoms told by the family
She must have had pneumonia.
A. J. R. Thayer

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Form V. S. No. 5. 12½ M. 7-24-11

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics
File No. 5831
Registered No. 28

1. PLACE OF DEATH Idaho Registration District No. 100
County of Idaho Primary Registration District No. 2178
City of Sugar (No. _____, _____ St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

Evelyn Roberts

If death occurred in a hospital, institution or camp give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX Female 4. COLOR OR RACE White 5. SINGLE, MARRIED, WIDOWED OR DIVORCED. Child

(Write the word.)

6. DATE OF BIRTH Feb 4 1912
(Month) (Day) (Year)

7. AGE 1 yrs. 7 mos. 22 ds. IF LESS than 1 day how many _____ hrs. or _____ min?

8. OCCUPATION

(a) Trade, profession or particular kind of work.
(b) General nature of industry business or establishment in which employed (or employer)

Child

9. BIRTHPLACE

(State or Country)

Idaho

10. NAME OF FATHER

John J Roberts

11. BIRTHPLACE OF FATHER

(State or Country)

Idaho

12. MAIDEN NAME OF MOTHER

Sybil A Cook

13. BIRTHPLACE OF MOTHER

(State or Country)

Idaho

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) John J Roberts
(Address) Sugar

15. G. L. Egan
Filed 10-2 1913 Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH

Sep 26 1913
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from Sep 19 1913, to Sep 26 1913

that I last saw her alive on Sep 26 1913 and that death occurred on the date stated above, at 6:00 M.

The CAUSE OF DEATH* was as follows:

Chorea Infantum
Primary gastric enteritis

1 (Duration) yrs. mos. 7 ds.

Contributory (Secondary)

(Duration) yrs. mos. 1 ds.

(Signed) J. M. D.

10 (Address) Sugar

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place In the
of death _____ yrs. _____ mos. _____ ds. State _____ yrs. _____ mos. _____ ds.

Where was disease contracted,

If not at place of death?

Former or

usual residence.

19. PLACE OF BURIAL OR REMOVAL DATE OF BURIAL

Idaho 9-28 1913

20. UNDERTAKER ADDRESS

Reynolds

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. ETHNIC
ORIGIN should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact state-
ment of OCCUPATION is very important. See instructions on back of certificate.

Form V. S. No. 5. 12½ M. 7-24-11

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics
File No. 5832
Registered No. 27

1. PLACE OF DEATH/ Registration District No. 100
County of Benewah Primary Registration District No. 2178
City of McCall (No. , St.)

If death occurs away from usual residence, give facts called for under special information. 2. FULL NAME Nora Clegg
If death occurred in a hospital, institution or camp give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX Female 4. COLOR OR RACE White 5. SINGLE, MARRIED, WIDOWED OR DIVORCED. Widowed
(Write the word.)

6. DATE OF BIRTH June 11 1895
(Month) (Day) (Year)

7. AGE 58 yrs. 3 mos. 12 ds. IF LESS than 1 day
how many hrs. or min?

8. OCCUPATION (a) Trade, profession or particular kind of work. Housewife
(b) General nature of industry, business or establishment in which employed (or employer)

9. BIRTHPLACE Utah
(State or Country)

10. NAME OF FATHER Peter Jackson

11. BIRTHPLACE OF FATHER New York
(State or Country)

12. MARRIAGE NAME OF MOTHER Sodaoma Mills

13. BIRTHPLACE OF MOTHER New York
(State or Country)

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE (Informant) M. C. Clegg
(Address) McCall

15. Filed 10-2-1913 G. H. E. Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH 9-23-1913
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from 9/20-1913, to 9/23-1913, that I last saw her alive on 9/23-1913, and that death occurred on the date stated above, at 4 P.M.

The CAUSE OF DEATH* was as follows:
metastatic carcinoma of lung following carcinoma of stomach.
(Duration) 2 yrs. mos. ds.

Contributory (Secondary)
(Duration) yrs. mos. ds.
(Signed) E. A. Caper M. D.
(Address) McCall

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place In the
of death yrs. mos. ds. State yrs. mos. ds.
Where was disease contracted,
If not at place of death?
Former or usual residence.

19. PLACE OF BURIAL OR REMOVAL DATE OF BURIAL
Reynolds 9/25-1913

20. UNDERTAKER ADDRESS
Reynolds Reynolds

MARGIN RESERVED FOR BINDING
WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Form V. S. No. 5 20M.1-16-12

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH

Registration District No. 117

County of Cassia

Primary Registration District No. 2196

City of Burley

(No. , St.)

File No. 5533

Registered No. 7

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Elias Hudley Burton

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX

4. COLOR OR RACE

5. SINGLE, MARRIED, WIDOWED OR DIVORCED

Male White Single

6. DATE OF BIRTH

May 16 1898
(Month) (Day) (Year)

7. AGE

65 yrs 4 mos 13 ds

IF LESS than 1 day
how many hrs. or mins.?

8. OCCUPATION

(a) Trade, profession or particular kind of work

Farmer

(b) General nature of industry business, or establishment in which employed (or employer)

9. BIRTHPLACE

(State or Country)

Pipeley Co. Ind.

10. NAME OF FATHER

Elyson Burton

11. BIRTHPLACE OF FATHER

(State or Country)

North Carolina

12. MAIDEN NAME OF MOTHER

Sibyl Hudley

13. BIRTHPLACE OF MOTHER

(State or Country)

Maine

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

W. L. Burton

(Address)

Burley Ida.

15.

Filed Sept 30 1913

D. J. C. Patterson

Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

Sep 29 1913
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from

Sep 1st 1913 to Sep 29 1913
that I last saw him alive on Sep 29 1913

and that death occurred on the date stated above, at 6:58 P.M.

The CAUSE OF DEATH* was as follows:

Cancer of Liver

(Duration) Several years

Contributory (Secondary)

old age

(Duration) yrs mos ds

(Signed)

Joseph Fremstad M. D.

19 (Address)

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death yrs mos days In the State yrs mos days

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

Turninalls Ida

Oct 1st 1913

20. UNDERTAKER

ADDRESS

L. B. Gallogly

Burley Ida

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Form V. S. No. 5 20M.1-16-12

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics
File No. 5834

1. PLACE OF DEATH,
County of Cassia
City of Burley

Registration District No. 117
Primary Registration District No. 2196
(No. _____, _____ St.)

Registered No. 6

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Thaddens Merrin

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX Male 4. COLOR OR RACE white 5. SINGLE, MARRIED, WIDOWED OR DIVORCED Married

6. DATE OF BIRTH

Sept 9 1860
(Month) (Day) (Year)

7. AGE

23 yrs. 9 mos. 9 ds.

IF LESS than 1 day
how many _____ hrs. or
_____ mins.

8. OCCUPATION

(a) Trade, profession or particular kind of work
(b) General nature of industry, business, or establishment in which employed (or employer)

Farmer

9. BIRTHPLACE

(State or Country)

Ogden Utah

10. NAME OF FATHER

Isidore M. Merrin

11. BIRTHPLACE OF FATHER

(State or Country)

Unknown

12. MAIDEN NAME OF MOTHER

Martha Bronson

13. BIRTHPLACE OF MOTHER

(State or Country)

Unknown

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

Thaddens Merrin

(Address)

Burley Ida

15.

Filed

9-19-13

191

L. J. C. Patterson
Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH

September 18 1913
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from Sept 16 1913, to Sept 18 1913, that I last saw him alive on Sept 18 1913

and that death occurred on the date stated above, at 6 A.M.

The CAUSE OF DEATH* was as follows:

Septicemia generalized from an infection in mouth

(Duration) _____ yrs. _____ mos. _____ ds.

Contributory (Secondary)

(Duration) _____ yrs. _____ mos. _____ ds.

(Signed)

Sept 19 1913 J. M. Minter M. D.
(Address) Burley Ida

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death _____ yrs. _____ mos. _____ days. In the State _____ yrs. _____ mos. _____ days.

Where was disease contracted if not at place of death?

Former or usual residence.

19. PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

Burley Ida Sept 20 1913

20. UNDERTAKER

ADDRESS

L. B. Gallegos Burley, Ida.

SPRAGUE & TERHUNE

"BOOK STORE PHARMACY"

NE 105

BURLEY, IDAHO

Ry

For.....

Name Thodden M. Ferris

Date of Death 2 Sept 18 = 1913

Cause of Death 3 Septicemia

Generalized from an infection
in mouth

Miller M. D.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Form V. S. No. 5 20M.1-16-12

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH

Registration District No. 117

County of Cassia

Primary Registration District No. 2196

City of Burley

(No. , St.)

File No. 533

Registered No. 5

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Andrew J. Kronquist

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX

4. COLOR OR RACE

5. SINGLE, MARRIED, WIDOWED OR DIVORCED.

Male white Married (Write the word.)

6. DATE OF BIRTH

April 4 1868
(Month) (Day) (Year)

7. AGE

45 yrs. 5 mos. 4 ds.

IF LESS than 1 day
how many . hrs. or
mins.?

8. OCCUPATION

(a) Trade, profession or particular kind of work Farmer
(b) General nature of industry business, or establishment in which employed (or employer)

9. BIRTHPLACE

(State or Country) Finland

10. NAME OF FATHER

Unknown

11. BIRTHPLACE OF FATHER

(State or Country) Finland

12. MAIDEN NAME OF MOTHER

Unknown

13. BIRTHPLACE OF MOTHER

(State or Country) Finland

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Gust. Hallman

(Address) Burley Ida.

15.

Filed Sept 12 1913 Dr. J. C. Patterson
Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH

Sep 9th 1913
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from

Sep 4th 1913, to Sep 8th 1913
that I last saw him alive on Sep 8th 1913

and that death occurred on the date stated above, at 10:20 AM.

The CAUSE OF DEATH* was as follows:

Hemorrhage of lungs
from Tuberculosis

(Duration) yrs. 6 mos. ds.

Contributory Tuberculosis
(Secondary)

(Duration) 4 yrs. — mos. — ds.

(Signed) Joseph Fremstad M.D.

1913 (Address) Burley Idaho

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death . . . yrs . . . mos . . . days. In the State . . . yrs . . . mos . . . days.

Where was disease contracted if not at place of death?

Former or usual residence . . .

19. PLACE OF BURIAL OR REMOVAL DATE OF BURIAL

Burley Ida Sept 14 1913

20. UNDERTAKER ADDRESS

L. B. Gallogly Burley Ida.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Form V. S. No. 5. 12½ M. 7-24-11

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics
File No. 5836
Registered No. 4

1. PLACE OF DEATH. Registration District No. 117
County of Cassia Primary Registration District No. 2196
City of Burley (No. _____, _____ St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

John Burley Meiser

If death occurred in a hospital, institution or camp give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX Male 4. COLOR OR RACE white 5. SINGLE, MARRIED, WIDOWED OR, DIVORCED. Single

6. DATE OF BIRTH Aug 21 1913
(Month) (Day) (Year)

7. AGE _____ yrs. _____ mos. 16 ds. IF LESS than 1 day how many _____ hrs. or _____ min.

8. OCCUPATION

(a) Trade, profession or particular kind of work. at home
(b) General nature of industry business or establishment in which employed (or employer)

9. BIRTHPLACE

(State or Country) Burley Cassia Co. Ida.

10. NAME OF FATHER

Francis H. Meiser

11. BIRTHPLACE OF FATHER

(State or Country) Ind.

12. MAIDEN NAME OF MOTHER

Katharine Heingen

13. BIRTHPLACE OF MOTHER

(State or Country) Germany

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) C. J. Patterson

(Address) Burley Idaho

15.

Filed Sept. 5th 1913

Dr. J. C. Patterson
Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH

Sept. 6th 1913
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from Sept. 6th 1913, to Sept. 6th 1913 that I last saw him alive on Sept. 6th 1913 and that death occurred on the date stated above, at 6 P. M.

The CAUSE OF DEATH* was as follows:

Pneumonia

(Duration) _____ yrs. _____ mos. 1 ds.

Contributory (Secondary) Malnutrition

(Duration) _____ yrs. _____ mos. 16 ds.

(Signed) J. C. Patterson M. D.
Sept. 5th 1913 (Address) Burley, Ida.

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place _____ In the _____
of death _____ yrs. _____ mos. _____ ds. State _____ yrs. _____ mos. _____ ds.

Where was disease contracted,
If not at place of death?

Former or
usual residence _____

19. PLACE OF BURIAL OR REMOVAL DATE OF BURIAL

Burley Ida Sept. 7 1913

20. UNDERTAKER

ADDRESS

L. B. Gallogly Burley Ida

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Form V. S. No. 5 20M.1-16-12

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH

Registration District No.

County of *Cassia*

Primary Registration District No.

City of *Burley*

(No. St.)

File No. *5837*

Registered No.

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME *George W. Beckman*

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX

4. COLOR OR RACE

5. SINGLE, MARRIED, WIDOWED OR DIVORCED.

Male *white* *Married*

6. DATE OF BIRTH

Aug 25 1868
(Month) (Day) (Year)

7. AGE

56 yrs. mos. ds.

IF LESS than 1 day
how many hrs. or
..... mins.

8. OCCUPATION

(a) Trade, profession or particular kind of work

(b) General nature of industry business, or establishment in which employed (or employer)

Farmer

9. BIRTHPLACE

(State or Country)

Ill.

10. NAME OF FATHER

Unknown

11. BIRTHPLACE OF FATHER

(State or Country)

Unknown

12. MAIDEN NAME OF MOTHER

Rachel Davis

13. BIRTHPLACE OF MOTHER

(State or Country)

Ill.

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) *Frederic O. Beckman*

(Address) *Burley Idaho*

15.

Filed *Sept 27* 1913 *H. J. C. Patterson*
Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

September 26 1913
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from *August 20* 1913, to *Sept 26* 1913, that I last saw him alive on *Sept 26* 1913, and that death occurred on the date stated above, at *8:30* M.

The CAUSE OF DEATH* was as follows:

Tuberculosis Pulmonary
(Duration) *4* yrs. *8* mos. *26* ds.

Contributory (Secondary)

(Duration) yrs. mos. ds.

(Signed)

J. M. Winter M. D.
Sept 27 1913 (Address) *Burley Ida*

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death yrs. mos. days. In the State yrs. mos. days.

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

Idaho 191...

20. UNDERTAKER

ADDRESS

L. B. Gallagher *Burley, Idaho*

J. C. Patterson

-SUPPLEMENTARY DEATH CERTIFICATE-

(Please reply on this sheet to
the registrar of Vital Statistics)

Death Certificate No.

Name Geo W Beckman

Date of Death September 2, 1912

Cause of Death Pulmonary Tuberculosis

Contributory Cause of death None

(Sign here) J M. Winter M.D.

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Form V. S. No. 5 20M.1-16-12

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH.

Registration District No. 728

County of Bonneville

Primary Registration District No. 1170

City of Ucon

(No. _____ St.)

File No. 523

Registered No. 27

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Eleanor Robinson

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX

4. COLOR OR RACE

5. SINGLE, MARRIED, WIDOWED OR DIVORCED.

Female White

Married
(Write the word.)

6. DATE OF BIRTH

Feb 20 1858
(Month) (Day) (Year)

7. AGE

55 yrs. 6 mos. 25 ds.

IF LESS than 1 day
how many hrs. or
..... mins.?

8. OCCUPATION

(a) Trade, profession or particular kind of work
(b) General nature of industry business, or establishment in which employed (or employer)

Housewife

9. BIRTHPLACE

(State or Country)

Utah

10. NAME OF FATHER

Wm. Bennett

11. BIRTHPLACE OF FATHER

(State or Country)

England

12. MAIDEN NAME OF MOTHER

Sarah Ann Woodhead

13. BIRTHPLACE OF MOTHER

(State or Country)

England

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

(Address)

E. G. Robinson
Ucon Idaho

15.

Filed Sept 16

1913

Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH

Sept 15 1913
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from July 15 1913, to Sept 15 1913, that I last saw h. alive on Aug 15 1913, and that death occurred on the date stated above, at 3:00 P.M.

The CAUSE OF DEATH* was as follows:

Chronic Pulmonary Tuberculosis

(Duration) 1 yrs. mos. ds.

Contributory
(Secondary)

(Duration) yrs. mos. ds.

(Signed) J. R. Moore M. D.
9/17 1913 (Address) Idaho Falls

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death yrs. mos. days. In the State yrs. mos. days.

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

Ucon Idaho

9/18 1913

20. UNDERTAKER

ADDRESS

J. R. Moore

Idaho Falls

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Form V. S. No. 5 20M.1-16-12

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH, Registration District No. 73
County of Bonneville Primary Registration District No. 215-0
City of Idaho Falls (No. _____, St.)

File No. 5839
Registered No. 126

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Harold Shirley
If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX Male 4. COLOR OF RACE White 5. SINGLE, MARRIED, WID-
OWED OR DIVORCED Child
(Write the word.)

6. DATE OF BIRTH Aug 26 1913
(Month) (Day) (Year)

7. AGE X yrs. 1 mos. X ds.
IF LESS than 1 day
how many hrs. or
..... mins.?

8. OCCUPATION
(a) Trade, profession or particular kind of work Child
(b) General nature of industry, business, or establishment in which employed (or employer)

9. BIRTHPLACE Idaho Falls Ida
(State or Country)

10. NAME OF FATHER Thomas Shirley

11. BIRTHPLACE OF FATHER South Africa
(State or Country)

12. MAIDEN NAME OF MOTHER Mary Aworth

13. BIRTHPLACE OF MOTHER England
(State or Country)

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Thomas Shirley
(Address) Idaho Falls Ida

15. Filed Sept 25 1913 W. J. Cunningham
Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH Sept 25 1913
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from Sept 22 1913 to Sept 24 1913
that I last saw him alive on Sept 24 1913
and that death occurred on the date stated above, at 6 P.M.
The CAUSE OF DEATH* was as follows:

gastro-intestinal
(Duration) yrs. mos. 1 ds.
Contributory (Secondary)
(Duration) yrs. mos. ds.
(Signed) W. J. Cunningham M. D.
9/25 1913 (Address) Idaho Falls Ida

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death yrs. mos. days. In the State yrs. mos. days.
Where was disease contracted if not at place of death?
Former or usual residence
19. PLACE OF BURIAL OR REMOVAL Rexburg, Ida DATE OF BURIAL Sept 26 1913
20. UNDERTAKER B. E. Dimwoodey ADDRESS Idaho Falls

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Form V. S. No. 5 20M.1-16-12

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH.

Registration District No. 73County of BoonevillePrimary Registration District No. 211-0City of Idaho Falls

(No. _____)

(St. _____)

File No. 5840Registered No. 67

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

Joseph Faber

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX

4. COLOR OR RACE

5. SINGLE, MARRIED, WIDOWED OR DIVORCED.

MaleWhiteSingle
(Write the word.)

6. DATE OF BIRTH

May
(Month)18
(Day)1901
(Year)

7. AGE

12 yrs. 3 mos. 27 ds.

IF LESS than 1 day
how many hrs. or
..... mins.?

8. OCCUPATION

(a) Trade, profession or particular kind of work
(b) General nature of industry, business, or establishment in which employed (or employer)

School boy

9. BIRTHPLACE

(State or Country)

Ill.

10. NAME OF FATHER

Nicholas Faber

11. BIRTHPLACE OF FATHER

(State or Country)

Luxemburg

12. MAIDEN NAME OF MOTHER

Mary Macdonald

13. BIRTHPLACE OF MOTHER

(State or Country)

Germany

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

Nicholas Faber

(Address)

Idaho Falls

15.

Filed Sept 26 1913

Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH

Sept.
(Month)15
(Day)1913
(Year)

17. I HEREBY CERTIFY, That I attended deceased from

191., to191.,

that I last saw h. — alive on — 191

and that death occurred on the date stated above, at — M.

The CAUSE OF DEATH* was as follows:

Drowning, Accidental.

(Duration) yrs. mos. ds.

Contributory

(Secondary)

(Duration) yrs. mos. ds.

(Signed)

Jos. Mooney M.D.9-25 1913 (Address) County Coroner

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL OR HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death yrs. mos. days. In the State yrs. mos. days.

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

Idaho Falls9/28 1913

20. UNDERTAKER

ADDRESS

G. H. HuntIdaho Falls

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH.

Registration District No. 73County of BonnevillePrimary Registration District No. 211-0File No. 5-41City of Reidy, R.I. (No. 2 St.)Registered No. 67

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

Annah Hambrell Ross

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX Female 4. COLOR OR RACE White 5. SINGLE, MARRIED, WIDOWED OR DIVORCED Widowed
(Write the word.)

6. DATE OF BIRTH

June 3-1832
(Month) (Day) (Year)

7. AGE

81 yrs. 3 mos. 20 ds.IF LESS than 1 day
how many hrs. or mins.?

8. OCCUPATION

(a) Trade, profession or particular kind of work
(b) General nature of industry, business, or establishment in which employed (or employer)Housewife

9. BIRTHPLACE

(State or Country)

10. NAME OF FATHER

John Hambrell

11. BIRTHPLACE OF FATHER

(State or Country)

Maryland

12. MAIDEN NAME OF MOTHER

Eliiz. Hambrell

13. BIRTHPLACE OF MOTHER

(State or Country)

Maryland

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

Harry Ross

(Address)

Kalisprel Mont.

15.

Filed Sept 27 1913

Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH

Sept 23 1913
(Month) (Day) (Year)17. I HEREBY CERTIFY, That I attended deceased from Sept 23 1913, to Sept 25 1913,that I last saw her alive on Sept 23 1913, and that death occurred on the date stated above, at 7 P. M.

The CAUSE OF DEATH* was as follows:

Myocarditis.
General debility.

(Duration) yrs. mos. ds.

Contributory
(Secondary)

(Duration) yrs. mos. ds.

(Signed)

Ray H. Fisher M. D.9/26/1913 (Address) Reidy, R.I.

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death yrs. mos. days. In the State yrs. mos. days.

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL DATE OF BURIAL

Kalisprel Mont. Sept 29 1913

20. UNDERTAKER

ADDRESS

M. J. Peck & Sons, Reidy, Ida.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

PLACE OF DEATH.

of *Bonneville,*
Milo.

Registration District No. *73*

Primary Registration District No. *2150*

(No., (St.)

File No. *542*

Registered No. *69*

causes away from usu-
ally, give facts called
for special information.

2. FULL NAME

Donald E Armstrong

If death occurred in a hospital, in-
stitution or camp, give its NAME
instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

4. COLOR OR RACE 5. SINGLE, MARRIED, WID-
OWED OR DIVORCED.

M W
Bald
(Write the word.)

DATE OF BIRTH

Sept. 9 *1913*
(Month) (Day) (Year)

..... yrs. mos. *18* ds.

IF LESS than 1 day
how many hrs. or
..... mins.?

OCCUPATION

Occupation, profession or
other kind of work
General nature of industry
or establishment in
which employed (or employer)

Bald

PLACE OF BIRTH

State or Country)

Idaho.

NAME OF FATHER

J. S. Armstrong
Utah.

PLACE OF BIRTH OF FATHER

State or Country)

Susannah Dalley

NAME OF MOTHER

PLACE OF BIRTH OF MOTHER

State or Country)

Utah

THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Signature of Informant)

J. S. Armstrong
Highly. R. F. H.

(Address)

Sept 29 *1913* *C. J. Fennell*
Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH

Sept. 27 *1913*
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from

..... 191....., to 191.....,

that I last saw him alive on 191.....,

and that death occurred on the date stated above, at..... M.

The CAUSE OF DEATH* was as follows:

Presumably 8 mos.
General feeble condition
No physician in attendance
(Duration) yrs. mos. ds.

Contributory
(Secondary)

..... (Duration) yrs. mos. ds.

(Signed) *Ray W. Fisher* M. D.

Sept 27 *1913* (Address) *Highly. 2da*

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death yrs. mos. days. In the State yrs. mos. days.

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL DATE OF BURIAL

Milo. *Sept 28* *1913*

20. UNDERTAKER ADDRESS

Freed's *Highly. R. F. H.*

+ M. G. Peck & Sons

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Form V. S. No. 5 20M.1-16-12

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH.

Registration District No. 41

County of Lemhi

Primary Registration District No. 2116

City of Carmen

(No. _____, _____ St.)

File No. 5843

Registered No. 2

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

John Daniels

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX

4. COLOR OR RACE

5. SINGLE, MARRIED, WID-
OWED OR DIVORCED.

male

white

Married (the word.)

6. DATE OF BIRTH

July

28th

1838

7. AGE

75 yrs. 1 mos. 27 ds.

IF LESS than 1 day
how many _____ hrs. or
_____ mins.

8. OCCUPATION

(a) Trade, profession or
particular kind of work

Farmer

(b) General nature of industry
business, or establishment in
which employed (or employer)

9. BIRTHPLACE

(State or Country)

England

10. NAME OF
FATHER

John Daniels

11. BIRTHPLACE
OF FATHER

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Form V. S. No. 5 20M.1-16-12

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH. Registration District No. 41
County of Lemhi Primary Registration District No. 2116
City of Post Office Lemhi (No. _____ St.)

File No. 5844
Registered No. 9

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Edith Louise Harris

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX female 4. COLOR OR RACE white 5. SINGLE, MARRIED, WIDOWED OR DIVORCED. Married

6. DATE OF BIRTH

Feb. 30 1875
(Month) (Day) (Year)

7. AGE

38 yrs. 7 mos. 28 ds.

IF LESS than 1 day
how many hrs. or
..... mins.

8. OCCUPATION

(a) Trade, profession or particular kind of work
(b) General nature of industry business, or establishment in which employed (or employer)

Housewife

9. BIRTHPLACE

(State or Country)

Missouri

10. NAME OF FATHER

Geo. E. Miller

11. BIRTHPLACE OF FATHER

(State or Country)

New Jersey

12. MAIDEN NAME OF MOTHER

Elizabeth Watson

13. BIRTHPLACE OF MOTHER

(State or Country)

Ohio

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

Thomas A. Harris

(Address)

Lemhi P. O. Idaho

15.

Filed 10/21913

Helen L. Smith
Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH

Oct 1st 1913
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from Sept 30 1913 to Oct 1 1913,
that I last saw her alive on Oct 1 1913,
and that death occurred on the date stated above, at 7 A M.

The CAUSE OF DEATH* was as follows:

Acute nephritis

about 2 weeks

(Duration) yrs. mos. ds.

Contributory Suppression of urine
(Secondary) 48 hours

(Duration) yrs. mos. ds.

(Signed) Chas. F. Hanner M. D.

Oct 2 1913 (Address) Salmon, Ida

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death yrs. mos. days. In the State yrs. mos. days.

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL DATE OF BURIAL

Salmon Cemetery Oct 2nd 1913

20. UNDERTAKER

ADDRESS

Wm. C. Noebler Salmon

WRITE PLAINLY, WITH UNFADING INK--THIS IS A PERMANENT RECORD. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Form V. S. No. 5 20M.1-16-12

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH.

Registration District No. 4County of LemhiPrimary Registration District No. 2/16City of Salmon

(No. _____ St.)

File No. 5845Registered No. 10

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

John Hart Wheeler

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX

4. COLOR OR RACE

5. SINGLE, MARRIED, WIDOWED OR DIVORCED.

male white Married

6. DATE OF BIRTH

Feb. 27th 1838
(Month) (Day) (Year)

7. AGE

75 yrs. 7 mos. 4 ds.

IF LESS than 1 day
how many hrs. or
..... mins.?

8. OCCUPATION

- (a) Trade, profession or particular kind of work
(b) General nature of industry business, or establishment in which employed (or employer)

Farmer Retired
4 years

9. BIRTHPLACE

(State or Country)

Ohio

10. NAME OF FATHER

dont know

11. BIRTHPLACE OF FATHER

(State or Country)

dont know

12. MAIDEN NAME OF MOTHER

dont know

13. BIRTHPLACE OF MOTHER

(State or Country)

dont know

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

Emma Wheeler

(Address)

Salmon Id

15.

Filed

October 4 1913 Walter L Smith
Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH

Oct 2nd 1913
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from
1906, to Oct 2nd 1913,

that I last saw him alive on Oct 2nd 1913,

and that death occurred on the date stated above, at 4 P.M.

The CAUSE OF DEATH* was as follows:

Old age

(Duration) yrs. mos. ds.

Contributory
(Secondary)

(Duration) yrs. mos. ds.

(Signed)

F. D. Wright

M. D.

Oct 3 1913

(Address)

Salmon Id

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death yrs. mos. days. In the State yrs. mos. days.

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

Salmon CemeteryOct 4th 1913

20. UNDERTAKER

ADDRESS

Wm. E. WoelkerSalmon

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. N. B.—Every item of information should be carefully supplied. AGE should be state EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Form V. S. No. 5. 10M. 6-20-11.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics
File No. 5846

1. PLACE OF DEATH. Registration District No. 9
County of Fremont Primary Registration District No. 2038
City of st Anthony. (No. _____, _____ St.)

Registered No. _____

If death occurs away from usual residence, give facts called for under special information.

If death occurred in a hospital, institution or camp give its NAME instead of street and number.

2. FULL NAME George K Bailey

PERSONAL AND STATISTICAL PARTICULARS

3. SEX M 4. COLOR OR RACE White 5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word) Married

6. DATE OF BIRTH

April 10th, 1884 1
(Month) (Day) (Year)

7. AGE

29 yrs. 4 mos. 17 ds. IF LESS than 1 day how many _____ hrs. or _____ min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work Farmer
(b) General nature of industry business or establishment in which employed (or employer) _____

9. BIRTHPLACE

(State or Country) Mo.

10. NAME OF FATHER

F.D. Bailey

11. BIRTHPLACE OF FATHER

(State or Country) Mo.

12. MAIDEN NAME OF MOTHER

Jennie E Butler,

13. BIRTHPLACE OF MOTHER

(State or Country) Mo.

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) P. E. Bailey,

(Address) Drummond, Idaho,

15.

Filed Oct 8 1913

W. D. Yager
Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

Aug 27th 1913, 191_____
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from

Aug. 26 191_____, to Aug. 27 191_____,

that I last saw h. im alive on Aug 27th 191_____,

and that death occurred on the date stated above, at I M.

The CAUSE OF DEATH* was as follows:

Bright's Disease (Chronic)

(Duration) 5 yrs. _____ mos. _____ ds.

Contributory (Secondary)

(Duration) _____ yrs. _____ mos. _____ ds.

(Signed) G. W. Mansfield M. D.

19 (Address) _____

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death _____ yrs. _____ mos. _____ ds. In the State _____ yrs. _____ mos. _____ ds.

Where was disease contracted.

If not at place of death? _____

Former or

usual residence. _____

19. PLACE OF BURIAL OR REMOVAL

Whitville Mo,

DATE OF BURIAL

Wm. D. Yager,

191____

20. UNDERTAKER

ADDRESS

St Antho

-SUPPLEMENTARY DEATH CERTIFICATE-

(Please reply on this sheet to
the registrar of Vital Statistics)

Death Certificate No. _____

Name George T. Bailey (not Geo. H. Naley)

Date of Death Aug. 27 1913

Cause of Death Chronic Bright's disease

Contributory Cause of death Exposure

(Sign here)

A. Morfield M.D.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Form V. S. No. 5 20M.1-16-12

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH

Registration District No. 99

County of Fremont

Primary Registration District No. 2177

City of St. Anthony

(No. 2 St.)

File No. 5849

Registered No.

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

Sharon Harnden

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX

4. COLOR OR RACE

5. SINGLE, MARRIED, WIDOWED OR DIVORCED.

M

W

(Single word.)

6. DATE OF BIRTH

Mar

15

1912

(Month)

(Day)

(Year)

7. AGE

yrs. 18 mos. ds.

IF LESS than 1 day
how many hrs. or
mins.?

8. OCCUPATION

(a) Trade, profession or particular kind of work

(b) General nature of industry, business, or establishment in which employed (or employer)

9. BIRTHPLACE

(State or Country)

Laramie Wyo.

10. NAME OF FATHER

Orvin Harnden

11. BIRTHPLACE OF FATHER

(State or Country)

Neb.

12. MAIDEN NAME OF MOTHER

Essie McFadden

13. BIRTHPLACE OF MOTHER

(State or Country)

Laramie

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

O. J. Harnden

(Address)

Laramie

15.

Filed

Sept 14

1913

W. J. Harnden

Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

Sept

14

1913

(Month)

(Day)

(Year)

17. I HEREBY CERTIFY, That I attended deceased from

Sept 10 1913, to Sept 13 1913,

that I last saw him alive on Sept 13 1913,

and that death occurred on the date stated above, at 10 P. M.

The CAUSE OF DEATH* was as follows:

Tubercular Meningitis

(Duration) yrs.

about 30

mos. ds.

Contributory (Secondary)

(Duration) yrs.

mos. ds.

(Signed)

W. J. Harnden

Sept 15 1913 (Address) St. Anthony, Ida.

State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL OR HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death

yrs. mos. days.

In the

State. yrs. mos. days.

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

Laramie

1913

20. UNDERTAKER

ADDRESS

W. J. Harnden

St. Anthony

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Form V. S. No. 5 20M.1

1. PLACE OF DEATH.

County of Fremont
City of St. Anthony

Registration District No. _____

Primary Registration District No. 2177

(No. _____, _____ St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Bruce Woolstenhulme

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

File No. 5859

Registered No. _____

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX

Female

4. COLOR OR RACE

White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED.

married
(Write the word.)

6. DATE OF BIRTH

Sept 4 1884
(Month) (Day) (Year)

7. AGE

38 yrs. 11 mos. 7 ds.

IF LESS than 1 day
how many _____ hrs. or
_____ mins.

8. OCCUPATION

(a) Trade, profession or particular kind of work

Housewife

(b) General nature of industry, business, or establishment in which employed (or employer)

9. BIRTHPLACE

(State or Country)

Wisconsin

10. NAME OF FATHER

Lancing Bates

11. BIRTHPLACE OF FATHER

(State or Country)

England

12. MAIDEN NAME OF MOTHER

Mary Hill

13. BIRTHPLACE OF MOTHER

(State or Country)

Don't know

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

A. Morefield

(Address)

St. Anthony

15.

Filed Oct 8 1913

W. S. Yager

Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH

Aug 11 1913
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from

May 20 1913, to Aug 10 1913,

that I last saw her alive on Aug 10 1913,

and that death occurred on the date stated above, at 3:45 A.M.

The CAUSE OF DEATH* was as follows:

Pericarditis

(Duration) _____ yrs. _____ mos. 3 ds.

Contributory Arterio sclerosis et
(Secondary) acute Brights disease

(Duration) _____ yrs. 2 mos. 20 ds.

(Signed) A. Morefield M. D.

Aug 10 1913 (Address) St. Anthony

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death _____ yrs. _____ mos. _____ days. In the State _____ yrs. _____ mos. _____ days.

Where was disease contracted if not at place of death?

Former or usual residence _____

19. PLACE OF BURIAL OR REMOVAL DATE OF BURIAL

Wilford Cemetery Aug 13 1913

20. UNDERTAKER

ADDRESS

W. S. Yager St. Anthony, Ida

O. K. Meservey, Sexton

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Form V. S. No. 5. 12½ M. 7-24-11

CERTIFICATE OF DEATH

1. PLACE OF DEATH.

County of Sremont
City of St Anthony

Registration District 9

Primary Registration District No. 2038
(No. _____, _____ St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

Manny Early Norrell

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

File No. 5851

Registered No. _____

If death occurred in a hospital, institution or camp give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX

Male

4. COLOR OR RACE

White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED.

Single
(Write the word.)

6. DATE OF BIRTH

September 18 1897
(Month) (Day) (Year)

7. AGE

15 yrs. 10 mos. 27 ds.

IF LESS than 1 day
how many... hrs. or
min?

8. OCCUPATION

Student

- (a) Trade, profession or particular kind of work
(b) General nature of industry business or establishment in which employed (or employer)

9. BIRTHPLACE

(State or Country)

Hillsville Va

10. NAME OF FATHER

Jerome B Norrell

11. BIRTHPLACE OF FATHER

(State or Country)

Woodlawn Va

12. MAIDEN NAME OF MOTHER

Mary K Cochran

13. BIRTHPLACE OF MOTHER

(State or Country)

Hillsville Va.

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

(Address)

Jerome B. Norrell

15.

Filed Cox 1913Cox

Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH

Aug 10th 1913
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from

Aug 10 1913, to 191

that I last saw he was dead 191

and that death occurred on the date stated above, at 100, M.

The CAUSE OF DEATH* was as follows:

Accidental Gun Shot
wound

(Duration) _____ yrs. _____ mos. _____ ds.

Contributory
(Secondary)

(Duration) _____ yrs. _____ mos. _____ ds.

(Signed) C. B. Cox M. D.

19 (Address) St Anthony St

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place _____ In the _____
of death _____ yrs. _____ mos. _____ ds. State _____ yrs. _____ mos. _____ ds.

Where was disease contracted,

If not at place of death?

Former or

usual residence.

19. PLACE OF BURIAL OR REMOVAL DATE OF BURIAL

Wilford Id Aug 12 1913

20. UNDERTAKER

ADDRESS

None

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Form V. S. No. 5 20M.1-16-12

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH.

Registration District No. 70

County of *Shoshone*

Primary Registration District No. 1011

City of *Wallace*

(No. _____, _____ St.)

Registered No. 68

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

Beers Young Robertson

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX

male

4. COLOR OR RACE

*white*5. SINGLE, MARRIED, WID-
OWED OR DIVORCED
married
(Write the word.)

6. DATE OF BIRTH

(Month)

(Day)

(Year)

7. AGE

54 yrs. — mos. — ds.IF LESS than 1 day
how many hrs. or
..... min.

8. OCCUPATION

(a) Trade, profession or
particular kind of work
(b) General nature of industry
business, or establishment in
which employed (or employer)*Farmer*

9. BIRTHPLACE

(State or Country)

*Ill.*10. NAME OF
FATHER*Jas. K. Robertson*11. BIRTHPLACE
OF FATHER

(State or Country)

*New York*12. MAIDEN NAME
OF MOTHER*unknown*13. BIRTHPLACE
OF MOTHER

(State or Country)

unknown

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

(Address)

*G. P. Robertson
Ravilla, Mont.*

15.

Filed *Sept. 4,*

1913

*F. Leo Lingley
Local Registrar*

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH

Sept

(Month)

1st

(Day)

1913

(Year)

17. I HEREBY CERTIFY, That I attended deceased from

*Aug. 3, 1913, to Sept. 1, 1913,*that I last saw him alive on *Sept. 1, 1913,*and that death occurred on the date stated above, at *12 PM.*

The CAUSE OF DEATH* was as follows:

*Chronic Parenchymatous
Nephritis*

(Duration)

*not known*Contributory
(Secondary)

(Duration)

not known

(Signed)

W. J. Smith M. D.

19.

(Address)

Wallace, Idaho

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place
of death.....yrs.....mos.....days.In the
State.....yrs.....mos.....days.Where was disease contracted
if not at place of death?.....Former or
usual residence.....

19. PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

*Turlock, Cal.**9/5/13* 191

20. UNDERTAKER

ADDRESS

*O. E. Smith**Spokane, Wash.*

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Form V. S. No. 5 20M.1-16-12

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH

Registration District No. 70

County of Shoshone

Primary Registration District No. 1011

City of Wallace

(No. Providence Hospital St.)

File No. 5853

Registered No. 69

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Jenny Kedyierski

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX

female

4. COLOR OR RACE

white

5. SINGLE, MARRIED, WID-OWED OR DIVORCED.

single
(Write the word.)

6. DATE OF BIRTH

2 9 1912.
(Month) (Day) (Year)

7. AGE

0 yrs. 10 mos. 25 ds.

IF LESS than 1 day
how many hrs. or
mins.?

8. OCCUPATION

(a) Trade, profession, or particular kind of work none

(b) General nature of industry, business, or establishment in which employed (or employer)

9. BIRTHPLACE

(State or Country) Gem, Idaho

10. NAME OF FATHER

Tomy Kedyierski

11. BIRTHPLACE OF FATHER

Poland

12. MAIDEN NAME OF MOTHER

Antonie Caworska

13. BIRTHPLACE OF MOTHER

Poland

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Tony Kedyierski
(Address) Black Bear, Idaho

15.

Filed Sept. 5, 1913 F. Leo Dingley
Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH

9 4 1913
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from Sept 2 1913, to Sept 4 1913

that I last saw her alive on Sept 4 1913

and that death occurred on the date stated above, at 10³⁰ M.

The CAUSE OF DEATH* was as follows:

Cerebro-spinal
meningitis

(Duration) yrs. mos. 3 ds.

Contributory
(Secondary)

(Duration) yrs. mos. ds.

(Signed)

9/5 1913 (Address) Wallace, Idaho

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

Providence Hospital
At place of death 0 yrs. 0 mos. 1 days. In the State yrs. mos. days.

Where was disease contracted if not at place of death?

Former or usual residence Black Bear Idaho

19. PLACE OF BURIAL OR REMOVAL DATE OF BURIAL

Wallace, Idaho 9/6 1913

20. UNDERTAKER ADDRESS

Wallace, Id.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Form V. S. No. 5 20M.1-16-12

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH.

Registration District No. 1011

County of Shoshone

Primary Registration District No. 70

City of Wallace

(No. Providence Hospital St.)

File No. 5851

Registered No. 70

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Daniel J. McLaughlin

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX

male

4. COLOR OR RACE

white

5. SINGLE, MARRIED, WIDOWED OR DIVORCED.

married
(Write the word.)

6. DATE OF BIRTH

1860
(Month) (Day) (Year)

7. AGE

53 yrs. mos. ds.

IF LESS than 1 day
how many hrs. or
mins.?

8. OCCUPATION

(a) Trade, profession or
particular kind of work

merchant

(b) General nature of industry
business, or establishment in
which employed (or employer)

9. BIRTHPLACE

(State or Country)

New York

10. NAME OF
FATHER

Dennis McLaughlin

11. BIRTHPLACE
OF FATHER

(State or Country)

Ireland

12. MAIDEN NAME
OF MOTHER13. BIRTHPLACE
OF MOTHER

(State or Country)

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

(Address) Wallace, Idaho.

15.

Filed Sept. 15, 1913

Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH

Sept 17 1913
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from

May 1910, to Sept 17 1913
that I last saw him alive on Sept 17 1913

and that death occurred on the date stated above, at 10:30 P.M.

The CAUSE OF DEATH* was as follows:

Locomotor Ataxia

(Duration) 6 yrs. mos. ds.

Contributory
(Secondary)

(Duration) yrs. mos. ds.

(Signed)

9/18 1913

(Address) Wallace, Idaho

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions,
Transients or Recent Residents.)At place of death Providence Hosp. In the
yrs. mos. days. State yrs. mos. days.Where was disease contracted
if not at place of death?Former or
usual residence Wallace, Idaho.

19. PLACE OF BURIAL OR REMOVAL

Wallace, Idaho.

DATE OF BURIAL

9/19 1913.

20. UNDERTAKER

Bureau Mortuary

ADDRESS

Wallace, Idaho

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Form V. S. No. 5 20M.1-16-12

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH. Registration District No. 70
County of Shoshone Primary Registration District No. 1011
City of Wallace (No. Wallace Hospital St.)

File No. 5855
Registered No. 72

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME John Arkillian

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX male 4. COLOR OR RACE Malay 5. SINGLE, MARRIED, WIDOWED OR DIVORCED. single
(Write the word.)

6. DATE OF BIRTH
(Month) (Day) (Year)

7. AGE 30 yrs. mos. ds. IF LESS than 1 day how many hrs. or mins.?

8. OCCUPATION
(a) Trade, profession or particular kind of work miner
(b) General nature of industry business, or establishment in which employed (or employer)

9. BIRTHPLACE Armenia
(State or Country)

10. NAME OF FATHER

11. BIRTHPLACE OF FATHER
(State or Country)

12. MAIDEN NAME OF MOTHER

13. BIRTHPLACE OF MOTHER
(State or Country)

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Helen Stephens
(Address) Wallace, Idaho

15.

Filed Sept. 22, 1913 F. Leo Tupper Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

9 22 1913
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from Aug 30th 1913, to 22nd Sept. 1913, that I last saw him alive on 22nd Sept. 1913, and that death occurred on the date stated above, at 2 A.M.

The CAUSE OF DEATH* was as follows:

Fracture of Spine causing
Quadruplegia of cord and
paralysis
(Duration) yrs. mos. ds.

Contributory
(Secondary)

(Duration) yrs. mos. ds.

(Signed) J. H. Jean M. D.

9/22/1913 (Address) Wallace, Idaho

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
Wallace Hospital

At place of death... yrs... mos... days. State... yrs... mos... days.

Where was disease contracted if not at place of death?

Former or usual residence... Wallace Idaho

19. PLACE OF BURIAL OR REMOVAL DATE OF BURIAL
Wallace, Idaho 9/24 1913

20. UNDERTAKER ADDRESS
Wallace

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Form V. S. No. 5 20M.1-16-12

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH.

Registration District No. 70

County of *Shoshone*

Primary Registration District No. 1011

City of *Wallace*

(No. _____ St.)

File No. *5856*Registered No. *72*

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

Charlie Carlson

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX

M

4. COLOR OR RACE

White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED.

Single
(Write the word.)

6. DATE OF BIRTH

Don't know

(Month) (Day) (Year)

7. AGE

60

yrs. mos. ds.

IF LESS than 1 day
how many hrs. or
..... mins.?

8. OCCUPATION

- (a) Trade, profession or particular kind of work
(b) General nature of industry, business, or establishment in which employed (or employer)

Doctor
Tailor

9. BIRTHPLACE

(State or Country)

Sweden

10. NAME OF FATHER

Don't know

11. BIRTHPLACE OF FATHER

(State or Country)

unknown

12. MAIDEN NAME OF MOTHER

Don't know

13. BIRTHPLACE OF MOTHER

(State or Country)

Don't know

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

H. C. Mowery

(Address)

15.

Filed *Sept 23* 191*3**F. Leasure* *Wallace Idaho*

Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH

Sept 21

(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from

Sept 19 191*3*, to *Sept 21* 191*3*that I last saw him alive on *Sept 21* 191*3*and that death occurred on the date stated above, at *4:30 P.M.*

The CAUSE OF DEATH* was as follows:

Acute Lobes Pneumonia

(Duration) yrs. mos. ds.

Contributory (Secondary) *alcoholism*

(Duration) yrs. mos. ds.

(Signed) *W. S. Mowery M. D.**Sept 23* 191*3* (Address) *Wallace Ida*

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death yrs. mos. days. In the State yrs. mos. days.

Where was disease contracted if not at place of death?

Former or usual residence.

19. PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

9/23 191*3*

20. UNDERTAKER

ADDRESS

*Ward Undertaking**Wallace**Wallace*

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Form V. S. No. 5 20M.1-16-12

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH.

Registration District No. 70

County of *Shoshone*

Primary Registration District No. 1011

City of *Wallace*(No. *Hope Hospital* St.)File No. *555*Registered No. *373*

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

Grace Clark

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX

Female

4. COLOR OR RACE

white

5. SINGLE, MARRIED, WIDOWED OR DIVORCED.

single
(Write the word.)

6. DATE OF BIRTH

(Month)

(Day)

(Year)

7. AGE

*2 yrs. 8 mos. — ds.*IF LESS than 1 day
how many hrs. or
..... mins.?

8. OCCUPATION

(a) Trade, profession or particular kind of work

none

(b) General nature of industry business, or establishment in which employed (or employer)

9. BIRTHPLACE

(State or Country)

Wallace Ida

10. NAME OF FATHER

Wm G. Clark

11. BIRTHPLACE OF FATHER

(State or Country)

Iowa

12. MAIDEN NAME OF MOTHER

Mellie Johnson

13. BIRTHPLACE OF MOTHER

(State or Country)

Minnesota

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

Wm G. Clark

(Address)

Wallace Idaho

15.

Filed

Sept. 27,

1913

F. Leo Quimper
Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH

*Sept**24**1913*

(Month)

(Day)

(Year)

17. I HEREBY CERTIFY, That I attended deceased from

Sept 24 1913 to *Sept 24* 1913that I last saw her alive on *Sept 24* 1913and that death occurred on the date stated above, at *10 P.M.*

The CAUSE OF DEATH* was as follows:

Cholerae Poisoning
(Salmon probably)

(Duration) yrs. mos. ds.

Contributory

(Secondary)

(Duration) yrs. mos. ds.

(Signed)

Wm G. Clark M. D.9-27-19 (Address) *Wallace, Idaho*

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL OR HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death yrs. mos. days. In the State yrs. mos. days.

Where was disease contracted if not at place of death?

Former or usual residence.

19. PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

*Wallace Ida**Sept 28, 1913*

20. UNDERTAKER

ADDRESS

*Ward Undertaking Co**Wallace Idaho*

-SUPPLEMENTARY DEATH CERTIFICATE-

(Please reply on this sheet to
the registrar of Vital Statistics)

Death Certificate No.

Name Grace Clark

Date of Death Sept 24th 1913

Cause of Death Stomach Pirouette Salmon (probably)

Contributory Cause of death

(Sign here)

Max R. Smith

M.D.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Form V. S. No. 5 20M.1-16-12

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH. Registration District No. 121
County of Bingham Primary Registration District No. 1007
City of Blackfoot Blackfoot Hospital Francis St.)

File No. 5-5
Registered No. 80

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME George W Lay

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX Male 4. COLOR OR RACE White 5. SINGLE, MARRIED, WIDOWED OR DIVORCED. married
(Write the word.)

6. DATE OF BIRTH Jan 13 1859
(Month) (Day) (Year)

7. AGE 54 yrs. 6 mos. 23 ds.
IF LESS than 1 day how many hrs. or mins.?

8. OCCUPATION
(a) Trade, profession or particular kind of work Farmer
(b) General nature of industry business, or establishment in which employed (or employer)

9. BIRTHPLACE
(State or Country) Main.

10. NAME OF FATHER Geo W Lay
(State or Country) New York

11. BIRTHPLACE OF FATHER
(State or Country)

12. MAIDEN NAME OF MOTHER ?

13. BIRTHPLACE OF MOTHER ?
(State or Country)

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Dora Lay
(Address) Blackfoot RTD 3

15. Filed Aug. 14 1913 W. E. Patric
Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH Aug 6 1913
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from July 1 1913, to Aug 6 1913, that I last saw him alive on Aug 6 1913, and that death occurred on the date stated above, at 12:45 A.M.
The CAUSE OF DEATH* was as follows:

Tuberculosis lungs
(Duration) 10 yrs. 3 mos. — ds.

Contributory (Secondary)
(Duration) yrs. mos. ds.
(Signed) J. W. Mitchell M. D.
Aug 6 1913 (Address) Blackfoot Idaho

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death 7 yrs. 14 mos. — days. In the State — yrs. — mos. — days.

Where was disease contracted if not at place of death? Eastern States
Former or usual residence Maple Idaho

19. PLACE OF BURIAL OR REMOVAL Gene City Cemetery DATE OF BURIAL Aug 8 1913

20. UNDERTAKER E. J. Rich ADDRESS Blackfoot

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH.

Registration District No. 121County of BinghamPrimary Registration District No. 2194City of Thomas

(No. _____, St.)

File No. 5-54Registered No. 81

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

James Bowen Crawford

If death occurred in a hospital, institution or camp give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX

male

4. COLOR OR RACE

White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED.

married
(Write the word.)

6. DATE OF BIRTH

October 15 1917
(Month) (Day) (Year)

7. AGE

95 yrs. 9 mos. 21 ds. 54 min.
IF LESS than 1 day how many hrs. or

8. OCCUPATION

(a) Trade, profession, or particular kind of work
(b) General nature of industry, business, or establishment in which employed (or employer)Farmer

9. BIRTHPLACE

(State or Country)

Columbiana County Ohio

10. NAME OF FATHER

John Crawford

11. BIRTHPLACE OF FATHER

(State or Country)

State of Virginia

12. MAIDEN NAME OF MOTHER

Elizabeth Bowers

13. BIRTHPLACE OF MOTHER

(State or Country)

Atlantic Ocean

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

N. A. Crawford

(Address)

Blackfoot Idaho

15.

Filed

Aug 12 1918 W. E. Latie
Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

August 11 1913
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from

July 29 1913, to Aug 10 1913that I last saw him alive on Aug 10 1913,and that death occurred on the date stated above, 9540 A. M.

The CAUSE OF DEATH* was as follows:

General Senility

(Duration) yrs. mos. ds.

Contributory
(Secondary)

(Duration) yrs. mos. ds.

(Signed)

8-12 1913 (Address) Blackfoot Idaho

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place yrs. mos. ds. In the
of death yrs. mos. ds. State yrs. mos. ds.

Where was Disease contracted,

If not at place of death?

Former or

usual residence.

19. PLACE OF BURIAL OR REMOVAL OF BODIES

Thomas Cemetery Aug 14 1913

20. UNDERTAKER

ADDRESS

Blackfoot Idaho

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIAN should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Form V. S. No. 5 20M.1-16-12

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH.

Registration District No. 121

County of Bingham

Primary Registration District No. 2194

City of Blackfoot

(No. _____ St.)

File No. 5-611

Registered No. 82

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Ruella Wilson

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX

4. COLOR OR RACE

5. SINGLE, MARRIED, WIDOWED OR DIVORCED.

Female

White

Widowed
(Write the word.)

6. DATE OF BIRTH

Jan
(Month)

16
(Day)

1844
(Year)

7. AGE

69 yrs. 1 mos. 29 ds.

IF LESS than 1 day
how many _____ hrs. or
_____ mins.?

8. OCCUPATION

(a) Trade, profession or particular kind of work

Housewife

(b) General nature of industry business, or establishment in which employed (or employer)

9. BIRTHPLACE

(State or Country)

England

10. NAME OF FATHER

Robert Blacket

11. BIRTHPLACE OF FATHER

(State or Country)

England

12. MAIDEN NAME OF MOTHER

?

13. BIRTHPLACE OF MOTHER

(State or Country)

?

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

Claude Wilson

(Address)

Blackfoot Ida

15.

Filed

Aug 13th 1913

McE. Tuttle
Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH

Aug
(Month)

13
(Day)

1913
(Year)

17. I HEREBY CERTIFY, That I attended deceased from

Aug 9 1913, to Aug 13 1913.

that I last saw h.e. alive on Aug 12 1913

and that death occurred on the date stated above, at 38

The CAUSE OF DEATH* was as follows:

Cholecystitis

(Duration)

yrs.

mos.

ds.

Contributory
(Secondary)

Stitching Punctures

(Duration)

yrs.

mos.

ds.

(Signed)

H. J. Simmons, D.

Aug 13 1913, (Address) Blackfoot

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death

X yrs. X mos. _____ days.

In the State

1 yrs. 4 mos. _____ days.

Where was disease contracted if not at place of death?

Former or usual residence

Utah

19. PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

Ross Utah

1913

20. UNDERTAKER

ADDRESS

E. J. Ruck

Blackfoot

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Form V. S. No. 5. 12½ M. 7-24-11

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH. Registration District No. 121
County of Blaine Primary Registration District No. 2194
City of Blackfoot (No. _____, _____ St.)
3 miles East

File No. 5861Registered No. 83

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME May M. Hodson

If death occurred in a hospital, institution or camp give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX F 4. COLOR OR RACE W 5. SINGLE, MARRIED, WIDOWED OR DIVORCED. Single
(Write the word.)

6. DATE OF BIRTH July 5 1913
(Month) (Day) (Year)

7. AGE 1 yrs. 15 mos. 15 ds. IF LESS than 1 day how many hrs. or mins. 7

8. OCCUPATION

(a) Trade, profession or particular kind of work.
(b) General nature of industry business or establishment in which employed (or employer)

9. BIRTHPLACE Blackfoot Ida
(State or Country)

10. NAME OF FATHER John B. Hodson

11. BIRTHPLACE OF FATHER Utah
(State or Country)

12. MAIDEN NAME OF MOTHER Russie Watson

13. BIRTHPLACE OF MOTHER Idaho
(State or Country)

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) J. B. Davis M.D.
(Address) Blackfoot Ida

15. Filed Aug 20 1913 W. E. Patis
Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH Aug 20 1913
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from Aug 8 1913, to Aug 20 1913
that I last saw her alive on Aug 20 1913
and that death occurred on the date stated above, at 2:30 P.M.
The CAUSE OF DEATH* was as follows:

Whooping Cough

(Duration) 15 yrs. 15 mos. 15 ds.

Contributory (Secondary) _____

(Duration) _____ yrs. _____ mos. _____ ds.

(Signed) J. B. Davis M. D.

(Address) _____

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place In the
of death _____ yrs. _____ mos. _____ ds. State _____ yrs. _____ mos. _____ ds.
Where was disease contracted,
If not at place of death? _____
Former or
usual residence _____

19. PLACE OF BURIAL OR REMOVAL DATE OF BURIAL

Gann City Cemetery Aug 20 1913

20. UNDERTAKER ADDRESS

Mrs J. Stodson Blackfoot

A stillbirth must be registered both as a birth and death. The date of death should be the date of delivery and the death certificate should further state, if known, the cause of the stillbirth and the period of utero gestation in months.

STATEMENT OF OCCUPATION.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer, Physician, Stenographer, Composer, Architect, Locomotive engineer, Civil engineer, Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner*, (b) *Cotton mill*; (a) *Salesman*, (b) *Grocery*; (a) *Foreman*, (b) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification, as *Day laborer, Farm laborer, Laborer—Coal mine*, etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers*, who receive a definite salary), may be entered as *Housewife, Housework*, or *At home*, and children, not gainfully employed, as *At school* or *At home*. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer (retired, 6 yrs.)*. For persons who have no occupation whatever, write *None*.

STATEMENT OF CAUSE OF DEATH.—Name, first the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebro-*

spinal fever (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid Pneumonia"); *Lobar pneumonia*; *Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritoneum*, etc., *Carcinoma, Sarcoma*, etc., of (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent affection need not be stated unless important. Example: *Measles* (disease causing death), 29 ds.; *Bronchopneumonia* (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "Asthenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility, (Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Haemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uraemia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify as "PUERPERAL, septicemia", "PUERPERAL peritonitis," etc., all diseases resulting from childbirth or miscarriage. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning; Struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "Contributory."

2 # 6

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Form V. S. No. 5 20M.1-16-12

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH. Registration District No. 121
County of Bannock Primary Registration District No. 2194
City of Thomas Ward (No. _____ St.)

File No. 5862
Registered No. 84

If death occurs away from usual residence, give facts called for under special instruction.

2. FULL NAME Arnold Mc Bride

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX Male 4. COLOR OR RACE W 5. SINGLE, MARRIED, WIDOWED OR DIVORCED. S (Write the word.)

6. DATE OF BIRTH James 1913
(Month) (Day) (Year)

7. AGE _____ yrs. _____ mos. _____ ds. IF LESS than 1 day how many _____ hrs. or _____ mins.

8. OCCUPATION

- (a) Trade, profession or particular kind of work _____
(b) General nature of industry business, or establishment in which employed (or employer) _____

9. BIRTHPLACE (State or Country) Idaho

10. NAME OF FATHER Edwin Mc Bride

11. BIRTHPLACE OF FATHER (State or Country) Utah

12. MAIDEN NAME James

13. BIRTHPLACE OF MOTHER (State or Country) Utah

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) John Mc Bride
(Address) Blackfoot R40, #2

15. Filed Aug 26 1913 W E Patie
Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH Aug 25 1913
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from Aug 23 1913 to Aug 25 1913, that I last saw him alive on Aug 23 1913 and that death occurred on the date stated above, at 11 P M.

The CAUSE OF DEATH* was as follows:

Cholera Infantum
due to artificial feeding
of cows milk, & flies
(Duration) _____ yrs. _____ mos. _____ ds.

Contributory (Secondary) _____

(Signed) W E Patie M. D.
8-26-13 (Address) Blackfoot

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death _____ yrs. _____ mos. _____ days. In the State _____ yrs. _____ mos. _____ days.

Where was disease contracted if not at place of death? _____

Former or usual residence _____

19. PLACE OF BURIAL OR REMOVAL Thomas Burial DATE OF BURIAL Aug 27 1913

20. UNDERTAKER John Mc Bride ADDRESS Blackfoot

MARGIN RESERVED FOR BINDING
WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Form V. S. No. 5 20M.1-16-12

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH

Registration District No. 121

County of Benham

Primary Registration District No. 1007

City of Blackfoot

(No. 1007) Carbon House St.

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

George Frank Wolfe

File No. 549

Registered No. 85

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX

Male

4. COLOR OR RACE

White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED

Divorced
(Write the word.)

6. DATE OF BIRTH

Feb

1861

(Month)

(Day)

(Year)

7. AGE

52 yrs. 6 mos. - ds.

IF LESS than 1 day
how many hrs. or
mins.?

8. OCCUPATION

(a) Trade, profession or particular kind of work

Farmer

(b) General nature of industry business, or establishment in which employed (or employer)

9. BIRTHPLACE

(State or Country)

Ohio

10. NAME OF FATHER

Rezin Wolfe

11. BIRTHPLACE OF FATHER

(State or Country)

Ohio

12. MAIDEN NAME OF MOTHER

Anne Bonner

13. BIRTHPLACE OF MOTHER

(State or Country)

Ohio

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

Kenneth B. Wolfe

(Address)

1775 E. 11th St.
South Portland Or.

15.

Filed

Aug 22 1913

W. E. Patric
Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

Aug

21

1913

(Month)

(Day)

(Year)

17. I HEREBY CERTIFY, That I attended deceased from

Aug 9 1913, to Aug 21 1913,

that I last saw him alive on Aug 21 1913

and that death occurred on the date stated above, at 12 P.M.

The CAUSE OF DEATH was as follows:

Myocardial infarction

(Duration)

22 yrs. mos. ds.

Contributory

(Secondary)

Toxemia

Exhaustion

(Duration)

10 mos. ds.

(Signed)

W. E. Patric

M. D.

Aug 19 1913 (Address) Blackfoot Idaho

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place

of death.....yrs.....mos.....days.

In the

State.....yrs.....mos.....days.

Where was disease contracted if not at place of death?

Former or usual residence.....

19. PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

Burial

Aug 23 1913

20. UNDERTAKER

ADDRESS

E. J. Puck

Blackfoot Idaho

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Form V. S. No. 5 20M.1-16-12

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH.

Registration District No. 121

County of Bingham

Primary Registration District No. 21921

File No. 5564

City of Blackfoot

(No. _____, St.)

Registered No. 86

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

Marshall Frank Allen

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX

male

4. COLOR OR RACE

white

5. SINGLE, MARRIED, WIDOWED OR DIVORCED.

married
(Write the word.)

6. DATE OF BIRTH

Sept 11 1860
(Month) (Day) (Year)

7. AGE

52 yrs. 11 mos. 2 ds.

IF LESS than 1 day
how many hrs. or
..... mins.?

8. OCCUPATION

(a) Trade, profession or particular kind of work

Farmer

(b) General nature of industry business, or establishment in which employed (or employer)

9. BIRTHPLACE

(State or Country)

Williams Utah

10. NAME OF FATHER

Marshall F. Allen

11. BIRTHPLACE OF FATHER

(State or Country)

N. Y.

12. MAIDEN NAME OF MOTHER

Mary E. Holmes

13. BIRTHPLACE OF MOTHER

(State or Country)

England

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

A. O. Allen

(Address)

Blackfoot Idaho

15.

Filed

Aug 26 1913

M. E. L. L.
Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

Aug 25 1913
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from April 1 1913, to Aug 21 1913, that I last saw him alive on Aug 21 1913, and that death occurred on the date stated above, at 10 P. M.

The CAUSE OF DEATH* was as follows:

Uremia

(Duration) 1 yrs. 1 mos. 1 ds.

Contributory (Secondary)

Bright's disease

(Duration) 1 yrs. 1 mos. 1 ds.

(Signed)

F. W. Mutchler

M. D.

Aug 21 1913 (Address) Blackfoot Idaho

State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death yrs. mos. days. In the State yrs. mos. days.

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

From City Cem

Aug 27 1913

20. UNDERTAKER

ADDRESS

A. O. Allen

Blackfoot

MARGIN RESERVED FOR BINDING
WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Form V. S. No. 5. 10M. 6-20-11.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH.

County of Bingham
City of Blackfoot

Registration District No. 121
Primary Registration District No. 2194
(No. Danko Brame Englem St.)

File No. 5860
Registered No. 87

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Hugh R. Brett

If death occurred in a hospital, institution or camp give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX

Male

4. COLOR OR RACE

White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED.

Single
(Write the word.)

6. DATE OF BIRTH

1884
(Month) (Day) (Year)

7. AGE

29 yrs. 0 mos. 0 ds.
IF LESS than 1 day how many hrs. or min.?

8. OCCUPATION

(a) Trade, profession, or particular kind of work Fireman on Locomotive
(b) General nature of industry, business, or establishment in which employed (or employer)

9. BIRTHPLACE

(State or Country) Westport, Mo.

10. NAME OF FATHER

Hugh Brett

11. BIRTHPLACE OF FATHER

(State or Country) England

12. MAIDEN NAME OF MOTHER

Mary Axel

13. BIRTHPLACE OF MOTHER

(State or Country) England

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) G. W. E. Hyde
(Address) Blackfoot, Idaho

15.

Filed Aug 26 1913 W. E. Patric
Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

August 24 1913
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from

July 1st 1913, to Aug. 24th 1913
that I last saw him alive on Aug. 24th 1913,
and that death occurred on the date stated above, at 4- P. M.

The CAUSE OF DEATH* was as follows:

Maniacal Exhaustion

(Duration) — yrs. — mos. Seven ds.

Contributory Destruction of Cerebral tissue by blow
(Secondary) of an axe

(Duration) 15 yrs. — mos. — ds.

(Signed) Geo E. Hyde M. D.
Aug 26 1913 (Address) Blackfoot

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL,

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place Idaho Brame Englem In the County of Bingham
of death 1 yrs. 11 mos. 20 ds. State 7 yrs. — mos. — ds.

Where was Disease contracted,
If not at place of death? —

Former or usual residence Boise

19. PLACE OF BURIAL OR REMOVAL

Caldwell Idaho

DATE OF BURIAL

191

20. UNDERTAKER

E. J. Luck

ADDRESS

Blackfoot

WHITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Form V. S. No. 5 20M.1-16-12

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics
File No. 5866
Registered No. 88

1. PLACE OF DEATH.

Registration District No. 121

County of

Primary Registration District No. 2194

City of

(No. , St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

Unmarried Male

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX

4. COLOR OR RACE

5. SINGLE, MARRIED, WIDOWED OR DIVORCED.

Male

W

2 (Write the word.)

6. DATE OF BIRTH

Aug 29 1913
(Month) (Day) (Year)

7. AGE

..... yrs. mos. ds.

IF LESS than 1 day
how many hrs. or
..... mins.?

8. OCCUPATION

(a) Trade, profession or particular kind of work

(b) General nature of industry business, or establishment in which employed (or employer)

9. BIRTHPLACE

(State or Country)

Idaho Goodland

10. NAME OF FATHER

William W. Hall

11. BIRTHPLACE OF FATHER

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Form V. S. No. 5 20M.1-16-12

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH.

Registration District No.

County of Blaine

Primary Registration District No. 2194E

File No. 5867

City of Blaine

(No. _____, _____ St.)

Registered No. 89

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Unmarried Male

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX Male

4. COLOR OR RACE W

5. SINGLE, MARRIED, WIDOWED OR DIVORCED.

(Write the word.)

6. DATE OF BIRTH Aug 29 1913

(Month)

(Day)

(Year)

7. AGE

IF LESS than 1 day
how many _____ hrs. or
_____ mins.?

_____ yrs. _____ mos. _____ ds.

8. OCCUPATION

(a) Trade, profession or particular kind of work

(b) General nature of industry business, or establishment in which employed (or employer)

9. BIRTHPLACE

(State or Country) Portland Idaho

10. NAME OF FATHER Alvin W Hare

11. BIRTHPLACE OF FATHER

(State or Country) Utah

12. MAIDEN NAME OF MOTHER Julia Dean

13. BIRTHPLACE OF MOTHER

(State or Country) Utah

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) John P. Deane

(Address) Blackfoot Route #1

15.

Filed Aug 29 1913

1913

Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH Aug 29 1913

(Month)

(Day)

(Year)

17. I HEREBY CERTIFY, That I attended deceased from 1913 to 1913, that I last saw him live on 1913

and that death occurred on the date stated above, at 4:00 M.

The CAUSE OF DEATH* was as follows:

Primature delivery

(Duration) _____ yrs. _____ mos. _____ ds.

Contributory (Secondary)

(Duration) _____ yrs. _____ mos. _____ ds.

(Signed) M. D. Deane

(Address) Blackfoot

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death _____ yrs. _____ mos. _____ days. In the State _____ yrs. _____ mos. _____ days.

Where was disease contracted if not at place of death?

Former or usual residence.

19. PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

20. UNDERTAKER

ADDRESS

Funeral Cemetery, Blackfoot

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Form V. S. No. 3. 10M-8

1. PLACE OF DEATH. Registration District No. 121
County of Bingham Primary Registration District No. 2194
City of Blackfoot (No. _____ St.) Registered No. _____
If death occurs away from usual residence, give facts called for under special information. 2. FULL NAME Arthur W. Eldredge
If death occurred in institution or camp instead of street and

PERSONAL AND STATISTICAL PARTICULARS

3. SEX Male 4. COLOR OR RACE White 5. SINGLE, MARRIED, WIDOWED OR DIVORCED. Married
(Write the word.)

6. DATE OF BIRTH — about 1863
(Month) (Day) (Year)

7. AGE 50 yrs. — mos. — ds. IF LESS than 1 day how many — hrs. or — min.?

8. OCCUPATION

(a) Trade, profession, or particular kind of work Shoemaker
(b) General nature of industry business, or establishment in which employed (or employer) —

9. BIRTHPLACE Illinois
(State or Country)

10. NAME OF FATHER —

11. BIRTHPLACE OF FATHER —
(State or Country)

12. MAIDEN NAME OF MOTHER —

13. BIRTHPLACE OF MOTHER —
(State or Country)

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Geo. J. Boyd
(Address) Blackfoot

15. Filed Aug 31 1913 W. E. Pettit
Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH August 29th
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from July 3rd 1913, to Aug 29th 1913
that I last saw him alive on Aug 29th 1913,
and that death occurred on the date stated above, at 4:10 P.M.

The CAUSE OF DEATH* was as follows:

Cerebral Hemorrhage

(Duration) — yrs. — mos. — ds.
Contributory (Secondary) Partial Dementia

(Duration) One yrs. — mos. — ds.
(Signed) Geo. J. Boyd M. D.
Sept 6 1913 (Address) Blackfoot

*State the DISEASE CAUSING DEATH; or in deaths from VICIDENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place In the
of death — yrs. One mos. 26 ds. State Idaho yrs. — mos. — ds.
Where was Disease contracted, Don't know
If not at place of death?
Former or usual residence Wendell, Idaho

19. PLACE OF BURIAL OR REMOVAL DATE OF BURIAL
Asylum Cemetery, Blackfoot Aug 31st 1913

20. UNDERTAKER ADDRESS
Geo. J. Boyd Blackfoot
Idaho

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Form V. S. No. 5 20M.1-16-12

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH Registration District No. 3131
County of Bingham Primary Registration District No. 2194
City of Morland (No. _____ St.)

File No. 5869Registered No. 91

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Edwin Capson

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX 4. COLOR OR RACE 5. SINGLE, MARRIED, WIDOWED OR DIVORCED.

MaleWhiteSingle
(Write the word.)

6. DATE OF BIRTH

11

(Month)

23

(Day)

1875

(Year)

7. AGE

37

yrs.

9

mos.

8

ds.

IF LESS than 1 day
how many hrs. or
..... mins.?

8. OCCUPATION

(a) Trade, profession or particular kind of work

Farming

(b) General nature of industry, business, or establishment in which employed (or employer)

9. BIRTHPLACE

(State or Country)

Salt Lake Co. Utah

10. NAME OF FATHER

Carl Capson

11. BIRTHPLACE OF FATHER

(State or Country)

Sweden

12. MAIDEN NAME OF MOTHER

Caroline Neelgrau

13. BIRTHPLACE OF MOTHER

(State or Country)

Sweden

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

Geo. H. Capson

(Address)

R. F. D. No. 1 Blackfoot

15.

Filed

Sept 11913W. E. Patis

Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH

8

(Month)

31

(Day)

1913

(Year)

17. I HEREBY CERTIFY, That I attended deceased from

Aug 30 1913, to Aug 31 1913,that I last saw him alive on Aug 30 1913,and that death occurred on the date stated above, at 5 P.M.

The CAUSE OF DEATH* was as follows:

Heart failure, due to
sp. adenoma, profuse
hemorrhage from lungs(Duration) yrs. mos. 1 ds.

Contributory (Secondary)

Pulmonary Cavity(Duration) yrs. mos. 2 ds.

(Signed)

E. J. Patis M.D.9/1 1913 (Address) Blackfoot, Ida

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place

of death yrs. mos. days.

In the

State yrs. mos. days.

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

Salt Lake City191

20. UNDERTAKER

ADDRESS

E. J. PatisBlackfoot

WITH UNFADING INK—THIS IS A PERMANENT RECORD.
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIAN'S CLASSES should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

1. PLACE OF DEATH. Registration District No. 2194
County of Birmingham Primary Registration District No. 2194
City of Blackfoot (No. _____ St.)
Bureau of Vital Statistics
File No. 5870
Registered No. 92
If death occurs away from usual residence, give facts called for under special information. 2. FULL NAME George M. Miles
If death occurred in a hospital, institution or camp give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX Male 4. COLOR OR RACE White 5. SINGLE, MARRIED, WIDOWED OR DIVORCED. Married
(Write the word.)

6. DATE OF BIRTH 1886
(Month) (Day) (Year)

7. AGE 57 yrs. - mos. - ds. IF LESS than 1 day how many hrs. or min.?

8. OCCUPATION Stone Mason
(a) Trade, profession, or particular kind of work
(b) General nature of industry business, or establishment in which employed (or employer)

9. BIRTHPLACE Princeton, Ill.
(State or Country)

10. NAME OF FATHER W. Miles

11. BIRTHPLACE OF FATHER England
(State or Country)

12. MAIDEN NAME OF MOTHER

13. BIRTHPLACE OF MOTHER

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Geo. E. Hyde
(Address) Blackfoot

15. Filed Sept 4 1913
W. E. Latimer
Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH Sept 2nd 1913
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from July 1st 1913, to Sept 2nd 1913
that I last saw him alive on Sept 2nd 1913,
and that death occurred on the date stated above, at 120 A.M.

The CAUSE OF DEATH* was as follows:

Senile Dementia

(Duration) Three yrs. - mos. - ds.

Contributory (Secondary) arterial Sclerosis

(Duration) Don't know yrs. - mos. - ds.

(Signed) Geo. E. Hyde M. D.
Sept 6 1913 (Address) Blackfoot, Idaho

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death. 5 yrs. 2 mos. 4 ds. State. Id. yrs. - mos. - ds.

Where was Disease contracted, If not at place of death?

Former or usual residence. Shoshone, Idaho

19. PLACE OF BURIAL OR REMOVAL Bogham Cemetery, Blackfoot DATE OF BURIAL Sept 4 1913

20. UNDERTAKER Geo E Hyde ADDRESS Blackfoot

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Form V. S. No. 5 20M.1-16-12

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH

Registration District No. 121County of BinghamPrimary Registration District No. 1007City of Blackfoot(No. 216, West side St.)File No. 5871Registered No. 98

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

Saloma E. Hymas

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX

Female

4. COLOR OR RACE

White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED

Married
(Write the word.)

6. DATE OF BIRTH

March 22 1845
(Month) (Day) (Year)

7. AGE

68 yrs. 5 mos. 14 ds.IF LESS than 1 day
how many hrs. or
mins.?

8. OCCUPATION

(a) Trade, profession or particular kind of work

Housewife

(b) General nature of industry, business, or establishment in which employed (or employer)

9. BIRTHPLACE

(State or Country)

Iowa, U.S.A.

10. NAME OF FATHER

Leroy Hammond

11. BIRTHPLACE OF FATHER

(State or Country)

Penns. U.S.A.

12. MAIDEN NAME OF MOTHER

Valley Bybee

13. BIRTHPLACE OF MOTHER

(State or Country)

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

(Address)

B. H. Desjardis
Cleveland, Ida.

15.

Filed

Sept 8 1913

Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

9 1913
(Month) (Day) (Year)17. I HEREBY CERTIFY, That I attended deceased from
many years 1911, to Sept 6 1913,
that I last saw her alive on Sept 3 1913,
and that death occurred on the date stated above, at 11 P.M.

The CAUSE OF DEATH* was as follows:

Heart Failure, due to
valvular disease with dilatation(Duration) 5 yrs. — mos. — ds.Contributory
(Secondary)Valvular Disease of
Heart(Duration) 5 yrs. — mos. — ds.

(Signed)

C. T. Hooper M. D.9/7 1913 (Address) Blackfoot, Ida.

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place

of death.....yrs.....mos.....days.

In the

State.....yrs.....mos.....days.

Where was disease contracted
if not at place of death?Former or
usual residence

19. PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

Blackfoot, Idaho1913

20. UNDERTAKER

ADDRESS

E. J. RuckBlackfoot

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Form V. S. No. 5. 12½ M. 7-24-11

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics
File No. 5562
Registered No. 94

1. PLACE OF DEATH. Registration District No. 121
County of Brigham Primary Registration District No. 1007
City of Blackfoot (No. East Juarez St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

Flora Campbell

If death occurred in a hospital, institution or camp give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX F 4. COLOR OR RACE W. 5. SINGLE, MARRIED, WIDOWED OR DIVORCED. Married
6. DATE OF BIRTH Jan 18 86 4
(Month) (Day) (Year)
7. AGE 49 yrs. 7 mos. 19 ds. IF LESS than 1 day how many hrs. or min?

8. OCCUPATION

(a) Trade, profession or particular kind of work.
(b) General nature of industry business or establishment in which employed (or employer)

At Home

9. BIRTHPLACE

(State or Country)

Minnesota

10. NAME OF FATHER

Hugh Campbell

11. BIRTHPLACE OF FATHER

(State or Country)

Pennsylvania

12. MAIDEN NAME OF MOTHER

Lucinda Free

13. BIRTHPLACE OF MOTHER

(State or Country)

Pennsylvania

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

J. B. Davis M.D.
Blackfoot Ida

15.

Filed Sept 7 1913W. E. Patric
Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH

Sept 7 1913
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from

Nov 1912, to Sept 7 1913

that I last saw her alive on Sept 6 1913

and that death occurred on the date stated above, at 8 a M.

The CAUSE OF DEATH* was as follows:

Chronic Rheumatoid Arthritis

(Duration) 25 yrs. — mos. — ds.

Contributory Cerebral Hemorrhage
(Secondary)

(Duration) — yrs. 3 mos. — ds.

(Signed) J. B. Davis M. D.

19 (Address) Blackfoot Ida

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place In the
of death — yrs. — mos. — ds. State — yrs. — mos. — ds.

Where was disease contracted,

If not at place of death?

Former or

usual residence.

19. PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

Marion Mills Minn. Sept 8 1913

20. UNDERTAKER

ADDRESS

E. J. Peck Blackfoot

Form V. S. No. 5 20M.1-16-12

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH.

Registration District No. 121

County of Bingham

Primary Registration District No. 1007

City of Blackfoot

(No. Hospital Francis St.)

File No. 54

Registered No. 90

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME unnamed Cape

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX

Male

4. COLOR OR RACE

white

5. SINGLE, MARRIED, WIDOWED OR DIVORCED.

Single
(Write the word.)

6. DATE OF BIRTH

Sept 10 1913
(Month) (Day) (Year)

7. AGE

— yrs. — mos. — ds.

IF LESS than 1 day
how many 2 hrs. or
..... mins.?

8. OCCUPATION

(a) Trade, profession or particular kind of work

(b) General nature of industry business, or establishment in which employed (or employer)

9. BIRTHPLACE

(State or Country) Blackfoot, Idaho

10. NAME OF FATHER

Ralph P. Cape

11. BIRTHPLACE OF FATHER

(State or Country) Mo.

12. MAIDEN NAME OF MOTHER

Myrtlewood

13. BIRTHPLACE OF MOTHER

(State or Country) Mo

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

Ralph P. Cape

(Address)

15.

Filed

Sept 10 1913 M. E. Letic
Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH

Sept 10 1913
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from

Sept 10 1913, to Sept 10 1913

that I last saw him alive on Sept 10 1913

and that death occurred on the date stated above, at 4 P. M.

The CAUSE OF DEATH* was as follows:

Pneumonia 7 mo.

(Duration) — yrs. — mos. — ds.

Contributory
(Secondary)

(Duration) — yrs. — mos. — ds.

(Signed) F. W. Mitchell M. D.

9/10 1913 (Address) Blackfoot, Idaho

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death — yrs. — mos. — days. In the State — yrs. — mos. — days.

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

Idaho City Cem. Blackfoot Sept 10 1913

20. UNDERTAKER

ADDRESS

E. J. Rick Blackfoot

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH.

Registration District No. 121

County of Bingham

Primary Registration District No. 1007

City of Blackfoot(No. Blackfoot Hosp. Francis St St.)

File No. 5874

Registered No. 96

If death occurs away from usual residence, give facts called for under special information.

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Myrtle Lee Leafe

PERSONAL AND STATISTICAL PARTICULARS

3. SEX

4. COLOR OR RACE

5. SINGLE, MARRIED, WIDOWED OR DIVORCED.

Female whiteMarried
(Write the word.)

6. DATE OF BIRTH

Sept 9 1881
(Month) (Day) (Year)

7. AGE

32 yrs. — mos. 5 ds.IF LESS than 1 day
how many hrs. or
..... mins.?

8. OCCUPATION

(a) Trade, profession or particular kind of work

(b) General nature of industry, business, or establishment in which employed (or employer)

Housewife

9. BIRTHPLACE

(State or Country)

Mo.

10. NAME OF FATHER

J M Wood

11. BIRTHPLACE OF FATHER

(State or Country)

Ind

12. MAIDEN NAME OF MOTHER

Elizabeth Lee

13. BIRTHPLACE OF MOTHER

(State or Country)

Mo

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

R. P. Cope

(Address)

Blackfoot

15.

Filed Sept 15 1913

Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH

Sept. 15 1913
(Month) (Day) (Year)17. I HEREBY CERTIFY, That I attended deceased from Sept 8 1913, to Sept 15 1913that I last saw her alive on Sept 15 1913and that death occurred on the date stated above, at 7:4 A.M.

The CAUSE OF DEATH* was as follows:

Intestinal obstruction(Duration) — yrs. 8 mos. — ds.Contributory
(Secondary)(Duration) — yrs. — mos. — ds.(Signed) F. W. Mitchell M. D.9/15 1913 (Address) Blackfoot, Idaho

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death — yrs. — mos. — days. In the State — yrs. — mos. — days.

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL DATE OF BURIAL

Riverside Thomas Cem Sept 16 1913

20. UNDERTAKER

ADDRESS

E. J. RuckBlackfoot

Form V. S. No. 5 20M.1-16-12

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH

Registration District No.

County of

Primary Registration District No.

City of

(No. 204, E. Albee

St.)

File No.

Registered No.

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX

4. COLOR OR RACE

5. SINGLE, MARRIED, WIDOWED OR DIVORCED.

(Write the word.)

6. DATE OF BIRTH

7. AGE

yrs. mos. ds.

IF LESS than 1 day
how many hrs. of
mins.?

8. OCCUPATION

(a) Trade, profession or particular kind of work
(b) General nature of industry business, or establishment in which employed (or employer)

9. BIRTHPLACE

(State or Country)

10. NAME OF FATHER

11. BIRTHPLACE OF FATHER

(State or Country)

12. MAIDEN NAME OF MOTHER

13. BIRTHPLACE OF MOTHER

(State or Country)

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

(Address)

15.

Filed

1913

Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH

17. I HEREBY CERTIFY, That I attended deceased from

Sept 17 1913, to Sept 17 1913

that I last saw him alive on Sept 17 1913

and that death occurred on the date stated above, at 4⁴⁰ P.M.

The CAUSE OF DEATH* was as follows:

Contributory
(Secondary)

(Signed)

Sept 18 1913 (Address) Blackfoot

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death.....yrs.....mos.....days. In the State.....yrs.....mos.....days.

Where was disease contracted if not at place of death?.....

Former or usual residence.....

19. PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

G. E. Com. Blackfoot Sept 18 1913

20. UNDERTAKER

ADDRESS

G. E. Boyle Blackfoot

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Form V. S. No. 5 20M.1-16-12

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH.

Registration District No. 121County of BinghamPrimary Registration District No. 1007City of Blackfoot(No. 154, No. Alice St.)File No. 5877Registered No. 99

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME William J. Duncan

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX

Male

4. COLOR OR RACE

white

5. SINGLE, MARRIED, WIDOWED OR DIVORCED.

Married
(Write the word.)

6. DATE OF BIRTH

10 (Month) 17 (Day) 1848 (Year)

7. AGE

64 yrs. 10 mos. 17 ds.IF LESS than 1 day
how many hrs. or
..... mins.?

8. OCCUPATION

(a) Trade, profession or particular kind of work

Farmer

(b) General nature of industry business, or establishment in which employed (or employer)

9. BIRTHPLACE

(State or Country)

Ind.

10. NAME OF FATHER

Henry Duncan

11. BIRTHPLACE OF FATHER

(State or Country)

Ind.

12. MAIDEN NAME OF MOTHER

May & Malott

13. BIRTHPLACE OF MOTHER

(State or Country)

Ind.

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

James O. Duncan

(Address)

Aberdeen, Ida.

15.

Filed

Sept. 5th 1913 W. E. Petrie

Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH

4 Sept.

(Month)

(Day)

1913 (Year)

17. I HEREBY CERTIFY, That I attended deceased from

Sept 3 1913, to Sept 4 1913,that I last saw him alive on Sept 4 1913,and that death occurred on the date stated above, at P.M.

The CAUSE OF DEATH* was as follows:

exhaustion of liver

(Duration)

yrs.

mos.

2 ds.Contributory lung disease
(Secondary)

(Duration)

yrs.

mos.

1 ds.

(Signed)

John B. Cooper, M. D.

19.

(Address)

Blackfoot

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death

yrs.

mos.

days.

In the State

yrs.

mos.

days.

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL DATE OF BURIAL

Fun. ch. cem. Blackfoot Sept 5 1913

20. UNDERTAKER

E. J. Ruk

ADDRESS

Blackfoot

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Form V. S. No. 5 20M.1-16-12

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH.

Registration District No. 121

County of Bannock

Primary Registration District No. 1007

City of Blackfoot

(No. 1838 out of judicial St.)

File No. 587

Registered No. 100

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

Eva May Myers

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX

Female

4. COLOR OR RACE

White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED.

Married
(Write the word.)

6. DATE OF BIRTH

2

(Month)

12

(Day)

1861

(Year)

7. AGE

32 yrs. 6 mos. 27 ds.

IF LESS than 1 day
how many hrs. or mins.?

8. OCCUPATION

(a) Trade, profession or particular kind of work

House wif

(b) General nature of industry business, or establishment in which employed (or employer)

9. BIRTHPLACE

(State or Country)

Iowa

10. NAME OF FATHER

Jack O. Kinney

11. BIRTHPLACE OF FATHER

(State or Country)

Ohio

12. MAIDEN NAME OF MOTHER

Marguerite Sellers

13. BIRTHPLACE OF MOTHER

(State or Country)

Ohio

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

Martha Myers

(Address)

15.

Filed

Sept 11 1913

M. E. Patric
Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH

Sept

(Month)

9

(Day)

1913

(Year)

17. I HEREBY CERTIFY, That I ~~attended deceased from~~

investigated death ~~1st~~ to on Sept 10 1913,

that I last saw h— alive on 191

and that death occurred on the date stated above, at 10 P M.

The CAUSE OF DEATH* was as follows:

Diabetes mellitus

(Duration) 2 yrs. — mos. — ds.

Contributory
(Secondary)

(Duration) — yrs. — mos. — ds.

(Signed)

J. Davis

M. D.

19 (Address) Health officer

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death — yrs. — mos. — days. In the State — yrs. — mos. — days.

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

Graves City Cemetery Blackfoot Sept 11 1913

20. UNDERTAKER

ADDRESS

E. J. Beck

Blackfoot

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. PHYSICIANS should be stated EXACTLY. Exact state-
ment of OCCUPATION is very important. See instructions on back of certificate.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. Exact state-
ment of CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact state-
ment of OCCUPATION is very important. See instructions on back of certificate.

Form V. S. No. 5. 10M. 6-20-11.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics
File No. 5879
Registered No. 21

1. PLACE OF DEATH.

Registration District No. 34

County of Elmore

Primary Registration District No. 2020

City of Inter Home

(No. _____, _____ St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

Vera W Rice

If death occurred in a hospital, institution or camp give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX

4. COLOR OR RACE

5. SINGLE, MARRIED, WIDOWED OR DIVORCED.

Female White

(Write Single)

6. DATE OF BIRTH

June 30 1913
(Month) (Day) (Year)

7. AGE

2 yrs. 25 mos. 25 ds. IF LESS than 1 day how many 25 hrs. or min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work
(b) General nature of industry business or establishment in which employed (or employer)

9. BIRTHPLACE

(State or Country)

Idaho
Elmore County

10. NAME OF FATHER

Edward C. Rice

11. BIRTHPLACE OF FATHER

(State or Country)

Minnesota

12. MAIDEN NAME OF MOTHER

Maudie E. Ashburn

13. BIRTHPLACE OF MOTHER

(State or Country)

Nebraska

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

Maudie E. Rice

(Address)

Inter Home Idaho

15.

Filed Sept. 25th 1913.

B. W. Mathew
Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

Sept 25 1913
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from

1913, to Sept 25 1913

that I last saw her alive on Sept 24 1913

and that death occurred on the date stated above, at 12 30 PM.

The CAUSE OF DEATH* was as follows:

Cholera Infantum

(Duration) _____ yrs. _____ mos. 6 ds.

Contributory (Secondary) Pneumonia

(Duration) _____ yrs. _____ mos. 2 ds.

(Signed) W. H. Strain M. D.
9/25 1913 (Address) Mountain Home

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death. _____ yrs. _____ mos. _____ ds. In the _____ State. _____ yrs. _____ mos. _____ ds.

Where was disease contracted.

If not at place of death?

Former or

usual residence.

19. PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

Inter Home

Sept 26 1913

20. UNDERTAKER

ADDRESS

H. J. Wilbur

Inter Home

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Form V. S. No. 5 20M.1-16-12

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics
File No. 5880
Registered No. 22

1. PLACE OF DEATH
County of Elmore
City of Mountain Home (No. _____ St.)
Registration District No. 34
Primary Registration District No. 2020

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Josefa Arvilliga Tajo

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX Female 4. COLOR OR RACE W 5. SINGLE, MARRIED, WIDOWED OR DIVORCED.
(Write the word.)

6. DATE OF BIRTH Sept. 25th 1913
(Month) (Day) (Year)

7. AGE _____ yrs. _____ mos. _____ ds.
IF LESS than 1 day how many _____ hrs. or _____ mins.?

8. OCCUPATION

(a) Trade, profession or particular kind of work
(b) General nature of industry, business, or establishment in which employed (or employer)

9. BIRTHPLACE

(State or Country) Idaho

10. NAME OF FATHER Antero Arvillaga
11. BIRTHPLACE OF FATHER Spain
(State or Country)

12. MAIDEN NAME OF MOTHER Josefa M. G. Tajo
13. BIRTHPLACE OF MOTHER Spain
(State or Country)

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Agapito Bideganita
(Address) Mountain Home

15. Filed Sept. 26th 1913 Blumfather
Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH Sept. 25th 1913
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from Sept. 25th 1913, to Sept. 25th 1913, that I last saw her alive on Sept. 25th 1913, and that death occurred on the date stated above, at 110. M

The CAUSE OF DEATH* was as follows:

Umbilical haemorrhage

(Duration) _____ yrs. _____ mos. _____ ds.
Contributory (Secondary) none

(Signed) Blumfather M. D.
Sept. 25th 1913 (Address) Mountain Home

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions Transients or Recent Residents.)

At place of death _____ yrs. _____ mos. _____ days. In the State _____ yrs. _____ mos. _____ ds.
Where was disease contracted if not at place of death?
Former or usual residence _____

19. PLACE OF BURIAL OR REMOVAL Mountain Home DATE OF BURIAL Sept. 27th 1913
20. UNDERTAKER H. D. Wilbur ADDRESS Mountain Home

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. N. B.—Every item of information should be carefully supplied. AGE should be state EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Form V. S. No. 5. 10M. 6-20-11.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH.

Registration District No. 34County of ElmorePrimary Registration District No. 2020City of Mountain Home No. _____ St.)File No. 551Registered No. 23

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

James Kenneth Guel

If death occurred in a hospital, institution or camp give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX

M

4. COLOR OR RACE 5. SINGLE, MARRIED, WIDOWED OR DIVORCED.

W

(Write the word.)

6. DATE OF BIRTH

July

(Month)

19

(Day)

1913

(Year)

7. AGE

2 yrs. 8 mos. 8 ds.

IF LESS than 1 day
how many hrs. or
..... min.?

8. OCCUPATION

- (a) Trade, profession or particular kind of work
(b) General nature of industry business or establishment in which employed (or employer)

9. BIRTHPLACE

(State or Country)

Intn Home - Idaho

10. NAME OF FATHER

J. H. Tuel

11. BIRTHPLACE OF FATHER

(State or Country)

Kentucky

12. MAIDEN NAME OF MOTHER

Ollie M. Overill

13. BIRTHPLACE OF MOTHER

(State or Country)

Kansas

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

J. H. Tuel

(Address)

Therman Idaho

15.

Filed Sept. 27th 1913B. W. Blather

Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

Sept

(Month)

28

(Day)

1913

(Year)

17. I HEREBY CERTIFY, That I attended deceased from

Aug 3 1913, to Sept 27 1913that I last saw him alive on Sept 27 1913and that death occurred on the date stated above, at 4:30 P M.

The CAUSE OF DEATH* was as follows:

Inability to digest his food from birth.(Duration) yrs. 2 mos. 8 ds.

Contributory (Secondary)

Gastro Enteritis(Duration) yrs. _____ mos. 6 ds.(Signed) W. L. Frazer M. D.Sept 19 1913 (Address) Intn Home

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted.

If not at place of death?

Former or usual residence.

19. PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

ThermanSept. 28th 1913

20. UNDERTAKER

ADDRESS

H. D. WilburIntn. Home

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. PHYSI-
 N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSI-
 CIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact state-
 ment of OCCUPATION is very important. See instructions on back of certificate.

Form V. S. No. 5. 10M. 6-20-11.

CERTIFICATE OF DEATH

 State of Idaho
 BOARD OF HEALTH
 Bureau of Vital Statistics

1. PLACE OF DEATH.

Registration District No. 34County of ElmorePrimary Registration District No. 2020City of Intn. Home

(No. _____, _____ St.)

File No. 5882Registered No. 20
 If death occurs away from usu-
 al residence, give facts called
 for under special information.

2. FULL NAME

James E. Williams
 If death occurred in a hospital, in-
 stitution or camp give its NAME
 instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX

4. COLOR OR RACE 5. SINGLE, MARRIED, WID-
OWED OR DIVORCED.
Male White Single
 (Write the word.)

6. DATE OF BIRTH

1866 1869
 (Month) (Day) (Year)

7. AGE

44 yrs. 44 mos. 44 ds.
 IF LESS than 1 day
 how many hrs. or
 min.

8. OCCUPATION

 (a) Trade, profession or
 particular kind of work
 (b) General nature of industry
 business or establishment in
 which employed (or employer)
Farmer.

9. BIRTHPLACE

(State or Country)

Kansas.10. NAME OF
FATHERThomas Williams11. BIRTHPLACE
OF FATHER

(State or Country)

Unknown12. MAIDEN NAME
OF MOTHERLuranie Camp13. BIRTHPLACE
OF MOTHER

(State or Country)

Unknown

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

Pearl O. Williams

(Address)

Surgeside Idaho

15.

Filed

Sept. 21st 1913B. W. Mather

Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

Sept 20 1913
 (Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from

Sept 17 1913, to Sept 20 1913

 that I last saw him alive on Sept 19 1913,

 and that death occurred on the date stated above, at 3 P.M.

The CAUSE OF DEATH* was as follows:

Quinsy

(Duration) yrs. mos. ds.

Contributory (Secondary)

Strangling from rupture(Signed) W. L. Frazier M. D.Sept 21/1913 (Address) Intn. Home
 *State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1)
 MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.
18. LENGTH OF RESIDENCE (For Hospitals, Institutions,
Transients or Recent Residents.)
 At place of death yrs. mos. ds. In the
 State yrs. mos. ds.

Where was disease contracted,

If not at place of death?

Former or

usual residence

19. PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

Mayfield IdaSept 22 1913

20. UNDERTAKER

ADDRESS

H. D. Wilbur.Intn. HomeIda

Form V. S. No. 5 20M.1-16-12

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH.

Registration District No. 50

County of Fewer

Primary Registration District No. 2129

City of Idaho

(No. _____, St.)

File No. 5880

Registered No. 4

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Mary Paul

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX

Female

4. COLOR OR RACE

white

5. SINGLE, MARRIED, WIDOWED OR DIVORCED.

married
(Write the word.)

6. DATE OF BIRTH

not known9-24-13
Eighty Seven (87)
(Month) (Day) (Year)

7. AGE

Eighty Seven years
yrs. mos. ds.IF LESS than 1 day
how many hrs. or
mins.?

8. OCCUPATION

(a) Trade, profession or particular kind of work

None

(b) General nature of industry business, or establishment in which employed (or employer)

9. BIRTHPLACE

(State or Country)

Cornwall England

10. NAME OF FATHER

Robins

11. BIRTHPLACE OF FATHER

(State or Country)

not known

12. MAIDEN NAME OF MOTHER

Mary Robins

13. BIRTHPLACE OF MOTHER

(State or Country)

not known

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

James H. Turner

(Address)

Idaho Idaho

15.

Filed

Sept 24 191H. C. Parrish

Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH

Sept24

191

(Month)

(Day)

(Year)

17. I HEREBY CERTIFY, That I attended deceased from

July 20 1913, to Sept 16 1913,that I last saw her alive on Sept 16 1913,and that death occurred on the date stated above, at 7 A.M.

The CAUSE OF DEATH* was as follows:

Senile Debility(Duration) One yrs. mos. ds.

Contributory

(Secondary)

(Duration) yrs. mos. ds.

(Signed)

H. C. Parrish M. D.9-24-1913 (Address) Idaho Idaho

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL OR HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death yrs. mos. days. In the State yrs. mos. days.

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

Ido CemeterySept 25 1913

20. UNDERTAKER

ADDRESS

Ido. Howe Imp CoIdo Idaho

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Form V. S. No. 5. 12½ M. 7-24-11

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics
File No. 5884
Registered No. 2

1. PLACE OF DEATH.
County of Custer
City of Mackay
Registration District No. 109
Primary Registration District No. 2187
(No. _____, _____ St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME David Mills

If death occurred in a hospital, institution or camp give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX M. 4. COLOR OR RACE Wh 5. SINGLE, MARRIED, WIDOWED OR DIVORCED.
Married
(Write the word.)

6. DATE OF BIRTH May 30 1848
(Month) (Day) (Year)

7. AGE 65 yrs. 3 mos. ds. IF LESS than 1 day
how many _____ hrs. or _____ min?

8. OCCUPATION Farmer
(a) Trade, profession or particular kind of work.
(b) General nature of industry business or establishment in which employed (or employer)

9. BIRTHPLACE Pa.
(State or Country)

10. NAME OF FATHER David Mills

11. BIRTHPLACE OF FATHER Vermont
(State or Country)

12. MAIDEN NAME OF MOTHER Julia Ann Penney

13. BIRTHPLACE OF MOTHER N.Y.
(State or Country)

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) F. P. Richards
(Address) Mackay Idaho

15. Filed Oct 4 1913 F. P. Richards
Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH August 29 1913
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from August 28 1913, to August 29 1913
that I last saw him alive on August 29 1913
and that death occurred on the date stated above, at 2 P. M.
The CAUSE OF DEATH* was as follows:

Perforated Sigmoid Uterus
(Duration) Several yrs. mos. ds.
Contributory Internal Hemorrhage
(Secondary)
(Duration) yes yrs. 2 mos. ds.
(Signed) Francis P. Richards M. D.
Aug 30 1913 (Address) Mackay Idaho

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place In the
of death _____ yrs. _____ mos. _____ ds. State _____ yrs. _____ mos. _____ ds.
Where was disease contracted,
If not at place of death? _____
Former or
usual residence _____

19. PLACE OF BURIAL OR REMOVAL Mackay Idaho DATE OF BURIAL Sept 1 1913

20. UNDERTAKER Baxter ADDRESS Mackay Idaho

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Form V. S. No. 5. 12½ M. 7-24-11

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics
File No. 5885
Registered No. 1

1. PLACE OF DEATH. Registration District No. 109
County of Custer Primary Registration District No. 2187
City of Mackay (No. , St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

Edward White

If death occurred in a hospital, institution or camp give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX M 4. COLOR OR RACE wh 5. SINGLE, MARRIED, WIDOWED OR DIVORCED. Unknown
(Write the word.)

6. DATE OF BIRTH Unknown
(Month) (Day) (Year)

7. AGE About 40 years - IF LESS than 1 day
yrs. mos. ds. how many hrs. or min?

8. OCCUPATION

- (a) Trade, profession or particular kind of work. Shepherd
(b) General nature of industry business or establishment in which employed (or employer)

9. BIRTHPLACE

(State or Country)

Unknown

10. NAME OF FATHER

Unknown

11. BIRTHPLACE OF FATHER

(State or Country)

Unknown

12. MAIDEN NAME OF MOTHER

Unknown

13. BIRTHPLACE OF MOTHER

(State or Country)

Unknown

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

(Address)

Mackay, Idaho

15.

Filed

9/26 1913

Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH

9 22 1913
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from found 1913, to dead. 1913

that I last saw him alive on 1913

and that death occurred on the date stated above, at M.

The CAUSE OF DEATH* was as follows:

Autopsy -
Acute Cardiac Dilatation - Hydro-
Nephrosis - Alcoholism.

(Duration) yrs. mos. ds.

Contributory Exposure to cold.
(Secondary)

(Duration) yrs. mos. ds.

(Signed) Francis P. Richards - Coroner M. D.

9/26 1913 (Address) Mackay, Idaho.

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place In the
of death yrs. mos. ds. State yrs. mos. ds.

Where was disease contracted,

If not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL DATE OF BURIAL

Mackay Idaho 9/26 1913

20. UNDERTAKER ADDRESS

Wiley Marshall Mackay

F. P. Richards

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Form V. S. No. 5. 12½ M. 7-24-11

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics
File No. 5986
Registered No. 3

1. PLACE OF DEATH. Registration District No. 109
County of Custer Primary Registration District No. 2187
City of Maerlay (No. Maerlay Hospital St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

John Wesley Perachy

If death occurred in a hospital, institution or camp give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX M 4. COLOR OR RACE Wh 5. SINGLE, MARRIED, WIDOWED OR DIVORCED. Single
(Write the word.)

6. DATE OF BIRTH 12 3 1894
(Month) (Day) (Year)

7. AGE 18 yrs. 8 mos. 26 ds. IF LESS than 1 day how many.....hrs. or min?

8. OCCUPATION
(a) Trade, profession or particular kind of work. Drainy miner
(b) General nature of industry business or establishment in which employed (or employer)

9. BIRTHPLACE
(State or Country) Payette, Idaho

10. NAME OF FATHER William Perachy

11. BIRTHPLACE OF FATHER
(State or Country) Wisconsin

12. MAIDEN NAME OF MOTHER R. A. Hughesbanks

13. BIRTHPLACE OF MOTHER
(State or Country) Iowa

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) R. A. Hughesbanks
(Address) Hailey, Idaho

15. 8/30 1913 F. P. Richards
Filed Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH 8 29 1913
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from August 15 1913, to August 29 1913 that I last saw him alive on August 29 1913 and that death occurred on the date stated above, at 3 P. M.
The CAUSE OF DEATH* was as follows:

Septic Peritonitis

(Duration) yrs. mos. 12 ds.
Contributory (Secondary) Appendicitis
(Duration) yrs. mos. 12 ds.
(Signed) Francis P. Richards M. D.
8/30 1913 (Address) Maerlay, Idaho

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place In the
of death.....yrs.....mos. 15 ds. State 18 yrs.....mos.....ds.
Where was disease contracted,
If not at place of death?
Former or usual residence. Hailey, Idaho

19. PLACE OF BURIAL OR REMOVAL Hailey, Idaho DATE OF BURIAL 9/1 1913

20. UNDERTAKER Barber ADDRESS Maerlay, Idaho

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Form V. S. No. 5 20M.1-16-12

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH.

Registration District No. 86

County of Washington

Primary Registration District No. 1010

File No. 5891

City of Weiser

(No. 3)

St.)

Registered No. 5

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

Edith Leora Dickerson

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX

Female

4. COLOR OR RACE

Wbr

5. SINGLE, MARRIED, WIDOWED OR DIVORCED.

Married
(Write the word.)

6. DATE OF BIRTH

Sept 16 1877
(Month) (Day) (Year)

7. AGE

36 yrs. 0 mos. 0 ds.

IF LESS than 1 day
how many hrs. or
mins.?

8. OCCUPATION

(a) Trade, profession or particular kind of work
(b) General nature of industry business, or establishment in which employed (or employer)

Housewife

9. BIRTHPLACE

(State or Country)

Wisconsin

10. NAME OF FATHER

S. L. Carpenter

11. BIRTHPLACE OF FATHER

(State or Country)

12. MAIDEN NAME OF MOTHER

Clorissa Smith

13. BIRTHPLACE OF MOTHER

(State or Country)

Vermont

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

Flora Black

(Address)

Weiser Idaho

15.

Filed

Sept. 2nd 1913 D. R. Smith
Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH

Sept. 1 1913
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from

Aug 19 - 1913, to Sept. 1 - 1913,
that I last saw her alive on Sept. 1 - 1913,
and that death occurred on the date stated above, at 2 PM.

The CAUSE OF DEATH* was as follows:

Septicemia - Puerperal

(Duration) yrs. 14 mos. 0 ds.

Contributory (Secondary)

Abortion

(Duration) yrs. 0 mos. 0 ds.

(Signed)

D. R. Smith M. D.

9/3 1913 (Address) Weiser Id

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death 0 yrs. 0 mos. 0 days. In the State 0 yrs. 0 mos. 0 days.

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL

Weiser Cemetery

DATE OF BURIAL

Sept 3 1913

20. UNDERTAKER

L. C. Northrup

ADDRESS

Weiser Ida

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

S. No. 5 20M.1-16-12

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH.
County Washington
City of Weiser

Registration District No. 26 76
Primary Registration District No. 1010
(No. East Main St.)

File No. 5891
Registered No. 6

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME George Daniel Gross

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX Male 4. COLOR OR RACE White 5. SINGLE, MARRIED, WIDOWED OR DIVORCED. Single
(Write the word.)

6. DATE OF BIRTH Nov. - 8 - 1911
(Month) (Day) (Year)

7. AGE 1 yrs. 10 mos. 12 ds.
IF LESS than 1 day how many hrs. or mins.?

8. OCCUPATION
(a) Trade, profession or particular kind of work none
(b) General nature of industry, business, or establishment in which employed (or employer)

9. BIRTHPLACE Mann Creek; Weiser, Idaho
(State or Country)

10. NAME OF FATHER Harvey R. Gross

11. BIRTHPLACE OF FATHER State of Missouri
(State or Country)

12. MAIDEN NAME OF MOTHER Isaie Brown

13. BIRTHPLACE OF MOTHER State of Missouri
(State or Country)

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) M. E. Brown

(Address) Weiser; Idaho

15. Filed Sept-21-1913 Dr. R. Hamilton
Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH Sept. - 20 - 1913
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from August 15 1913, to Sept 20 1913, that I last saw him alive on Sept 20 1913, and that death occurred on the date stated above, at 6 P.M.

The CAUSE OF DEATH* was as follows:

Gastro-enteritis

(Duration) yrs. mos. ds.

Contributory
(Secondary)

(Duration) yrs. mos. ds.

(Signed) James A. Young M. D.

9/20 1913 (Address) Weiser, Idaho

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death yrs. mos. days. In the State yrs. mos. days.

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL DATE OF BURIAL

Mann Creek Sept 21 1913

20. UNDERTAKER ADDRESS

R. S. Cordell Weiser, Ida.

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Form V. S. No. 5 20M.1-16-12		CERTIFICATE OF DEATH		State of Idaho BOARD OF HEALTH Bureau of Vital Statistics	
1. PLACE OF DEATH.		Registration District No. <u>86</u>		File No. <u>5892</u>	
County of <u>Washington</u>		Primary Registration District No. <u>2163</u>		Registered No. <u>7</u>	
City of _____ (No. _____ St.)		If death occurs away from usual residence, give facts called for under special information.		If death occurred in a hospital, institution or camp, give its NAME instead of street and number.	
2. FULL NAME <u>Berj Levi McPhetridge</u>					
PERSONAL AND STATISTICAL PARTICULARS					
3. SEX <u>Male</u>	4. COLOR OR RACE <u>White</u>	5. SINGLE, MARRIED, WIDOWED OR DIVORCED. <u>Married</u> (Write the word.)			
6. DATE OF BIRTH <u>Dec 21 1890</u> (Month) (Day) (Year)					
7. AGE <u>22 yrs. 9 mos. 5 ds.</u> IF LESS than 1 day how many hrs. or mins.?					
8. OCCUPATION (a) Trade, profession or particular kind of work (b) General nature of industry business, or establishment in which employed (or employer) <u>Railroad Employee.</u>					
9. BIRTHPLACE (State or Country) <u>Kentucky</u>					
10. NAME OF FATHER <u>Mitchell McPhetridge</u>					
11. BIRTHPLACE OF FATHER (State or Country) <u>Kentucky</u>					
12. MAIDEN NAME OF MOTHER <u>Susie Johnson</u>					
13. BIRTHPLACE OF MOTHER (State or Country) <u>Kentucky</u>					
14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE (Informant) <u>Lessie Tharuck</u> (Address) <u>Weiser Ida</u>					
15. Filed <u>Spt 26</u> 191 <u>3</u> <u>W.B. Hamilton</u> Local Registrar					
MEDICAL CERTIFICATE OF DEATH.					
16. DATE OF DEATH <u>September 25th 1913</u> (Month) (Day) (Year)					
17. I HEREBY CERTIFY, That I attended deceased from _____ 191 <u>3</u> , to _____ 191 <u>3</u> , that I last saw h. _____ alive on _____ 191 <u>3</u> , and that death occurred on the date stated above, at <u>2.9 A.M.</u> The CAUSE OF DEATH* was as follows: <u>Accidental Death by Being Struck by train No 118 on D.S. & A R</u> (Duration) <u>22 yrs. 9 mos. 5 ds.</u> Contributory (Secondary) _____ (Duration) _____ yrs. _____ mos. _____ ds. (Signed) <u>James J. McCann</u> <u>Coroner</u> <u>9/26 1913</u> (Address) <u>Weiser Ida</u>					
*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.					
18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.) At place of death _____ yrs. _____ mos. _____ days. In the State _____ yrs. _____ mos. _____ days. Where was disease contracted if not at place of death? _____ Former or usual residence _____					
19. PLACE OF BURIAL OR REMOVAL <u>Weiser, Ida</u> DATE OF BURIAL <u>Spt 27 1913</u>					
20. UNDERTAKER <u>L. C. Northon</u> ADDRESS <u>Weiser</u>					

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Form V. S. No. 5 20M.1-16-12

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics
File No. **5893**

1. PLACE OF DEATH.

Registration District No. **86**County of **Washington**Primary Registration District No. **1010**City of **Wenatchee**

(No. _____ St.)

Registered No. **8**

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME **Carrie W. Dean**

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX **Female**4. COLOR OR RACE **White**5. SINGLE, MARRIED, WIDOWED OR DIVORCED **Single**
(Write the word.)6. DATE OF BIRTH **Jan. 29 1865**
(Month) (Day) (Year)7. AGE **48** yrs. **8** mos. **—** ds.

IF LESS than 1 day
how many _____ hrs. or
_____ mins.?

8. OCCUPATION

(a) Trade, profession or particular kind of work
(b) General nature of industry, business, or establishment in which employed (or employer)

Housework

9. BIRTHPLACE

(State or Country)

Michigan10. NAME OF FATHER **Isaac Dean**

11. BIRTHPLACE OF FATHER

(State or Country)

Ohio12. MAIDEN NAME OF MOTHER **Anna Boulton**

13. BIRTHPLACE OF MOTHER

(State or Country)

N.Y.

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) **Mrs. G. H. Garrett**(Address) **Weiser, Idaho**

15.

Filed **Oct 14** 191**8****1918**

D. R. Hannah
Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH **Sept 29 1913**
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from **Jan 1st 1913**, to **Sept 29th 1913**, that I last saw her alive on **Sept 29 1913**.

and that death occurred on the date stated above, at **5:30 P.M.**

The CAUSE OF DEATH* was as follows:

Chronic Interstital nephritis.(Duration) **2** yrs. **—** mos. **—** ds.Contributory **Myocard Regeneration**
(Secondary)(Duration) **1** yrs. **—** mos. **—** ds.(Signed) **Samuel C. Garrett M. D.****Oct 1 1913** (Address) **Weiser, Idaho**

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death _____ yrs. _____ mos. _____ days. In the State _____ yrs. _____ mos. _____ days.

Where was disease contracted if not at place of death?

Former or usual residence _____

19. PLACE OF BURIAL OR REMOVAL **Kalamazoo Mich**DATE OF BURIAL **1913**20. UNDERTAKER **L. L. Northam**ADDRESS **Weiser, Idaho**

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Form V. S. No. 5 20M.1-16-12

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH.

County of WashingtonRegistration District No. 86City of UnionPrimary Registration District No. 1010

(No. _____, _____ St.)

File No. 589+Registered No. 9

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Emmanuel Williams

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX

Male

4. COLOR OR RACE

White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED.

Married
(Write the word.)

6. DATE OF BIRTH

Sept 9 1857
(Month) (Day) (Year)

7. AGE

62 yrs. — 21 mos. 21 ds.IF LESS than 1 day
how many hrs. or
..... mins.?

8. OCCUPATION

- (a) Trade, profession or particular kind of work
(b) General nature of industry, business, or establishment in which employed (or employer)

Farmer

9. BIRTHPLACE

(State or Country)

Cornwall, Eng.

10. NAME OF FATHER

Emmanuel Williams

11. BIRTHPLACE OF FATHER

(State or Country)

Cornwall, Eng.

12. MAIDEN NAME OF MOTHER

13. BIRTHPLACE OF MOTHER

(State or Country)

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

A. W. Williams

(Address)

Portage, Wash.

15.

Filed Oct 71913D. R. Haulk

Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH

September 30 1913
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from

September 8 1913, to Sept 30 1913
that I last saw him alive on September 29 1913and that death occurred on the date stated above, at 2⁰⁰ PM

The CAUSE OF DEATH* was as follows:

Carcinoma of Stomach(Duration) 6 or longer yrs. 6 mos. 0 ds.Contributory
(Secondary)(Duration) 0 yrs. 0 mos. 0 ds.(Signed) W. H. H. Idaho M. D.
Sept 30 1913 (Address) James A. Young

State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death yrs. mos. days. In the State yrs. mos. days.

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL

Waver, Ida

DATE OF BURIAL

Oct 1 1913

20. UNDERTAKER

L. B. Northman

ADDRESS

Waver, Ida

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Form V. S. No. 5 20M.1-16-12

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics
File No. 5895
Registered No. 437

1. PLACE OF DEATH. Registration District No. 8
County of Benewah Primary Registration District No. 2033
City of Bonner (No. _____ St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Harold Carter

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX Male 4. COLOR OR RACE White 5. SINGLE, MARRIED, WIDOWED OR DIVORCED. Single
(Write the word.)

6. DATE OF BIRTH

July 4 1906
(Month) (Day) (Year)

7. AGE

_____ yrs. _____ mos. _____ ds.

IF LESS than 1 day
how many _____ hrs. or
_____ mins.?

8. OCCUPATION

(a) Trade, profession or particular kind of work None
(b) General nature of industry business, or establishment in which employed (or employer)

9. BIRTHPLACE

(State or Country) Idaho

10. NAME OF FATHER J. F. Carter

11. BIRTHPLACE OF FATHER

(State or Country) Mich.

12. MAIDEN NAME OF MOTHER Mabel Holtan

13. BIRTHPLACE OF MOTHER

(State or Country) Mich.

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) J. F. Carter

(Address) Colburn Idaho

15. -

Filed June 6th 1913

1913

M. McKinnon

Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

June 5th 1913
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from

1913, to 1913,

that I last saw him alive on 1913,

and that death occurred on the date stated above, at M.

The CAUSE OF DEATH* was as follows:

Rheumatic Endocarditis

_____ (Duration) _____ yrs. _____ mos. _____ ds.

Contributory
(Secondary)

_____ (Duration) _____ yrs. _____ mos. _____ ds.

(Signed) R. Jackson M. D.

19 (Address) Benewah

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death _____ yrs. _____ mos. _____ days. In the State _____ yrs. _____ mos. _____ days.

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL DATE OF BURIAL

Colburn Idaho June 7 1913

20. UNDERTAKER

E. M. Barker Benewah

Form V. S. No. 5 20M.1-16-12

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH.

Registration District No. 8County of Bonner
City of SandpointPrimary Registration District No. 2033

(No. _____, St.)

File No. 589Registered No. 438

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

Racheal Lindstrom

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX

Female

4. COLOR OR RACE

wh.

5. SINGLE, MARRIED, WIDOWED OR DIVORCED.

Single
(Write the word.)

6. DATE OF BIRTH

Dec 11 1912
(Month) (Day) (Year)

7. AGE

6 yrs. 6 mos. ds.IF LESS than 1 day
how many _____ hrs. or
_____ mins.?

8. OCCUPATION

(a) Trade, profession or particular kind of work

none

(b) General nature of industry, business, or establishment in which employed (or employer)

9. BIRTHPLACE

(State or Country)

Idaho.

10. NAME OF FATHER

Oscar Lindstrom

11. BIRTHPLACE OF FATHER

(State or Country)

Sweden.

12. MAIDEN NAME OF MOTHER

Anna Dobrath.

13. BIRTHPLACE OF MOTHER

(State or Country)

Wis.

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

Oscar Lindstrom

(Address)

Sandpoint Id.

15.

Filed

6/101913Wm. M. Brown

Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH

June 10 1913
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from

1913, to 1913,that I last saw h. _____ alive on 1913,and that death occurred on the date stated above, at M.

The CAUSE OF DEATH* was as follows:

Acute disgestion

(Duration) _____ yrs. _____ mos. _____ ds.

Contributory
(Secondary)

(Duration) _____ yrs. _____ mos. _____ ds.

(Signed) W. M. Brown M. D.1913 (Address) Sandpoint

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death _____ yrs. _____ mos. _____ days. In the State _____ yrs. _____ mos. _____ days.

Where was disease contracted if not at place of death? _____

Former or usual residence _____

19. PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

Sandpoint 6/12 1913

20. UNDERTAKER

ADDRESS

W. M. Brown Id.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

1. PLACE OF DEATH. _____
County of Barnes Registration District No. 2033
City of Laclede (No. _____, _____ St.)
Primary Registration District No. 2033

BOARD OF HEALTH
Bureau of Vital Statistics
File No. 5897
Registered No. 439
If death occurred in a hospital, institution or camp give its NAME instead of street and number.

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

William Stang

PERSONAL AND STATISTICAL PARTICULARS

3. SEX Male 4. COLOR OR RACE White 5. SINGLE, MARRIED, WIDOWED OR DIVORCED. Married
(Write the word.)

6. DATE OF BIRTH September 1 1879
(Month) (Day) (Year)

7. AGE 37 yrs. 10 mos. 14 ds.
IF LESS than 1 day how many _____ hrs. or _____ min?

8. OCCUPATION
(a) Trade, profession or particular kind of work Timber trimmer
(b) General nature of industry business or establishment in which employed (or employer) Sawmill

9. BIRTHPLACE (State or Country) Germany

10. NAME OF FATHER Frederick Stang

11. BIRTHPLACE OF FATHER (State or Country) Germany

12. MAIDEN NAME OF MOTHER Don't know

13. BIRTHPLACE OF MOTHER (State or Country) Germany

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Frederick W. Didier
(Address) Laclede

15. July 16 1913 mmck...
Filed _____ Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH July 15 1913
(Month) (Day) (Year)

17. I HEREBY CERTIFY That I attended deceased from 191 to 191
that I last saw him alive on 191
and that death occurred on the date stated above, at _____ M.
The CAUSE OF DEATH* was as follows:

Accidental injury by saw.

(Duration) _____ yrs. _____ mos. _____ ds.

Contributory (Secondary) _____

(Duration) _____ yrs. _____ mos. _____ ds.

(Signed) Frederick Didier M. D.
July 16 1913 (Address) Laclede, Mo.

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place _____ In the _____
of death _____ yrs. _____ mos. _____ ds. State _____ yrs. _____ mos. _____ ds.
Where was disease contracted, _____
If not at place of death? _____
Former or _____
usual residence. _____

19. PLACE OF BURIAL OR REMOVAL DATE OF BURIAL

Laclede July 16, 1913
20. UNDERTAKER E. M. Bower ADDRESS Laclede

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Form V. S. No. 5 20M.1-16-12

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH.

Registration District No. 8County of BonnerPrimary Registration District No. 2033City of Shoshone(No.)

St.)

File No. 5895Registered No. 445

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME William Hallace Sparhawk

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX

Male

4. COLOR OR RACE

White5. SINGLE, MARRIED, WID-
OWED OR DIVORCEDMarried
(Write the word.)

6. DATE OF BIRTH

July
(Month)18
(Day)1850
(Year)

7. AGE

63

yrs. mos. ds.

IF LESS than 1 day
how many hrs. or
mins.?

8. OCCUPATION.

(a) Trade, profession or
particular kind of workBlacksmith(b) General nature of industry
business, or establishment in
which employed (or employer)

9. BIRTHPLACE

(State or Country)

N. Y.10. NAME OF
FATHERAmbrose Sparhawk11. BIRTHPLACE
OF FATHER

(State or Country)

Maine12. MAIDEN NAME
OF MOTHERAlice Eastwood13. BIRTHPLACE
OF MOTHER

(State or Country)

Conn.

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

Fannie M. Sparhawk

(Address)

Shoshone, Id.

15.

Filed 7/141911M. McTurian
Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

Aug
(Month)14
(Day)1913
(Year)

17. I HEREBY CERTIFY, That I attended deceased from

June 22 1913, to Aug 14 1913,that I last saw him alive on June 24 1913,and that death occurred on the date stated above, at M.

The CAUSE OF DEATH* was as follows:

Pulmonary Tuberculosis(Duration) 1 yrs. mos. ds.Contributory
(Secondary)(Duration) yrs. mos. ds.(Signed) E. P. Gracchous M. D.9/8 1913 (Address) Shoshone, Id.

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions,
Transients or Recent Residents.)

At place of death.....yrs.....mos.....days. In the State.....yrs.....mos.....days.

Where was disease contracted
if not at place of death?Former or
usual residence

19. PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

Lakerus, Conn.8/17 1913

20. UNDERTAKER

ADDRESS 2 Pm.Emm Brower

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
 B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Form V. S. No. 5. 10M. 6

1. PLACE OF DEATH

Registration District No.

County of Bosman

Primary Registration District No. 2035

City of Hope

(No. _____, _____ St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

Simon L. Russell

State of Idaho
 BOARD OF HEALTH
 Bureau of Vital Statistics

File No. 5899

Registered No. 44

If death occurred in a hospital, institution or camp give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX

Male

4. COLOR OR RACE

White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED

Married
 (Write the word.)

6. DATE OF BIRTH

June 16 1913
 (Month) (Day) (Year)

7. AGE

42 yrs. 1 mos. 28 ds.

IF LESS than 1 day
 how many _____ hrs. or
 _____ min.)

8. OCCUPATION

(a) Trade, profession or particular kind of work

Carpenter

(b) General nature of industry business or establishment in which employed (or employer)

9. BIRTHPLACE

(State or Country)

New York

10. NAME OF FATHER

W H Henry Russell

11. BIRTHPLACE OF FATHER

(State or Country)

N.Y. (Fields) ?
Boysen

12. MAIDEN NAME OF MOTHER

13. BIRTHPLACE OF MOTHER

(State or Country)

N.Y.

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

W H Henry Russell

(Address)

Hope

15.

Filed

Aug 16 1913

W H Henry Russell
 Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

Aug 15 1913
 (Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from

Aug 15 1913, to Aug 15 1913

that I last saw him alive on Aug 15 1913

and that death occurred on the date stated above, at 4:30 M.

The CAUSE OF DEATH* was as follows:

Accident Fall from
Scrubbed while painting
inside of 30 ft of water
 (Duration) Instant ds.

Contributory (Secondary)

(Duration) _____ yrs. _____ mos. _____ ds.

(Signed) W H Henry Russell M. D.

19. (Address) Hope

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place

In the

of death _____ yrs. _____ mos. _____ ds. State _____ yrs. _____ mos. _____ ds.

Where was disease contracted,

If not at place of death?

Former or

usual residence

19. PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

Hope

Aug 17 1913

20. UNDERTAKER

ADDRESS

Edw Brower & Co

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Form V. S. No. 5 20M.1-16-12

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH.

Registration District No. 5

County of BonnerPrimary Registration District No. 2033City of Sandpoint

(No. St.)

File No. 590Registered No. 442

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

K. B. McDonald

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX

Male

4. COLOR OR RACE

White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED.

Married

6. DATE OF BIRTH

Feb 2 1842
(Month) (Day) (Year)

7. AGE

71 yrs. 2 mos. 6 ds.IF LESS than 1 day
how many hrs. or mins.?

8. OCCUPATION

(a) Trade, profession or particular kind of work

Carpenter &

(b) General nature of industry business, or establishment in which employed (or employer)

Boat Builder

9. BIRTHPLACE

(State or Country)

Bierkshire Scotland

10. NAME OF FATHER

Murdoch McDonald

11. BIRTHPLACE OF FATHER

(State or Country)

Scotland

12. MAIDEN NAME OF MOTHER

McDonald

13. BIRTHPLACE OF MOTHER

(State or Country)

Scotland

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

William McDonald

(Address)

Sandpoint, Ida.

15.

Filed

8/191913M. McDonald

Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

Aug 28 1913
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from

1913, to Aug 28 1913.that I last saw him alive on Aug 27 1913.and that death occurred on the date stated above, at 4 AM.

The CAUSE OF DEATH* was as follows:

Pneumonia following anesthetic
amputation of leg at knee for senile
emphysema complicated with leg. & general
(Duration)..... yrs. mos. ds.Contributory Arteriosclerosis
(Secondary)

(Duration)..... yrs. mos. ds.

(Signed) M. McDonald M. D.19..... (Address) Sandpoint

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death..... yrs. mos. days. In the State..... yrs. mos. days.

Where was disease contracted if not at place of death?.....

Former or usual residence.....

19. PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

SandpointAug 31 1913

20. UNDERTAKER

ADDRESS

E. M. BrewerSandpoint

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. OCCUPATIONS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Form V. S. No. 5. 12-1 M. 7-24-11

CERTIFICATE OF DEATH—

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics
File No. **5901**

1. PLACE OF DEATH.

Registration District No. **8**

County of **Benewah**

Primary Registration District No. **2033**

City of **Sandpoint**

(No. _____ St.)

Registered No. **444**

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

Charles H. Brown

If death occurred in a hospital, institution or camp give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX

Male

4. COLOR OR RACE

White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED.

Single

6. DATE OF BIRTH

(Month) _____ (Day) **1** (Year) _____

7. AGE

42 yrs.

mos.

ds.

IF LESS than 1 day
how many _____ hrs. or
_____ min?

8. OCCUPATION

(a) Trade, profession or particular kind of work.
(b) General nature of industry business or establishment in which employed (or employer)

Farming & Teaching

9. BIRTHPLACE

(State or Country)

Unknown

10. NAME OF FATHER

H. G. Brown

11. BIRTHPLACE OF FATHER

(State or Country)

Unknown

12. MAIDEN NAME OF MOTHER

Unknown

13. BIRTHPLACE OF MOTHER

(State or Country)

Unknown

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

R. B. Shover

(Address)

Sandpoint Idaho

15.

Filed **Sept. 12 1913**

M. McKinnon
Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH

Sept 18 1913
(Month) _____ (Day) _____ (Year) _____

17. I HEREBY CERTIFY, That I attended deceased from

Sept 19 1913, to **1913**

that I last saw him alive on **1913**

and that death occurred on the date stated above, at **M.**

The CAUSE OF DEATH* was as follows:

Suicide, 58 W. Right side of heart

..... (Duration) yrs. mos. ds.

Contributory (Secondary)

..... (Duration) yrs. mos. ds.

(Signed) **Wm R Knapp** M. D.

Sept 19 1913 (Address) **Hope Idaho**

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place In the
of death yrs. mos. ds. State yrs. mos. ds.

Where was disease contracted,
If not at place of death?

Former or
usual residence

19. PLACE OF BURIAL OR REMOVAL . DATE OF BURIAL

Belle Plain Iowa Sept 22 1913

20. UNDERTAKER

C. M. Brown ADDRESS **Sandpoint.**

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Form V. S. No. 5. 12½ M. 7-24-11

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics
File No. 5902
Registered No. 445

1. PLACE OF DEATH.
County of Sandpoint
City of Bonner

Registration District No. 8
Primary Registration District No. 2033
(No. St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

John Bonerville

If death occurred in a hospital, institution or camp give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX Male 4. COLOR OR RACE White 5. SINGLE, MARRIED, WIDOWED OR DIVORCED. Married
(Write the word.)

6. DATE OF BIRTH
..... 1
(Month) (Day) (Year)

7. AGE 52 YRS. mos. ds.
IF LESS than 1 day how many hrs. or min?

8. OCCUPATION
(a) Trade, profession or particular kind of work. Handyman
(b) General nature of industry business or establishment in which employed (or employer) decking poles

9. BIRTHPLACE
(State or Country) Idaho

10. NAME OF FATHER

11. BIRTHPLACE OF FATHER
(State or Country)

12. MAIDEN NAME OF MOTHER

13. BIRTHPLACE OF MOTHER
(State or Country)

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Tha Ellison
(Address) Sandpoint Idaho

15. Filed 9/20 1913 mmckinn
Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH September 1913
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from 191....., to 191.....
that I last saw h..... alive on 191.....
and that death occurred on the date stated above, at..... M.

The CAUSE OF DEATH* was as follows:
Struck in head by falling pole (60 ft telegraph pole) fracturing skull died instantly. Accidental
(Duration) yrs. mos. ds.

Contributory (Secondary)
(Duration) yrs. mos. ds.
(Signed) W. M. K... M. D.
Sept 20 1913 (Address) Idaho

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place In the
of death..... yrs. mos. ds. State..... yrs. mos. ds.
Where was disease contracted,
If not at place of death?.....
Former or usual residence.....

19. PLACE OF BURIAL OR REMOVAL DATE OF BURIAL
Sandpoint Idaho Sept 21 1913

20. UNDERTAKER ADDRESS
Ervin Brown Sandpoint

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Form V. S. No. 5. 12½M. 7-24-11

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH.
County of Bonner
City of Sandpoint

Registration District No. 8
Primary Registration District No. 2033
(No. _____ St.)

File No. 590
Registered No. 446

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

Nalter Gable

If death occurred in a hospital, institution or camp give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX male 4. COLOR OR RACE white 5. SINGLE, MARRIED, WIDOWED OR DIVORCED. single
(Write the word.)

6. DATE OF BIRTH

_____ 1
(Month) (Day) (Year)

7. AGE

about
40 yrs. _____ mos. _____ ds.

IF LESS than 1 day
how many _____ hrs. or
_____ min?

8. OCCUPATION

(a) Trade, profession or particular kind of work. harboring in woods
(b) General nature of industry business or establishment in which employed (or employer) woods

9. BIRTHPLACE

(State or Country) Unknown

10. NAME OF FATHER

11. BIRTHPLACE OF FATHER

(State or Country) Unknown

12. MAIDEN NAME OF MOTHER

13. BIRTHPLACE OF MOTHER

(State or Country) Unknown

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Emm Brown

(Address) Sandpoint Idaho

15.

Filed Sept 21 1913

m. McKenna
Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH

Sept 20 1913
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from

_____ 191____, to _____ 191____

that I last saw h_____ alive on _____ 191____

and that death occurred on the date stated above, at _____ M.

The CAUSE OF DEATH* was as follows:

Accidental Struck by train
C

(Duration) _____ yrs. _____ mos. _____ ds.

Contributory
(Secondary)

(Duration) _____ yrs. _____ mos. _____ ds.

(Signed) Wm. Brown

Sept 21 1913 (Address) Sandpoint Idaho

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place _____ In the _____
of death _____ yrs. _____ mos. _____ ds. State _____ yrs. _____ mos. _____ ds.

Where was disease contracted,

If not at place of death?

Former or

usual residence.

19. PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

Sandpoint Ida 9/23 1913

20. UNDERTAKER

ADDRESS

Emm Brown Sandpoint

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Form V. S. No. 5. 12½ M. 7-24-11

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics
File No. 5904
Registered No. 447

1. PLACE OF DEATH. Registration District No. 8
County of Bonner Primary Registration District No. 2033
City of Landpoint (No. unknown St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Unknowner found on Pine St.

If death occurred in a hospital, institution or camp give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX male 4. COLOR OR RACE White 5. SINGLE, MARRIED, WIDOWED OR DIVORCED. unknown
(Write the word.)

6. DATE OF BIRTH unknown
(Month) (Day) (Year)

7. AGE about 20 years IF LESS than 1 day
yrs. mos. ds. how many hrs. or min?

8. OCCUPATION
(a) Trade, profession or particular kind of work. unknown
(b) General nature of industry business or establishment in which employed (or employer) "

9. BIRTHPLACE
(State or Country) "

10. NAME OF FATHER "

11. BIRTHPLACE OF FATHER
(State or Country) "

12. MAIDEN NAME OF MOTHER "

13. BIRTHPLACE OF MOTHER
(State or Country) "

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Dr. Knapp
(Address) Boise, Idaho

15. Filed Sept. 26, 1913 M. M. M. M. M.
Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH Sept. 24 1913
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from 191 , to 191

that I last saw h. alive on 191

and that death occurred on the date stated above, at M.

The CAUSE OF DEATH* was as follows:

Probable Suicide
gun shot wound
above right ear
(Duration) yrs. mos. ds.

Contributory (Secondary)

(Duration) yrs. mos. ds.

(Signed) Dr. Knapp M. D.

19 (Address) Boise

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place In the
of death yrs. mos. ds. State yrs. mos. ds.

Where was disease contracted,

If not at place of death?

Former or usual residence.

19. PLACE OF BURIAL OR REMOVAL DATE OF BURIAL
Landpoint Ida 9/27 1913

20. UNDERTAKER ADDRESS
E. M. Bowser Landpoint

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Form V. S. No. 5. 12½M.7-24-11

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics
File No. 590
Registered No. 278

1. PLACE OF DEATH. Registration District No. 8
County of Banner Primary Registration District No. 2033
City of Landpoint (No. _____, St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

Jerry Gleason

If death occurred in a hospital, institution or camp give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX 4. COLOR OR RACE 5. SINGLE, MARRIED, WIDOWED OR DIVORCED.

Male White Single
(Write the word.)

6. DATE OF BIRTH

____ (Month) ____ (Day) ____ (Year)

7. AGE

63 yrs. ____ mos. ____ ds.

IF LESS than 1 day
how many ____ hrs. or ____ min?

8. OCCUPATION

(a) Trade, profession or particular kind of work.
(b) General nature of industry business or establishment in which employed (or employer).

Rancher.

9. BIRTHPLACE

(State or Country)

Unknown

10. NAME OF FATHER

11. BIRTHPLACE OF FATHER

(State or Country)

Id

12. MAIDEN NAME OF MOTHER

13. BIRTHPLACE OF MOTHER

(State or Country)

Id

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

(Address)

Ernest Brainerd
Landpoint Idaho

15.

Filed

10/6 1913 m. McKinnis

Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH

Oct 5 1913
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from

July 28 1913, to Oct 5 1913

that I last saw him alive on Oct 4 1913

and that death occurred on the date stated above, at 12:00 A.M.

The CAUSE OF DEATH* was as follows:

Internal injury result of accident.

(Duration) ____ yrs. ____ mos. ____ ds.

Contributory (Secondary)

(Duration) ____ yrs. ____ mos. ____ ds.

(Signed)

G. F. Papp

M. D.

19 (Address) Landpoint Idaho

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place _____ In the _____
of death ____ yrs. ____ mos. ____ ds. State ____ yrs. ____ mos. ____ ds.

Where was disease contracted, _____
If not at place of death? _____

Former or usual residence _____

19. PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

Buried in the 10/6 1913

20. UNDERTAKER

ADDRESS

Ernest Brainerd Landpoint Idaho

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Form V. S. No. 5 20M.1-16-12

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH

Registration District No. 90

County of Blaine

Primary Registration District No. 2168

City of Green

(No. _____, St.)

File No. 590

Registered No. 34

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

John H. Bertholz

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX

Male

4. COLOR OR RACE

White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED.

Married
(Write the word.)

6. DATE OF BIRTH

Dec 1 1862
(Month) (Day) (Year)

7. AGE

51 yrs. 9 mos. ds.

IF LESS than 1 day
how many hrs. or
..... mins.?

8. OCCUPATION

(a) Trade, profession or particular kind of work

Farmer

(b) General nature of industry, business, or establishment in which employed (or employer)

9. BIRTHPLACE

(State or Country) X

10. NAME OF FATHER

✓

11. BIRTHPLACE OF FATHER

(State or Country) ✓

12. MAIDEN NAME OF MOTHER

X

13. BIRTHPLACE OF MOTHER

(State or Country) X

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

Mary Bertholz

(Address)

Green, Ida

15.

Filed

SEP. 16 1913

J. M. Fairley
Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

Sept 15 1913
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from

Sept 15 1913, to Sept 15 1913

that I last saw him alive on Sept 15 1913

and that death occurred on the date stated above, at 5 P.M.

The CAUSE OF DEATH* was as follows:

Kinking of bowel causing total obstruction & gangrene of small intestine

(Duration) yrs. mos. 1 da.

Contributory rupture of bowel with hemorrhage

(Secondary) effusion in peritoneum & meninges

(Duration) yrs. mos. ds.

(Signed) E. W. Horswell M. D.

Sept 7 1913 (Address) Ortonville, Idaho

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death yrs. mos. days. In the State yrs. mos. days.

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL

Frazier Cemetery

DATE OF BURIAL

Sept 17 1913

20. UNDERTAKER

W. C. Stoddard

ADDRESS

Gifford, Ida

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics
File No. 590
Registered No. 35
If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

1. PLACE OF DEATH. Registration District No. 90
County of Charlottesville Primary Registration District No. 2168
City of Profino (No. _____ St.)
If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Hilma Lyr

PERSONAL AND STATISTICAL PARTICULARS

3. SEX Female 4. COLOR OR RACE White 5. SINGLE, MARRIED, WIDOWED OR DIVORCED. Baby
(Write the word.)

6. DATE OF BIRTH Apr 29 1912
(Month) (Day) (Year)

7. AGE 1 yrs. 5 mos. ds.
IF LESS than 1 day how many hrs. or mins.?

8. OCCUPATION
(a) Trade, profession or particular kind of work Baby
(b) General nature of industry business, or establishment in which employed (or employer)

9. BIRTHPLACE (State or Country) Profino Ida

10. NAME OF FATHER D. B. Lyr

11. BIRTHPLACE OF FATHER (State or Country) Kentucky

12. MAIDEN NAME OF MOTHER Mieful

13. BIRTHPLACE OF MOTHER (State or Country) Shavans Wis

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) D. B. Lyr
(Address) Profino Ida

15. Filed Sept 15 1913 J. M. Jancy
Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH Sept 15 1913
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from Sept 11 1913, to Sept 15 1913, that I last saw her alive on Sept 15 1913 and that death occurred on the date stated above, at 8 A.M.

The CAUSE OF DEATH* was as follows:
Delirium, intoxication, Sh. Colitis, following indiscretions in diet.
(Duration) yrs. mos. 4 ds.

Contributory (Secondary)
(Duration) yrs. mos. ds.
(Signed) E. H. Marshall M. D.
Sept 17 1913 (Address) Profino Ida

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death yrs. mos. days. In the State yrs. mos. days.

Where was disease contracted if not at place of death?
Former or usual residence

19. PLACE OF BURIAL OR REMOVAL Profino Ida DATE OF BURIAL Sept 16 1913

20. UNDERTAKER H. C. Stoddard ADDRESS Gifford Ida

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Form V. S. No. 5 20M.1-16-12

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics
File No. 5903
Registered No. 36

1. PLACE OF DEATH

Registration District No. 90

County of Blaine

Primary Registration District No. 2168

City of Orfino

(No. _____, St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME J. F. Miller

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX

Male

4. COLOR OR RACE

White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED

Married
(Write the word.)

6. DATE OF BIRTH

Feb 3 1896
(Month) (Day) (Year)

7. AGE

77 yrs. 7 mos. 21 ds.

IF LESS than 1 day
how many hrs. or
..... mins.

8. OCCUPATION

(a) Trade, profession or particular kind of work

Farmer

(b) General nature of industry business, or establishment in which employed (or employer)

9. BIRTHPLACE

(State or Country) West Virginia

10. NAME OF FATHER

John Miller

11. BIRTHPLACE OF FATHER

(State or Country) West Virginia

12. MAIDEN NAME OF MOTHER

Horsbagen

13. BIRTHPLACE OF MOTHER

(State or Country) West Virginia

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) J. C. Ruelens

(Address) Orfino, Idaho

15.

Filed Sept 25 1913 J. M. Fairly
Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

Sept 24 1913
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from

July 8 1913, to Sept 24 1913,

that I last saw him alive on Sept 23 1913,

and that death occurred on the date stated above, at 8 A.M.

The CAUSE OF DEATH* was as follows:

Valvular Heart Disease

(Duration) 3 yrs. mos. ds.

Contributory Choking Dropsy
(Secondary)

(Duration) 3 yrs. mos. ds.

(Signed) J. M. Fairly M. D.

Sept 24 1913 (Address)

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death yrs. mos. days. In the State yrs. mos. days.

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL

Whiskey Creek Cem. Sept 25 1913

20. UNDERTAKER

W. E. Stoddard Gifford

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Form V. S. No. 5 20M.1-16-12

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH.

Registration District No. 90

County of Clearwater

Primary Registration District No. 2168

City of Orofino

(No. _____, _____ St.)

File No. 5901

Registered No. 37

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Margaret Malloy

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX

Female

4. COLOR OR RACE

White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED.

(Write the word.) Single

6. DATE OF BIRTH

May 18 1912
(Month) (Day) (Year)

7. AGE

1 yrs. 4 mos. 7 ds.

IF LESS than 1 day
how many hrs. or
..... mins.?

8. OCCUPATION

(a) Trade, profession or particular kind of work
(b) General nature of industry business, or establishment in which employed (or employer)

Infant

9. BIRTHPLACE

(State or Country) Orofino Ida.

10. NAME OF FATHER

Joe M. Malloy

11. BIRTHPLACE OF FATHER

(State or Country) Walla Wash.

12. MAIDEN NAME OF MOTHER

Mittie Higgins

13. BIRTHPLACE OF MOTHER

(State or Country) Dayton Wash.

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) J. M. Malloy

(Address) Orofino, Ida.

15.

Filed Sept 25 1913

J. M. Fairly
Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH

Sept 25 1913
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from

Sept 12 1913, to Sept 25 1913

that I last saw her alive on Sept 25 1913,

and that death occurred on the date stated above, at 7 P.M.

The CAUSE OF DEATH* was as follows:

Acute Enterocolitis

(Duration) yrs. mos. 13 ds.

Contributory
(Secondary)

(Duration) yrs. mos. ds.

(Signed)

Sept 25 1913 (Address) J. M. Fairly M. D.

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death yrs. mos. days. In the State yrs. mos. days.

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL

Leaverton Ida.

DATE OF BURIAL

Sept 28 1913

20. UNDERTAKER

W. C. Stoddard

ADDRESS

Gifford

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Form V. S. No. 5 20M.1-16-12

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics
File No. 591
Registered No. 38

1. PLACE OF DEATH. Registration District No. 90
County of Clearwater Primary Registration District No. 268
City of _____ (No. _____ St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Lela Fidler

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX Female 4. COLOR OR RACE White 5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.)

6. DATE OF BIRTH July 9 1913
(Month) (Day) (Year)

7. AGE 24 yrs. mos. ds. IF LESS than 1 day how many hrs. or mins.?

8. OCCUPATION
(a) Trade, profession or particular kind of work Baby
(b) General nature of industry business, or establishment in which employed (or employer)

9. BIRTHPLACE (State or Country) Near Orofino Ida

10. NAME OF FATHER Will Fidler

11. BIRTHPLACE OF FATHER (State or Country) Iowa

12. MAIDEN NAME OF MOTHER Bertha Carr

13. BIRTHPLACE OF MOTHER (State or Country) West Virginia

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Will Fidler +
(Address) Orofino Idaho

15. Filed Aug 2 1913 J. M. Fairly Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH Aug 2 1913
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from July 15 1913 to Aug 1 1913
that I last saw her alive on Aug 1 1913
and that death occurred on the date stated above, at 8 A.M.

The CAUSE OF DEATH* was as follows:
Gastroenterocolitis - Bacterial
Bronchitis - Hereditary
Nausea (Duration) yrs. mos. ds. 18
Contributory (Secondary)

(Signed) Earl W. Horanell M. D.
5/2 1913 (Address) Orofino Idaho

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death yrs. mos. days. In the State yrs. mos. days.

Where was disease contracted if not at place of death?
Former or usual residence.

19. PLACE OF BURIAL OR REMOVAL Idaho DATE OF BURIAL Aug 5 1913

20. UNDERTAKER None ADDRESS

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Form V. S. No. 5 20M.1-16-12

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH

Registration District No. 46

County of Clearwater

Primary Registration District No. 2168

City of Green

(No. St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

Yetta A. White

File No. 5911

Registered No. 39

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX

4. COLOR OR RACE

5. SINGLE, MARRIED, WID-
OWED OR DIVORCED.
Married
(Write the word.)

Female white

6. DATE OF BIRTH

March 13 1886
(Month) (Day) (Year)

7. AGE

27 yrs. mos. ds.

IF LESS than 1 day
how many hrs. or
 mins?

8. OCCUPATION

(a) Trade, profession or
particular kind of work
(b) General nature of industry
business, or establishment in
which employed (or employer)

Housewife

9. BIRTHPLACE

(State or Country)

N. Va.

10. NAME OF
FATHER

L. V. White

11. BIRTHPLACE
OF FATHER

(State or Country)

N. Va.

12. MAIDEN NAME
OF MOTHER

Sarah Banner

13. BIRTHPLACE
OF MOTHER

(State or Country)

N. Va.

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

Frank White

(Address)

Green, Idaho

15.

Filed

Aug 7 1913

J. M. Daily
Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH

August 6 1913
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from

 191 , to 191 ,

that I last saw him alive on 191 ,

and that death occurred on the date stated above, at 10 M.

The CAUSE OF DEATH* was as follows:

Tuberculosis Pulmonalis

(Duration) 4 yrs. mos. ds.

Contributory
(Secondary)

(Duration) yrs. mos. ds.

(Signed)

Aug 7 1913 (Address) Green, Idaho
J. M. Daily, M. D.

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death yrs. mos. days. In the State yrs. mos. days.

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL DATE OF BURIAL

Green, Idaho Aug 8 1913

20. UNDERTAKER

ADDRESS

None

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH. Registration District No. 12
County of Clearwater Primary Registration District No. 2168
City of Orfino (No. Assessable Asylum St.)

File No. 5913
Registered No. 41

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

J. E. Strobel

If death occurred in a hospital, institution or camp give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX Male 4. COLOR OR RACE White 5. SINGLE, MARRIED, WIDOWED OR DIVORCED. Single
(Write the word.)

6. DATE OF BIRTH
(Month) (Day) (Year)
1

7. AGE 35 yrs. 0 mos. 0 ds. IF LESS than 1 day how many... hrs. or min?

8. OCCUPATION
(a) Trade, profession or particular kind of work. Laborer & rancher
(b) General nature of industry business or establishment in which employed (or employer)

9. BIRTHPLACE
(State or Country) Ohio

10. NAME OF FATHER —

11. BIRTHPLACE OF FATHER
(State or Country) —

12. MAIDEN NAME OF MOTHER —

13. BIRTHPLACE OF MOTHER
(State or Country) —

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) John W. Givens
(Address) Orfino, Ida

15. Sept 3 1913
Filed Sept 3 1913 Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH September 23rd 1913
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from Jan 1 1913, to Sept. 23 1913.
That I last saw him alive on 21st Sept 1913
and that death occurred on the date stated above, at 6 am

The CAUSE OF DEATH* was as follows:

Mania

(Duration) 1 yrs. 0 mos. 0 ds.

Contributory (Secondary) Insanity

(Duration) 24 yrs. 0 mos. 0 ds.

(Signed) John W. Givens M. D.
Sept 30 1913 (Address) Orfino, Idaho

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place In the
of death... yrs... 8 mos... 12 ds. State 2 yrs... 2 mos... 12 ds.

Where was disease contracted,
If not at place of death?

Former or usual residence Joseph Plains

19. PLACE OF BURIAL OR REMOVAL DATE OF BURIAL

Way Cross Cemetery Sept 24 1913

20. UNDERTAKER ADDRESS

None

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Form V. S. No. 5 20M.1-16-12

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH
County of Owyhee
City of Bruneau
(No. _____ St.)
Registration District No. 44
Primary Registration District No. 2121
2. FULL NAME Maxine Lewis

File No. 5915
Registered No. 4

If death occurs away from usual residence, give facts called for under special information.

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX Female 4. COLOR OR RACE White 5. SINGLE, MARRIED, WID-
OWED OR DIVORCED. Single
(Write the word.)
6. DATE OF BIRTH June 10 1910
(Month) (Day) (Year)
7. AGE 3 yrs. 3 mos. 3 ds.
IF LESS than 1 day
how many _____ hrs. or
_____ mins.?

8. OCCUPATION
(a) Trade, profession or particular kind of work At Home
(b) General nature of industry business, or establishment in which employed (or employer)

9. BIRTHPLACE
(State or Country) Idaho

10. NAME OF FATHER Paul Lewis

11. BIRTHPLACE OF FATHER
(State or Country) Idaho

12. MAIDEN NAME OF MOTHER Bessie Johnston

13. BIRTHPLACE OF MOTHER
(State or Country) Idaho

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) J. C. Bartlett
(Address) Bruneau

15. Filed Oct 4 1913 J. C. Bartlett
Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH Sept. 16th 1913
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from Sept 6 1913, to Sept 15 1913,
that I last saw her alive on Sept 15 1913
and that death occurred on the date stated above, at 2 A.M.
The CAUSE OF DEATH* was as follows:

Cholera Infantum
(Duration) _____ yrs. _____ mos. 10 ds.

Contributory (Secondary)
(Duration) _____ yrs. _____ mos. _____ ds.

(Signed) J. C. Bartlett M.D.
10/4/13 (Address) Bruneau Idaho

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death _____ yrs. _____ mos. _____ days. In the State _____ yrs. _____ mos. _____ days.

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL Bruneau Valley DATE OF BURIAL Sept 17 1913

20. UNDERTAKER ADDRESS

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Form V. S. No. 5 20M.1-16-12

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics
File No. 591
Registered No. 3

1. PLACE OF DEATH. Registration District No. 44
County of Guyhee Primary Registration District No. 2121
City of Bruneau (No. _____ St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Ellen Masters

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX Female 4. COLOR OR RACE White 5. SINGLE, MARRIED, WIDOWED OR DIVORCED Widowed
(Write the word.)

6. DATE OF BIRTH October 3rd 1836
(Month) (Day) (Year)

7. AGE 77 yrs. — mos. — ds. IF LESS than 1 day how many hrs. or mins.?

8. OCCUPATION
(a) Trade, profession or particular kind of work Housework
(b) General nature of industry, business, or establishment in which employed (or employer)

9. BIRTHPLACE Iowa
(State or Country)

10. NAME OF FATHER Masters

11. BIRTHPLACE OF FATHER U. S.
(State or Country)

12. MAIDEN NAME OF MOTHER Don't know

13. BIRTHPLACE OF MOTHER " "
(State or Country)

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) J. C. Bartlett
(Address) Bruneau Idaho

15. Filed Oct 4 1913 J. C. Bartlett
Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH October 3rd 1913
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from Oct. 1st 1913, to Oct. 3rd 1913, that I last saw her alive on Oct. 2 1913 and that death occurred on the date stated above, at H.A.M.
The CAUSE OF DEATH* was as follows:

Cerebral Hemorrhage
(Duration) — yrs. — mos. 2 ds.

Contributory (Secondary) _____
(Duration) — yrs. — mos. — ds.
(Signed) J. C. Bartlett M. D.
10/4 1913 (Address) Bruneau Idaho

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death. — yrs. — mos. — days. In the State. — yrs. — mos. — days.

Where was disease contracted if not at place of death? _____

Former or usual residence _____

19. PLACE OF BURIAL OR REMOVAL Bruneau Valley DATE OF BURIAL Oct. 4 1913

20. UNDERTAKER _____ ADDRESS _____

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Form V. S. No. 5 20M.1-16-12

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH.

Registration District No. 98County of IdahoPrimary Registration District No. 2176City of Levensville

(No. _____) (St. _____)

File No. 5918Registered No. 12

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

Martin Harris

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX

4. COLOR OR RACE

5. SINGLE, MARRIED, WIDOWED OR DIVORCED

MWmarried
(Write the word.)

6. DATE OF BIRTH

Jan 281838

(Month)

(Day)

(Year)

7. AGE

75 yrs.7 mos.22 ds.IF LESS than 1 day
how many hrs. or
..... mins.?

8. OCCUPATION

- (a) Trade, profession or particular kind of work
(b) General nature of industry business, or establishment in which employed (or employer)

Farmer

9. BIRTHPLACE

(State or Country)

Ohio

10. NAME OF FATHER

Martin Harris

11. BIRTHPLACE OF FATHER

(State or Country)

Don't know.

12. MAIDEN NAME OF MOTHER

Miss Wright

13. BIRTHPLACE OF MOTHER

(State or Country)

Don't know.

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

John Harris

(Address)

Trigley-2da

15.

Filed

Oct 10 1913

191

Ray D. Fiske

Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH

Sept 201913

(Month)

(Day)

(Year)

17. I HEREBY CERTIFY, That I attended deceased from

Sept 13, 1913 to Sept 20, 1913that I last saw him alive on Sept 20, 1913and that death occurred on the date stated above, at 8:15 P.M.

The CAUSE OF DEATH* was as follows:

Chronic nephritis
" myocarditis(Duration) several yrs. mos. ds.Contributory
(Secondary)

(Duration) yrs. mos. ds.

(Signed)

R. D. Tucker M. D.Sept 13, 1913 (Address) Levensville-2da

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death yrs. mos. days. In the State yrs. mos. days.

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

LevensvilleSept 23, 1913

20. UNDERTAKER

ADDRESS

FriedsLevensville

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Form V. S. No. 5 20M.1-16-12

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH.

Registration District No. 98County of JeromePrimary Registration District No. 2976File No. 5919City of Leoville

(No. _____, _____ St.)

Registered No. 14

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

Ellen Cornelia Ellsworth

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX

F

4. COLOR OR RACE

W

5. SINGLE, MARRIED, WIDOWED OR DIVORCED.

married
(Write the word.)

6. DATE OF BIRTH

Oct. 121846

(Month)

(Day)

(Year)

7. AGE

66 yrs. 11 mos. 27 ds.IF LESS than 1 day
how many _____ hrs. or
_____ mins.

8. OCCUPATION

- (a) Trade, profession or particular kind of work
(b) General nature of industry business, or establishment in which employed (or employer)

Housewife

9. BIRTHPLACE

(State or Country)

France

10. NAME OF FATHER

Seth M. Blair

11. BIRTHPLACE OF FATHER

(State or Country)

12. MAIDEN NAME OF MOTHER

Cornelia Jane Espey

13. BIRTHPLACE OF MOTHER

(State or Country)

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

Paul Ellsworth

(Address)

Rigby - Ida.

15.

Filed

Oct. 101913Ray H. Fisher

Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH

Sept. 211913

(Month)

(Day)

(Year)

17. I HEREBY CERTIFY, That I attended deceased from

Aug. 10 1913, to Sept 27 1913that I last saw her alive on Sept 20 1913

and that death occurred on the date stated above, at _____ M.

The CAUSE OF DEATH* was as follows:

Senile Dementia
Hemiplegia

(Duration) yrs. _____ mos. _____ ds.

Contributory
(Secondary)(Duration) yrs. 7 mos. _____ ds.

(Signed)

Ray H. Fisher M. D.Sept 23 1913 (Address) Rigby - Idaho

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death _____ yrs. _____ mos. _____ days. In the State _____ yrs. _____ mos. _____ days.

Where was disease contracted if not at place of death?

Former or usual residence.

19. PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

Leoville Ida.Sept 24 1913

20. UNDERTAKER

ADDRESS

Joseph MorleyIdaho Falls - Ida.for Denwood Co.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Form V. S. No. 5 20M.1-16-12

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH

Registration District No. 9County of IdahoPrimary Registration District No. 2176City of Rigley

(No. _____, _____ St.)

File No. 592Registered No. 11

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

Miles Wilson

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX

M.

4. COLOR OR RACE

White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED.

married
(Write the word.)

6. DATE OF BIRTH

Oct 81866

(Month)

(Day)

(Year)

7. AGE

46 yrs. 11 mos. 14 ds.IF LESS than 1 day
how many _____ hrs. or
_____ mins.?

8. OCCUPATION

(a) Trade, profession or particular kind of work

(b) General nature of industry business, or establishment in which employed (or employer)

Farmer

9. BIRTHPLACE

(State or Country)

Neb.

10. NAME OF FATHER

Joseph M. Romney

11. BIRTHPLACE OF FATHER

(State or Country)

England

12. MAIDEN NAME OF MOTHER

Jane Wilson

13. BIRTHPLACE OF MOTHER

(State or Country)

Isle of Mann

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

James F. Glenn

(Address)

Rigley - Idaho

15.

Filed

Oct 101913Raymond L. M.

Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH

Sept 221913

(Month)

(Day)

(Year)

17. I HEREBY CERTIFY, That I attended deceased from

July 15 1913 to Sept 22 1913that I last saw him alive on Sept 21 1913and that death occurred on the date stated above, at 10:30 A.M.

The CAUSE OF DEATH* was as follows:

ArteriosclerosisMyocardial degeneration

(Duration) _____ yrs. _____ mos. _____ ds.

Contributory

(Secondary)

(Duration) _____ yrs. _____ mos. _____ ds.

(Signed)

H. A. Anderson, M. D.Sept 2 1913 (Address)

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death

_____ yrs. _____ mos. _____ days.

In the

State _____ yrs. _____ mos. _____ days.

Where was disease contracted if not at place of death?

Former or usual residence.

19. PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

RigleySept 25 1913

20. UNDERTAKER

ADDRESS

M. J. Vick & SonsRigley - Ida

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Form V. S. No. 5 20M.1-16-12

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH.

Registration District No. 32-69

County of Bingham

Primary Registration District No. 21544

City of Shelley

(No. _____ St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Rose Jane Huston

File No. 5922

Registered No. _____

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX Female

4. COLOR OR RACE White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED.
Divorced
(Write the word.)

6. DATE OF BIRTH Sept. 26, 1853
(Month) (Day) (Year)

7. AGE 60 yrs. 9 mos. 23 ds.

IF LESS than 1 day
how many _____ hrs. or
_____ mins.?

8. OCCUPATION

(a) Trade, profession or particular kind of work House Keeper

(b) General nature of industry business, or establishment in which employed (or employer)

9. BIRTHPLACE Utah
(State or Country)

10. NAME OF FATHER Lott Smith

11. BIRTHPLACE OF FATHER New York
(State or Country)

12. MAIDEN NAME OF MOTHER Jane Walker

13. BIRTHPLACE OF MOTHER Vermont
(State or Country)

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) U. M. Huston

(Address) Firth

15.

Filed 7-18-1913

1913

Edwin Cutler

Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH July 17, 1913
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from July 1, 1913, to July 17, 1913, that I last saw her alive on July 17, 1913, and that death occurred on the date stated above, at 2 P.M.

The CAUSE OF DEATH* was as follows:
Pneumonia

(Duration) _____ yrs. _____ mos. 17 - ds.

Contributory (Secondary)

(Duration) _____ yrs. _____ mos. _____ ds.

(Signed) Edwin Cutler M. D.

7-18-1913 (Address) Shelley

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death _____ yrs. _____ mos. _____ days. In the State _____ yrs. _____ mos. _____ days.

Where was disease contracted if not at place of death?

Former or usual residence.

19. PLACE OF BURIAL OR REMOVAL Paradise Idaho

DATE OF BURIAL 7-19-1913

20. UNDERTAKER [Signature]

ADDRESS

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Form V. S. No. 5 20M-1-30-12

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH

Registration District No. 69

County of Benewah

Primary Registration District No. 2141

City of Shelley

(No. _____)

St. _____

File No. 5923

Registered No. _____

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

Leonidas Clark

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX

Male

4. COLOR OR RACE

White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED.

Married
(Write the word.)

6. DATE OF BIRTH

Aug 3 1886
(Month) (Day) (Year)

7. AGE

76 yrs 11 mos 23 ds.

IF LESS than 1 day
how many hrs. or
mins.?

8. OCCUPATION

(a) Trade, profession or particular kind of work

Farming

(b) General nature of industry, business, or establishment in which employed (or employer)

9. BIRTHPLACE

(State or Country)

Indiana - U.S.

10. NAME OF FATHER

Martin Clark

11. BIRTHPLACE OF FATHER

(State or Country)

Indiana, U.S.

12. MAIDEN NAME OF MOTHER

Catherine

13. BIRTHPLACE OF MOTHER

(State or Country)

U.S.

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

Geo. G. Clark

(Address)

Shelley, Idaho

15.

Filed

7-27-1918 Edwin Cuthbert
Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH

July 26 1918
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from

June 7th 1918, to July 25th 1918,

that I last saw him alive on July 25th 1918,

and that death occurred on the date stated above, at 8 P.M.

The CAUSE OF DEATH* was as follows:

Old age

(Duration) 2 yrs. 1 mos. 1 ds.

Contributory Hypertrophied Heart
(Secondary)

(Duration) 5 yrs. 1 mos. 1 ds.

(Signed) F. E. Roberts M.D.

July 27 1918 (Address) Shelley, Idaho

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death yrs. mos. days. In the State yrs. mos. days.

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL DATE OF BURIAL

Taylor, Idaho 7/27 1918

20. UNDERTAKER ADDRESS

C. C. Riney Idaho Falls

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Form V. S. No. 5 20M.1-16-12

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH.

Registration District No. 69

County of Bingham

Primary Registration District No. 2147

City of Hoodville

(No. _____ St.)

File No. 5920

Registered No. _____

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME George LeRoy Everett

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX

Male

4. COLOR OR RACE

White

5. SINGLE, MARRIED, WID-
OWED OR DIVORCED
married
(Write the word.)

6. DATE OF BIRTH

Aug. 1 1882
(Month) (Day) (Year)

7. AGE

30 yrs. 10 mos. 20 ds.

IF LESS than 1 day
how many hrs. or
..... mins.

8. OCCUPATION

(a) Trade, profession or
particular kind of work
(b) General nature of industry
business, or establishment in
which employed (or employer)

Farming

9. BIRTHPLACE

(State or Country)

Utah

10. NAME OF
FATHER

John C Everett

11. BIRTHPLACE
OF FATHER

(State or Country)

Utah

12. MAIDEN NAME
OF MOTHER

Liantha Pierce

13. BIRTHPLACE
OF MOTHER

(State or Country)

Utah

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

Jno. C. Everett

(Address)

R D 4 - Idaho Falls

15.

Filed

6-20-

1913

Edw. Cutler M.

Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH

June 19 1913
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from

May 19 1913, to June 19 1913,

that I last saw him alive on June 19 1913,

and that death occurred on the date stated above, at 18 P.M.

The CAUSE OF DEATH* was as follows:

Typhoid fever

(Duration) yrs. 1 mos. 00 ds.

Contributory
(Secondary)

Heroin abuse of brands

(Duration) yrs. 2 mos. 2 ds.

(Signed)

F. E. Roberts

M. D.

June 20 1913 (Address) Shelley Idaho

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place
of death.....

.....yrs.mos.days.

In the
State.....

.....yrs.mos.days.

Where was disease contracted
if not at place of death?.....

Former or
usual residence.....

19. PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

Hoodville

6/21 1913

20. UNDERTAKER

ADDRESS

B. B. Hinwoodey

Idaho Falls

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Form V. S. No. 5 20M.1-16-12

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH.

Registration District No. 53-69County of BinghamPrimary Registration District No. 2147City of Janestown

(No. _____, _____ St.)

File No. 592

Registered No. _____

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Melvin David Dick

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX M.4. COLOR OR RACE W5. SINGLE MARRIED, WID-
OWED OR DIVORCED.(Write the word.) Single6. DATE OF BIRTH 7-25-1912

(Month)

(Day)

(Year)

7. AGE

_____ yrs. 7 mos. 17 ds.IF LESS than 1 day
how many _____ hrs. or
_____ mins.?

8. OCCUPATION

(a) Trade, profession or
particular kind of work(b) General nature of industry
business, or establishment in
which employed (or employer)H. Home

9. BIRTHPLACE

(State or Country)

Janestown, Ida10. NAME OF
FATHER David S. Dick11. BIRTHPLACE
OF FATHER

(State or Country)

Salt Lake City, Utah.12. MAIDEN NAME
OF MOTHER Mary P. Lyon13. BIRTHPLACE
OF MOTHER

(State or Country)

Murray Utah.

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) David S. Dick(Address) Shelley Idaho

15.

Filed 5-13-1913Edwin Cutler
Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH

5-12-1913
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from

4-29-1913, to 5-12-1913,that I last saw him alive on 5-12-1913and that death occurred on the date stated above, at 8:53 P.M.

The CAUSE OF DEATH* was as follows:

Bronche Pneumonia(Duration) _____ yrs. _____ mos. 14 ds.Contributory Measles
(Secondary)(Duration) _____ yrs. _____ mos. 72 ds.(Signed) Edwin Cutler M. D.5-13-1913 (Address) Shelley Ida

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death _____ yrs. _____ mos. _____ days. In the State _____ yrs. _____ mos. _____ days.

Where was disease contracted if not at place of death?

Former or usual residence _____

19. PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

Shelley Ida5-14-1913

20. UNDERTAKER

ADDRESS

C. E. DrimwooleyIdaho Falls. Ida.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Form V. S. No. 5 20M.1-16-12

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH. Registration District No. 33-69
County of Bear River Primary Registration District No. 21-47
City of Goshute (No. _____, St.)

File No. 592

Registered No. _____

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Sila May Monsen

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX F. 4. COLOR OR RACE White 5. SINGLE, MARRIED, WIDOWED OR DIVORCED. Single
(Write the word)

6. DATE OF BIRTH

3 1 1913
(Month) (Day) (Year)

7. AGE

_____ yrs. 2 mos. _____ ds.

IF LESS than 1 day
how many _____ hrs. or
_____ mins.?

8. OCCUPATION

(a) Trade, profession or particular kind of work
(b) General nature of industry, business, or establishment in which employed (or employer)

None

9. BIRTHPLACE

(State or Country)

Goshute, Idaho

10. NAME OF FATHER

Willard Monsen

11. BIRTHPLACE OF FATHER

(State or Country)

Idaho

12. MAIDEN NAME OF MOTHER

Rebecca Anderson

13. BIRTHPLACE OF MOTHER

(State or Country)

Norway

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

Willard Monsen

(Address)

Shelley R.D.#1.

15.

Filed

5-11913

Edu. Cutler
Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH

5 1 1913
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from

4-28 - 1913, to 5-1 - 1913

that I last saw her alive on 4-28 1913and that death occurred on the date stated above, at 6 P.M.

The CAUSE OF DEATH* was as follows:

Whooping Cough & Pneumonia

(Duration) _____ yrs. _____ mos. 12 ds.

Contributory (Secondary)

(Duration) _____ yrs. _____ mos. _____ ds.

(Signed)

Edwin Cutler

M. D.

5-1-1913 (Address) Shelley Idaho

State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death _____ yrs. _____ mos. _____ days. In the State _____ yrs. _____ mos. _____ days.

Where was disease contracted if not at place of death?

Former or usual residence _____

19. PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

Goshute Idaho5-3-1913

20. UNDERTAKER

Clifford Hayes

ADDRESS

Idaho Falls

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Form V. S. No. 5 20M.1-16-12

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH

Registration District No. 3369

County of Bingham

Primary Registration District No. 2132247

City of Shelley

(No. _____ St.)

File No. 5939

Registered No. _____

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

Leora Ferry

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX

M.

4. COLOR OR RACE

White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED.

Single
(Write the word.)

6. DATE OF BIRTH

Oct
(Month)

17
(Day)

1893
(Year)

7. AGE

15 yrs. 7 mos. 8 ds.

IF LESS than 1 day
how many hrs. or
..... mins.?

8. OCCUPATION

(a) Trade, profession or particular kind of work

Boys at home

(b) General nature of industry business, or establishment in which employed (or employer)

9. BIRTHPLACE

(State or Country)

Idaho

10. NAME OF FATHER

John D. Ferry

11. BIRTHPLACE OF FATHER

(State or Country)

Idaho

12. MAIDEN NAME OF MOTHER

Ruth D. Daniels

13. BIRTHPLACE OF MOTHER

(State or Country)

Idaho

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

John D. Ferry

(Address)

R.D. # 1, Shelley

15.

Filed 5-25 1913

Edwin Cuthbert
Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

May
(Month)

28
(Day)

1913
(Year)

17. I HEREBY CERTIFY, That I attended deceased from

5-12-1913, to 5-24-1913,

that I last saw him alive on 5-24-1913

and that death occurred on the date stated above, at 9 A.M.

The CAUSE OF DEATH* was as follows:

Endocarditis

(Duration) yrs. 4 mos. ds.

Contributory
(Secondary)

Rheumatism

(Duration) yrs. 4 mos. ds.

(Signed)

Edwin Cuthbert

M. D.

5-25-1913 (Address) Shelley, Ida.

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death yrs. mos. days. In the State yrs. mos. days.

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

Shelley, Ida.

5-26-1913

20. UNDERTAKER

ADDRESS

C. E. Dimmock

Idaho Falls

Form V. S. No. 5 20M.1-16-12

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH

Registration District No. 69County of BinghamPrimary Registration District No. 2149City of West Firth

(No. _____ St.)

File No. 5931

Registered No. _____

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

Emil P. Sundquist

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX

Male

4. COLOR OR RACE

White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED.

Single
(Write the word.)

6. DATE OF BIRTH

July
(Month)2
(Day)1895
(Year)

7. AGE

17 yrs. 10 mos. 28 ds.IF LESS than 1 day
how many hrs. or
..... mins.?

8. OCCUPATION

(a) Trade, profession or particular kind of work

at home -

(b) General nature of industry business, or establishment in which employed (or employer)

Farming

9. BIRTHPLACE

(State or Country)

Idaho

10. NAME OF FATHER

H. G. Sundquist

11. BIRTHPLACE OF FATHER

(State or Country)

Sweden

12. MAIDEN-NAME OF MOTHER

Hulda Anderson

13. BIRTHPLACE OF MOTHER

(State or Country)

Sweden

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

H. G. Sundquist

(Address)

R D # 1 - Blackfoot

15.

Filed

5-31-1913E. C. Custer

Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH

May
(Month)31
(Day)1913
(Year)

17. I HEREBY CERTIFY, That I attended deceased from

May 11 1913, to May 31 1913,that I last saw him alive on May 31 1913,and that death occurred on the date stated above, at 8:45 A.M.

The CAUSE OF DEATH* was as follows:

Appendicitis(Duration) ✓ yrs. ✓ mos. 20 ds.Contributory
(Secondary)(Duration) ✓ yrs. ✓ mos. 20 ds.

(Signed)

A. R. Sedgwick M.D.31 1913 (Address) Idaho Falls, Idaho

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death yrs. mos. days. In the State yrs. mos. days.

Where was disease contracted if not at place of death?

Former or usual residence.

19. PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

West Firth6/1 1913

20. UNDERTAKER

ADDRESS

B. E. HinwoodeyIdaho Falls

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

1. PLACE OF DEATH. _____
County of Bingham Registration District No. 2147 File No. 5932
City of Shelley (No. _____ St.) Registered No. _____
If death occurs away from usual residence, give facts called for under special information. 2. FULL NAME Della Larson If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX Female 4. COLOR OR RACE White 5. SINGLE, MARRIED, WIDOWED OR DIVORCED. Married
(Write the word.)

6. DATE OF BIRTH Jan. 24 1902
(Month) (Day) (Year)

7. AGE 11 yrs. 3 mos. 14 ds.
IF LESS than 1 day how many hrs. or mins.?

8. OCCUPATION Shop Girl
(a) Trade, profession or particular kind of work
(b) General nature of industry, business, or establishment in which employed (or employer)

9. BIRTHPLACE Utah
(State or Country)

10. NAME OF FATHER James Larson

11. BIRTHPLACE OF FATHER Utah
(State or Country)

12. MAIDEN NAME OF MOTHER Judah Larson also

13. BIRTHPLACE OF MOTHER Utah
(State or Country)

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Jas Larson
(Address) Shelley Idaho

15. Filed 4-19-1913 E. C. Custer
Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH April 18 1913
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from 4-15-1913, to 4-18-1913, that I last saw him alive on 4-18-1913, and that death occurred on the date stated above, at 3:4 M.

The CAUSE OF DEATH* was as follows:

Heart Failure

(Duration) yrs. mos. 2 ds.
Contributory Miscellaneous
(Secondary)

(Duration) yrs. mos. 5 ds.
(Signed) Edwin Custer M. D.
4-18-1913 (Address) Shelley Idaho

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death yrs. mos. days. In the State yrs. mos. days.

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL Shelley Idaho DATE OF BURIAL April 19 1913
20. UNDERTAKER G. H. Hunt ADDRESS Idaho Falls

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Form V. S. No. 5 20M.1-16-12

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH.

Registration District No. 69

County of Bingham

Primary Registration District No. 2147

City of Basalt

(No. _____ St.)

File No. 5934

Registered No. _____
If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Anne Grigsby

PERSONAL AND STATISTICAL PARTICULARS

3. SEX Female 4. COLOR OR RACE White 5. SINGLE, MARRIED, WIDOWED OR DIVORCED. Married
(Write the word.)

6. DATE OF BIRTH

Oct. 5 1882
(Month) (Day) (Year)

7. AGE

61 yrs. 5 mos. 8 ds.

IF LESS than 1 day
how many _____ hrs. or
_____ mins.?

8. OCCUPATION

(a) Trade, profession or particular kind of work
(b) General nature of industry, business, or establishment in which employed (or employer)

House wife

9. BIRTHPLACE

(State or Country)

Va.

10. NAME OF FATHER

Andrew Ailstock

11. BIRTHPLACE OF FATHER

(State or Country)

Va.

12. MAIDEN NAME OF MOTHER

Phoebe Vess

13. BIRTHPLACE OF MOTHER

(State or Country)

Va.

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

Charles Grigsby

(Address)

Shelley

15.

Filed

Mar. 14 E. Lenth

Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH

March 13 1913
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from

9-28-1912, to 3-13-1913

that I last saw her alive on 3-10-1913

and that death occurred on the date stated above, at _____ M.

The CAUSE OF DEATH* was as follows:

Cancer of Pancreas

(Duration) _____ yrs. 10 mos. _____ ds.

Contributory

(Secondary)

(Duration) _____ yrs. _____ mos. _____ ds.

(Signed)

Edwin Luther M. D.

3-13-1913 (Address) Shelley Idaho

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death _____ yrs. _____ mos. _____ days. In the State _____ yrs. 6 mos. _____ days.

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

Shelley, Idaho

3-13-1913

20. UNDERTAKER

ADDRESS

J. N. Hunt

Idaho Falls

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
 N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Form V. S. No. 5. 12½ M. 7-24-11

CERTIFICATE OF DEATH

State of Idaho
 BOARD OF HEALTH
 Bureau of Vital Statistics
 File No. 593

1. PLACE OF DEATH.
 County of Bingham
 City of Shelley

Registration District No. 33
 Primary Registration District No. 215247
 (No. _____ St.)

Registered No. _____

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

6. J. Vickery

If death occurred in a hospital, institution or camp give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX 4. COLOR OR RACE 5. SINGLE, MARRIED, WIDOWED OR DIVORCED.

Male White Single
 (Write the word.)

6. DATE OF BIRTH 1-12-1904
3-30-1913
 (Month) (Day) (Year)

7. AGE IF LESS than 1 day
9 yrs. 0 mos. 0 ds. how many _____ hrs. or _____ min?

8. OCCUPATION

(a) Trade, profession or particular kind of work.
 (b) General nature of industry business or establishment in which employed (or employer)

At home

9. BIRTHPLACE

(State or Country)

Wyoming

10. NAME OF FATHER

J. H. Vickery

11. BIRTHPLACE OF FATHER

(State or Country)

Mo.

12. MAIDEN NAME OF MOTHER

Matilda A. Baldwin

13. BIRTHPLACE OF MOTHER

(State or Country)

Mo.

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Matilda A. Vickery
 (Address) Firth Idah

15.

Filed 3-31 1913 Edwin Cuth
 Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH

3 30 1913
 (Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from 3-29-1913, to 3-30-1913

that I last saw him alive on 3-30 1913
 and that death occurred on the date stated above, at 830 PM

The CAUSE OF DEATH* was as follows:

Uremia

(Duration) _____ yrs. _____ mos. 1 ds.

Contributory (Secondary) Marasmus

(Duration) _____ yrs. _____ mos. 8 ds.

(Signed) Edwin Cuth M. D.
3-30 1913 (Address) Shelley Id.

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place _____ In the _____
 of death _____ yrs. _____ mos. _____ ds. State _____ yrs. _____ mos. _____ ds.
 Where was disease contracted,
 If not at place of death? _____
 Former or
 usual residence _____

19. PLACE OF BURIAL OR REMOVAL DATE OF BURIAL

Firth 4-3-1913

20. UNDERTAKER ADDRESS

None

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Form V. S. No. 5 20M.1-16-12

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH.

Registration District No. 69

County of Bingham

Primary Registration District No. 2147

City of Shells

(No., St.)

File No. 593

Registered No.

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

Geo. W. Young

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX

Male

4. COLOR OR RACE

White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED.

Widowed

6. DATE OF BIRTH

April 16 1945
(Month) (Day) (Year)

7. AGE

67 yrs. 9 mos. 16 ds.

IF LESS than 1 day
how many hrs. or
..... mins.?

8. OCCUPATION

- (a) Trade, profession or particular kind of work
(b) General nature of industry, business, or establishment in which employed (or employer)

Retired Brick mason

9. BIRTHPLACE

(State or Country)

Penn

10. NAME OF FATHER

John Young

11. BIRTHPLACE OF FATHER

(State or Country)

Penn

12. MAIDEN NAME OF MOTHER

Unknown

13. BIRTHPLACE OF MOTHER

(State or Country)

✓ ✓

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

(Address)

Shelley Ida
J. L. Moore

15.

Filed 2-2 1913

Edwin Cutler
Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH

Feb. 2 1913
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from Jan 31 1913, to Feb. 1 1913, that I last saw him alive on Feb. 1 1913, and that death occurred on the date stated above, at 6 A.M.

The CAUSE OF DEATH* was as follows:

Apoplexy

2 (Duration) yrs. 2 mos. 2 ds.

Contributory
(Secondary)

(Duration) yrs. 2 mos. 2 ds.

(Signed) F. C. Roberts M. D.

Feb 2 1913 (Address) Shells Idaho

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death yrs. mos. days. In the State yrs. mos. days.

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL DATE OF BURIAL

Clawson Iowa Feb 7 1913

20. UNDERTAKER

ADDRESS

E. H. Hunt Idaho Falls

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Form V. S. No. 5 20M.1-16-12

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

PLACE OF DEATH.

Registration District No. 69County of BinghamPrimary Registration District No. 2147City of Woodville

(No. _____)

St.)

File No. 5938

Registered No. _____

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Veda I Letta Littlefield

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX

4. COLOR OR RACE

5. SINGLE, MARRIED, WIDOWED OR DIVORCED.

FWChild
(Write the word.)

6. DATE OF BIRTH

281913

(Month)

(Day)

(Year)

7. AGE

5 yrs. 11 mos. 11 ds.

IF LESS than 1 day
how many _____ hrs. or
_____ mins?

8. OCCUPATION

(a) Trade, profession or particular kind of work

Child

(b) General nature of industry business, or establishment in which employed (or employer)

9. BIRTHPLACE

(State or Country)

Woodville

10. NAME OF FATHER

Wm. Omer Littlefield

11. BIRTHPLACE OF FATHER

(State or Country)

Utah

12. MAIDEN NAME OF MOTHER

Mary Elvira Campbell

13. BIRTHPLACE OF MOTHER

(State or Country)

Virgin City, Utah

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

W. O. Littlefield

(Address)

Woodville, P. D. 4 Idaho Falls

15.

Filed 2-9-19131913Edwin Butler

Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH

281913

(Month)

(Day)

(Year)

17. I HEREBY CERTIFY, That I attended deceased from

2-6-1913

to

2-7-1913that I last saw her alive on 2-7- 1913and that death occurred on the date stated above, at 5:30 P.M.

The CAUSE OF DEATH* was as follows:

Pneumonia

(Duration)

yrs.

mos.

10

ds.

Contributory Cold & Malnutrition
(Secondary)

(Duration)

yrs.

mos.

3

ds.

(Signed)

Edwin Butler

M. D.

19

(Address)

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death

yrs.

mos.

days

In the State

yrs.

mos.

days

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

Woodville, Idaho2-101913

20. UNDERTAKER

ADDRESS

Penwooders S. CoIdaho Falls

-SUPPLEMENTARY DEATH CERTIFICATE-

(Please reply on this sheet to
the registrar of Vital Statistics)

Death Certificate No. _____

Name Vida Littlefield

Date of Death 2-7-1912

Cause of Death Broncho Pneumonia

Contributory Cause of death Malnutrition

(Sign here) Edwin Center M.D.

1. PLACE OF DEATH.

Registration District No. 33 69County of BinghamPrimary Registration District No. 2152 47File No. 5940City of Basalt

(No. _____ St.)

Registered No. _____

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

Shel Bon

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX

4. COLOR OR RACE

5. SINGLE, MARRIED, WIDOWED OR DIVORCED.

Male White (Write the word.)

6. DATE OF BIRTH

2 (Month) 6 (Day) 1913 (Year)

7. AGE

____ yrs. ____ mos. ____ ds.

IF LESS than 1 day
how many ____ hrs. or
____ mins.?

8. OCCUPATION

- (a) Trade, profession or particular kind of work
-
- (b) General nature of industry business, or establishment in which employed (or employer)

S-till Bonar

9. BIRTHPLACE

(State or Country)

Basalt-Idaho

10. NAME OF FATHER

Elmer Jolley

11. BIRTHPLACE OF FATHER

(State or Country)

Idaho

12. MAIDEN NAME OF MOTHER

Retta Butler

13. BIRTHPLACE OF MOTHER

(State or Country)

Idaho

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

Ervin Jolley

(Address)

Basalt Idaho

15.

Filed 2 - 6 1913C. Butler

Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH

2 (Month) 6 (Day) 1913 (Year)

17. I HEREBY CERTIFY, That I attended deceased from

191____, to 191____,

that I last saw h.____ alive on 191____,

and that death occurred on the date stated above, at ____ M.

The CAUSE OF DEATH* was as follows:

unknown

(Duration) ____ yrs. ____ mos. ____ ds.

Contributory
(Secondary)

(Duration) ____ yrs. ____ mos. ____ ds.

(Signed) No physician M. D.

19____ (Address)

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death ____ yrs. ____ mos. ____ days. In the State ____ yrs. ____ mos. ____ days.

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

Basalt-Idaho2/7 1913

20. UNDERTAKER

ADDRESS

none

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Form V. S. No. 5 20M.1-16-12

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics
File No. 5942

Registered No. 321

1. PLACE OF DEATH

Registration District No. 17

County of

Primary Registration District No. 1003

City of

(No. , St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

Infant of H. E. Langdon

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX

4. COLOR OR RACE

5. SINGLE, MARRIED, WIDOWED OR DIVORCED.

Male

White

(Write the word.)

6. DATE OF BIRTH

Aug 3 1913

(Month)

(Day)

(Year)

7. AGE

— yrs. — mos. — ds.

IF LESS than 1 day
how many hrs. or
. mins.

8. OCCUPATION

(a) Trade, profession or particular kind of work

(b) General nature of industry business, or establishment in which employed (or employer)

9. BIRTHPLACE

(State or Country)

Idaho

10. NAME OF FATHER

H. E. Langdon

11. BIRTHPLACE OF FATHER

(State or Country)

Wis.

12. MAIDEN NAME OF MOTHER

N. Card

13. BIRTHPLACE OF MOTHER

(State or Country)

Wis.

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

(Address)

H. E. Langdon
Cour D'Alene Ida.

15.

Filed

9/10

1913

S. S. Newman

Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH

Aug

3

1913

(Month)

(Day)

(Year)

17. I HEREBY CERTIFY, That I attended deceased from

Aug 1

1913

to

Aug 3

1913

that I last saw him alive on Aug 2 1913

and that death occurred on the date stated above, at 2 P.M.

The CAUSE OF DEATH* was as follows:

Primative birth

(Duration)

yrs.

mos.

ds.

Contributory
(Secondary)

(Duration)

yrs.

mos.

ds.

(Signed)

Aug 4 1913

(Address)

J. O. Wynn
Cour D'Alene Idaho

M. D.

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place
of death

yrs.

mos.

days.

In the
State

yrs.

mos.

days.

Where was disease contracted
if not at place of death?Former or
usual residence

19. PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

Forest Com.

Aug 4 1913

20. UNDERTAKER

ADDRESS

Cassidy & Nelson

Cour D'Alene

MARGIN RESERVED FOR BINDING
WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Form V. S. No. 5 20M.1-16-12

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH

Registration District No. 14

County of Kootenai

Primary Registration District No. 1003

City of Boonville

(No. St.)

File No. 5943

Registered No. 322

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

Herman Manley

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX

Male

4. COLOR OR RACE

White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED.

Married
(Write the word.)

6. DATE OF BIRTH

Nov. 5 1830
(Month) (Day) (Year)

7. AGE

72 yrs. 9 mos. ds.

IF LESS than 1 day
how many hrs. or
 mins.

8. OCCUPATION

(a) Trade, profession or particular kind of work

Retired

(b) General nature of industry business, or establishment in which employed (or employer)

9. BIRTHPLACE

(State or Country)

Pennsylvania

10. NAME OF FATHER

Nathan Manley

11. BIRTHPLACE OF FATHER

(State or Country)

Vermont

12. MAIDEN NAME OF MOTHER

German

13. BIRTHPLACE OF MOTHER

(State or Country)

Massachusetts

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

Roy Manley

(Address)

1041 Bancroft

15.

Filed

9/10

1913

M. S. Sweeney
Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

Aug 5 1913
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from July 15th 1913, to Aug 5th 1913, that I last saw him alive on Aug 4th 1913, and that death occurred on the date stated above, at 8 A.M.

The CAUSE OF DEATH* was as follows:

Cardiac Insufficiency

(Duration) 2 yrs. mos. ds.

Contributory (Secondary)

Senility

(Duration) yrs. mos. ds.

(Signed)

Aug 5 1913

(Address)

Jno. B. M. D.
Crem. & Burial Co.

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death yrs. mos. days. In the State yrs. mos. days.

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

Forest Cem

Aug. 7 1913

20. UNDERTAKER

ADDRESS

Cassidy & Nelson
Crem. & Burial Co.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Form V. S. No. 5 20M.1-16-12

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH. Registration District No. 19
County of Boole Primary Registration District No. 1003
City of Coeur d'Alene (No. _____) (St.) _____

File No. 594Registered No. 324

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Melina J. Eustice

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX Female 4. COLOR OR RACE White 5. SINGLE, MARRIED, WIDOWED OR DIVORCED. married
(Write the word.)

6. DATE OF BIRTH 1 18 1842
(Month) (Day) (Year)

7. AGE 7 yrs. 25 mos. 25 ds. IF LESS than 1 day how many hrs. or mins.

8. OCCUPATION
(a) Trade, profession or particular kind of work Housewife
(b) General nature of industry, business, or establishment in which employed (or employer)

9. BIRTHPLACE Ohio
(State or Country)

10. NAME OF FATHER Wm Wood

11. BIRTHPLACE OF FATHER Ohio
(State or Country)

12. MAIDEN NAME OF MOTHER Ada Calhoun

13. BIRTHPLACE OF MOTHER Ohio
(State or Country)

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) J. J. Eustice
(Address) 1600 Penn. Ave.

15. Filed 9/1/10 1913
Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH Aug 12 1913
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from July 15 1913, to Aug 12 1913, that I last saw her alive on Aug 12 1913, and that death occurred on the date stated above, at 11:20 A.M.

The CAUSE OF DEATH* was as follows: Chronic Gastritis

* (Duration) 2 yrs. 1 mos. 1 ds.
Contributory Paralysis left side
(Secondary)

(Duration) 1 yrs. 1 mos. 1 ds.
(Signed) W. H. Koedeen M. D.

Aug 12 1913 (Address) Coeur d'Alene Idaho

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death. 1 yrs. 1 mos. 1 days. In the State 1 yrs. 1 mos. 1 days.

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL Forest Cem. DATE OF BURIAL Aug 14 1913

20. UNDERTAKER Cassidy & Nelson ADDRESS Coeur d'Alene

Form V. S. No. 5 20M.1-16-12

CERTIFICATE OF DEATH

State of Idaho
 BOARD OF HEALTH
 Bureau of Vital Statistics
 File No. 5946

Registered No. 325

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

1. PLACE OF DEATH.

Registration District No. 19County of GoshutePrimary Registration District No. 2051City of Parkland

(No. _____, St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Frank Brunk

PERSONAL AND STATISTICAL PARTICULARS

3. SEX

4. COLOR OR RACE

5. SINGLE, MARRIED, WIDOWED OR DIVORCED.

M.W.S. (Write the word.)

6. DATE OF BIRTH

(Month)

(Day)

(Year)

7. AGE

26 yrs. _____ mos. _____ ds.

IF LESS than 1 day
 how many _____ hrs. or
 _____ mins.?

8. OCCUPATION

(a) Trade, profession or particular kind of work

(b) General nature of industry, business, or establishment in which employed (or employer)

Labour

9. BIRTHPLACE

(State or Country)

Or.

10. NAME OF FATHER

11. BIRTHPLACE OF FATHER

(State or Country)

12. MAIDEN NAME OF MOTHER

13. BIRTHPLACE OF MOTHER

(State or Country)

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Agnes(Address) County Home, Parkland

15.

Filed 9/101913

Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH

(Month)

(Day)

(Year)

17. I HEREBY CERTIFY, That I attended deceased from

Aug 1 - 1913, to Aug 15 1913,that I last saw him alive on Aug 15 1913and that death occurred on the date stated above, at 99 M.

The CAUSE OF DEATH* was as follows:

Typhoid Fever

(Duration)

yrs.

mos.

ds.

Contributory

(Secondary)

Went in Co. Jail for 2 wks

(Duration)

yrs.

mos.

ds.

(Signed) A. D. Shuman

M. D.

916 1913 (Address) Parkland

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death

yrs.

mos.

days.

In the State

yrs.

mos.

days.

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

ParklandAug 16 1913

20. UNDERTAKER

ADDRESS

Bo toParkland

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Form V. S. No. 5 20M.1-16-12

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH _____ Registration District No. 17
County of Boone Primary Registration District No. 1003
City of Coeur D'Alene (No. _____ St.)

File No. 5941
Registered No. 326

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

Sam Louis

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX Male 4. COLOR OR RACE White 5. SINGLE, MARRIED, WID-
OWED OR DIVORCED. Single
(Write the word.)

6. DATE OF BIRTH

1831
(Month) (Day) (Year)

7. AGE

82 yrs. _____ mos. _____ ds.

IF LESS than 1 day
how many _____ hrs. or
_____ mins.?

8. OCCUPATION

(a) Trade, profession or
particular kind of work

Minor

(b) General nature of industry
business, or establishment in
which employed (or employer)

9. BIRTHPLACE

(State or Country)

Ohio

10. NAME OF FATHER

Louis

11. BIRTHPLACE OF FATHER

(State or Country)

12. MAIDEN NAME OF MOTHER

13. BIRTHPLACE OF MOTHER

(State or Country)

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

Tommy Anderson

(Address)

Coeur D'Alene

15.

Filed

9/10

1913

J. D. Stevenson

Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH

Aug 20th 1913
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from
July 1st 1913, to Aug 20th 1913,
that I last saw him alive on Aug 18 1913,
and that death occurred on the date stated above, at 4³⁰ M.

The CAUSE OF DEATH* was as follows:

cardiac insufficiency

(Duration) _____ yrs. 6 mos. _____ ds.

Contributory
(Secondary)

Senility

(Duration) _____ yrs. _____ mos. _____ ds.

(Signed)

Geo. B. B. M. D.

Aug 21 1913 (Address) Coeur D'Alene Id

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death _____ yrs. _____ mos. _____ days. In the State _____ yrs. _____ mos. _____ days.

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

Forest Cem

Aug 21 1913

20. UNDERTAKER

ADDRESS

Cassidy & Nelson Coeur D'Alene

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Form V. S. No. 5 20M.1-16-12

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics
File No. 594

1. PLACE OF DEATH. Registration District No. 17
County of Kootenai Primary Registration District No. 1003
City of Coeur D'Alene (No. , St.)

Registered No. 327

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

Fred E. Woods

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX Male 4. COLOR OR RACE White 5. SINGLE, MARRIED, WIDOWED OR DIVORCED. Married
(Write the word.)

6. DATE OF BIRTH

Oct 13 1879
(Month) (Day) (Year)

7. AGE

33 yrs. 10 mos. 8 ds.

IF LESS than 1 day
how many hrs. or
mins.?

8. OCCUPATION

(a) Trade, profession or particular kind of work
(b) General nature of industry, business, or establishment in which employed (or employer)

R. R.

9. BIRTHPLACE

(State or Country)

Manitoba

10. NAME OF FATHER

John Woods

11. BIRTHPLACE OF FATHER

(State or Country)

12. MAIDEN NAME OF MOTHER

Madlebrook

13. BIRTHPLACE OF MOTHER

(State or Country)

Scotland

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

Mrs. Rosa V. Woods

(Address)

15.

Filed

9/10

1913

S. S. Drumm

Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH

Aug 22 1913
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from July 15 1913, to Aug 21 1913, that I last saw him alive on Aug 1st 1913, and that death occurred on the date stated above, at 8 A. M.

The CAUSE OF DEATH* was as follows:

Chronic Tuberculosis of Lungs

(Duration) 2 yrs. — mos. — ds.

Contributory (Secondary)

Tubercular Laryngitis

(Duration) 3 yrs. — mos. — ds.

(Signed)

Jno Bunby M. D.

Aug 23 1913

(Address) Coeur D'Alene Ida

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death yrs. mos. days. In the State yrs. mos. days.

Where was disease contracted if not at place of death?

Former or usual residence.

19. PLACE OF BURIAL OR REMOVAL

Forest Corn.

DATE OF BURIAL

Aug 23 1913

20. UNDERTAKER

Cassidy & Nelson

ADDRESS

Coeur D'Alene

MARGIN RESERVED FOR BINDING
WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Form V. S. No. 5 20M.1-16-12

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH.

Registration District No. 12

County of Boatwin

Primary Registration District No. 2057

City of Pastidum

(No. 1, 1 St.)

File No. 5949

Registered No. 328

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Gene Edwin Feely

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX

M

4. COLOR OR RACE

W

5. SINGLE, MARRIED, WIDOWED OR DIVORCED.

S

(Write the word.)

6. DATE OF BIRTH

July

11

13

(Month)

(Day)

(Year)

7. AGE

1 yrs. 21 mos. 21 ds.

IF LESS than 1 day
how many hrs. or
..... mins.?

8. OCCUPATION

(a) Trade, profession or particular kind of work

Baker

(b) General nature of industry business, or establishment in which employed (or employer)

9. BIRTHPLACE

(State or Country)

Pastidum T.F.D

10. NAME OF FATHER

Irvin Feely

11. BIRTHPLACE OF FATHER

(State or Country)

W

12. MAIDEN NAME OF MOTHER

Feely

13. BIRTHPLACE OF MOTHER

(State or Country)

Id

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

Gene Feely

(Address)

Pastidum

15.

Filed 9/10

1913

D. D. Newman
Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH

Aug

29

1913

(Month)

(Day)

(Year)

17. I HEREBY CERTIFY, That I attended deceased from

Aug 29

1913

to Aug 29

1913

that I last saw him alive on 1913

and that death occurred on the date stated above, at M.

The CAUSE OF DEATH* was as follows:

Acute Pneumonia

(Duration)

yrs.

mos.

ds.

Contributory (Secondary)

Throat Angina

(Duration)

yrs.

mos.

ds.

(Signed)

D. D. Newman M. D.

9/29 1913

(Address)

Pastidum

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death

..... yrs.

..... mos.

..... days.

In the State

..... yrs.

..... mos.

..... days.

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

Pastidum

Aug 30 1913

20. UNDERTAKER

ADDRESS

Babo

Pastidum

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Form V. S. No. 5 20M.1-16-12

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH
County of Kootenai Registration District No.
City of Coeur D'Alene (No.) St.
Primary Registration District No. 1003

File No. 5950
Registered No. 329

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME George L. Hays

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX Male 4. COLOR OR RACE White 5. SINGLE, MARRIED, WIDOWED OR DIVORCED. Widowed
(Write the word.)

6. DATE OF BIRTH Sept 27 1834
(Month) (Day) (Year)

7. AGE 78 yrs 10 mos 29 ds. IF LESS than 1 day how many hrs. or mins.?

8. OCCUPATION Retired
(a) Trade, profession or particular kind of work
(b) General nature of industry business, or establishment in which employed (or employer)

9. BIRTHPLACE Ohio
(State or Country)

10. NAME OF FATHER James Hays

11. BIRTHPLACE OF FATHER Ohio
(State or Country)

12. MAIDEN NAME OF MOTHER Margaret McQuire

13. BIRTHPLACE OF MOTHER Ohio
(State or Country)

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Margaret L. Patterson
(Address) 904 5th St

15. Filed 9/10 1913 S. D. Druman
Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH Aug 25 1913
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from July 20 1913, to Aug 25 1913, that I last saw h. in alive on Aug 25 1913, and that death occurred on the date stated above, at 5²⁰ P.M.

The CAUSE OF DEATH* was as follows:

Acute Nephritis

(Duration) 5 yrs. 5 mos. 5 ds.
Contributory By accident
(Secondary)

(Duration) 5 yrs. 5 mos. 5 ds.
(Signed) W. H. Holden M. D.

Aug 26 1913 (Address) Coeur d'Alene Idaho

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death yrs. mos. days. In the State yrs. mos. days.

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL Forest Cem. DATE OF BURIAL Aug 27 1913

20. UNDERTAKER Cassidy & Nelson ADDRESS Coeur D'Alene

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Form V. S. No. 5 20M.1-16-12

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH.

Registration District No. *17*

County of *Blaine*

Primary Registration District No. *1003*

City of *Corn & Elm*

(No. _____, St.)

File No. *5951*

Registered No. *330*

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

Elmer Snyder

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX

male

4. COLOR OR RACE

white

5. SINGLE, MARRIED, WIDOWED OR DIVORCED.

single
(Write the word.)

6. DATE OF BIRTH

1900
(Month) (Day) (Year)

7. AGE

13 yrs. *0* mos. *0* ds.

IF LESS than 1 day
how many hrs. or
..... mins.?

8. OCCUPATION

(a) Trade, profession or particular kind of work

(b) General nature of industry, business, or establishment in which employed (or employer)

9. BIRTHPLACE

(State or Country)

Spokane

10. NAME OF FATHER

Peter Snyder

11. BIRTHPLACE OF FATHER

(State or Country)

Germany

12. MAIDEN NAME OF MOTHER

Mary Peters

13. BIRTHPLACE OF MOTHER

(State or Country)

N.Y.

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

Father

(Address) *13 W. Miller*

15.

Filed

9/10

191*0*

A. J. Norman
Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH

Aug 30 191*3*
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from

Aug 29 191*3*, to *Aug 29* 191*3*,
that I last saw h. *in* alive on *Aug 29* 191*3*,
and that death occurred on the date stated above, at *12:50* M.

The CAUSE OF DEATH* was as follows:

Gun shot wound

(Duration) yrs. mos. ds.

Contributory
(Secondary)

(Duration) yrs. mos. ds.

(Signed)

Aug 30, 1913

(Address)

Wm. Miller, Idaho

M. D.

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death yrs. mos. days. In the State yrs. mos. days.

Where was disease contracted if not at place of death?

Former or usual residence.

19. PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

St. James

Aug 31, 1913

20. UNDERTAKER

ADDRESS

E. J. Jones

C. W. A.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Form V. S. No. 5 20M.1-16-12

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH.

Registration District No. *14*County of *Bonner*Primary Registration District No. *2049*City of *McArthur*

(No. _____ St.)

File No. *5953*Registered No. *382*

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME *Miles B. Gomes*

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX

Male

4. COLOR OR RACE

White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED.

Single
(Write the word.)

6. DATE OF BIRTH

(Month)

(Day)

(Year)

7. AGE

53

yrs. mos. ds.

IF LESS than 1 day
how many _____ hrs. or
_____ mins.?

8. OCCUPATION

(a) Trade, profession or particular kind of work

Farmer

(b) General nature of industry business, or establishment in which employed (or employer)

9. BIRTHPLACE

(State or Country)

Mo.

10. NAME OF FATHER

J. W. Gomes

11. BIRTHPLACE OF FATHER

(State or Country)

Indiana

12. MAIDEN NAME OF MOTHER

Agnes Sharp

13. BIRTHPLACE OF MOTHER

(State or Country)

Mo.

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

J. W. Gomes Jr.

(Address)

Harrison Ida.

15.

Filed *10/10*191*3**L. M. Munn*
Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH

*9**3**1913*

(Month)

(Day)

(Year)

17. I HEREBY CERTIFY, That I attended deceased from

191*1*, to191*1*,

that I last saw h. _____ alive on

191*1*,and that death occurred on the date stated above, at *4 P.* M.

The CAUSE OF DEATH* was as follows:

Probably contusion of brain (caused by blow on head from falling tree) Death instantaneous

(Duration)

yrs.

mos.

ds.

Contributory
(Secondary)

(Duration)

yrs.

mos.

ds.

(Signed)

9/6 1913

(Address)

McArthur Idaho

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place

of death

yrs.

mos.

days.

In the

State

yrs.

mos.

days.

Where was disease contracted if not at place of death?

Former or usual residence.

19. PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

*Union Star**10/6*191*3*

20. UNDERTAKER

ADDRESS

*Carvedy & Nelson**McArthur Idaho*

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Form V. S. No. 5 20M.1-16-12

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics
File No. 595+
Registered No. 333

1. PLACE OF DEATH
County of Boatman
City of Crowd's Blum
Registration District No. 17
Primary Registration District No. 1003
(No. _____ St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Batherine Haskins

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX Female 4. COLOR OR RACE White 5. SINGLE, MARRIED, WIDOWED OR DIVORCED. Divorced
(Write the word.)

6. DATE OF BIRTH Sept 7 1846
(Month) (Day) (Year)

7. AGE 66 yrs. 11 mos. 27 ds.
IF LESS than 1 day how many _____ hrs. or _____ mins.?

8. OCCUPATION
(a) Trade, profession or particular kind of work House wife
(b) General nature of industry business, or establishment in which employed (or employer)

9. BIRTHPLACE
(State or Country) Penn.

10. NAME OF FATHER Newgent

11. BIRTHPLACE OF FATHER
(State or Country) Ireland

12. MAIDEN NAME OF MOTHER

13. BIRTHPLACE OF MOTHER
(State or Country) Ireland

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) John Haskins

(Address) 10

15. 10/10 1913

Filed 10/10 1913 W. H. Haskins
Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH Sept 3 1913
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from August 3rd 1913, to Sept 2nd 1913, that I last saw her alive on Sept 2nd 1913, and that death occurred on the date stated above, at 6:30 AM.

The CAUSE OF DEATH* was as follows:

Interstitial Nephritis

(Duration) _____ yrs. _____ mos. _____ ds.
Contributory old age
(Secondary)

(Duration) _____ yrs. _____ mos. _____ ds.
(Signed) Alexander Cairns M. D.

9/3/1913 (Address) Crowd's Blum Idaho

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death _____ yrs. _____ mos. _____ days. In the State _____ yrs. _____ mos. _____ days.

Where was disease contracted if not at place of death?

Former or usual residence _____

19. PLACE OF BURIAL OR REMOVAL DATE OF BURIAL

St Thomas Cem Sept 5 1913

20. UNDERTAKER ADDRESS

Cassidy & Nelson Crowd's Blum

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Form V. S. No. 5 20M.1-16-12

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH
County of Booleman
City of Cour D'Alene (No. _____ St.)
Registration District No. _____
Primary Registration District No. 1003

File No. 5955
Registered No. 884

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

Isabella Lang

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX Female 4. COLOR OR RACE White 5. SINGLE, MARRIED, WIDOWED OR DIVORCED. widow
(Write the word.)

6. DATE OF BIRTH

Dec 17 1832
(Month) (Day) (Year)

7. AGE

87 yrs. 8 mos. 27 ds.

IF LESS than 1 day
how many _____ hrs. or
_____ mins.?

8. OCCUPATION

(a) Trade, profession or particular kind of work

Housewife

(b) General nature of industry business, or establishment in which employed (or employer)

9. BIRTHPLACE

(State or Country)

Vermont

10. NAME OF FATHER

Sommerville

11. BIRTHPLACE OF FATHER

(State or Country)

Ireland

12. MAIDEN NAME OF MOTHER

Tarley

13. BIRTHPLACE OF MOTHER

(State or Country)

Ireland

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

Robt Lang.

(Address)

Cour D'Alene Ida.

15.

Filed

10/10

1913

J. S. Newman
Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

Sept. 14 1913
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from

Sept. 7 1913 to Sept. 14 1913

that I last saw h. ex alive on Sept. 12 1913

and that death occurred on the date stated above, at 8 P. M.

The CAUSE OF DEATH* was as follows:

Chronic interstitial nephritis

(Duration) _____ yrs. _____ mos. _____ ds.

Contributory
(Secondary)

(Duration) _____ yrs. _____ mos. _____ ds.

(Signed)

Sept. 13 1913 (Address) Cour D'Alene Ida.

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death _____ yrs. _____ mos. _____ days. In the State _____ yrs. _____ mos. _____ days.

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL

Forest Cem.

DATE OF BURIAL

Sept. 16 1913

20. UNDERTAKER

Cassedy & Nelson

ADDRESS

Cour D'Alene

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Form V. S. No. 5 20M.1-16-12

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics
File No. 5956
Registered No. 535

1. PLACE OF DEATH

Registration District No. 17

County of Bohmer

Primary Registration District No. 1003

City of Idaho

(No. _____, St.)

Registered No. 535

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Infant son of S. Carlsson

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX

male

4. COLOR OR RACE

white

5. SINGLE, MARRIED, WIDOWED OR DIVORCED.

single
(Write the word.)

6. DATE OF BIRTH

Apr

(Month)

1913

(Day)

(Year)

7. AGE

_____ yrs. 6 mos. _____ ds.

IF LESS than 1 day
how many _____ hrs. or
_____ mins.

8. OCCUPATION

(a) Trade, profession or particular kind of work

(b) General nature of industry, business, or establishment in which employed (or employer)

9. BIRTHPLACE

(State or Country)

Idaho Kootenai

10. NAME OF FATHER

Ed Carlsson

11. BIRTHPLACE OF FATHER

(State or Country)

Sweden

12. MAIDEN NAME OF MOTHER

Mary Simmonds

13. BIRTHPLACE OF MOTHER

(State or Country)

Utah

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

Ed Carlsson

(Address)

R. 8 10-1

15.

Filed

10/10

1913

S. J. Arnesen
Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH

Sept

(Month)

14

(Day)

1913

(Year)

17. I HEREBY CERTIFY, That I attended deceased from Sept 11 1913, to Sept 14 1913, that I last saw he was alive on 13 1913, and that death occurred on the date stated above, at 9 P. M.

The CAUSE OF DEATH* was as follows:

Gastro-enteritis

(Duration) _____ yrs. _____ mos. 4 ds.

Contributory (Secondary)

(Duration) _____ yrs. _____ mos. _____ ds.

(Signed)

A. Shultz M. D.

19 (Address) Coum d'Alone

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death _____ yrs. _____ mos. _____ days. In the State _____ yrs. _____ mos. _____ days.

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL

Forest Cem

DATE OF BURIAL

Sept 14 1913

20. UNDERTAKER

S. J. Arnesen

ADDRESS

C. W. A

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Form V. S. No. 5 20M.1-16-12

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH.

Registration District No. 12County of BozemanPrimary Registration District No. 1008City of Coeur D'Alene

(No. _____, _____ St.)

File No. 5957Registered No. 336

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Francis W. McDonald

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX

Female

4. COLOR OR RACE

White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED.

Single
(Write the word.)

6. DATE OF BIRTH

Sept 17 1913
(Month) (Day) (Year)

7. AGE

_____ yrs. _____ mos. 4 ds.

IF LESS than 1 day
how many _____ hrs. or
_____ mins.?

8. OCCUPATION

(a) Trade, profession or particular kind of work

(b) General nature of industry business, or establishment in which employed (or employer)

9. BIRTHPLACE

(State or Country)

Coeur D'Alene

10. NAME OF FATHER

E. L. McDonald

11. BIRTHPLACE OF FATHER

(State or Country)

Ill.

12. MAIDEN NAME OF MOTHER

Elsie Overton

13. BIRTHPLACE OF MOTHER

(State or Country)

Iowa

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

E. L. McDonald

(Address)

Coeur D'Alene Ida.

15.

Filed 10/101913S. A. Drewman

Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH

10 20 1913
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from

Sept 17 1913, to 9/20 1913,
that I last saw her alive on 9/19 1913,
and that death occurred on the date stated above, at 44 M.

The CAUSE OF DEATH* was as follows:

Patient found dead(Duration) _____ yrs. _____ mos. 4 ds.Contributory
(Secondary)

(Duration) _____ yrs. _____ mos. _____ ds.

(Signed)

John H. Smith M. D.9/21 1913 (Address) Coeur D'Alene Ida.

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death _____ yrs. _____ mos. _____ days. In the State _____ yrs. _____ mos. _____ days.

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

Forest CemeterySept. 21 1913

20. UNDERTAKER

ADDRESS

Cassidy & NelsonCoeur D'Alene

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Form V. S. No. 5. 12½ M. 7-24-11

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics
File No. 5958
Registered No. 887

1. PLACE OF DEATH. Registration District No. 12
County of Booleman Primary Registration District No. 2057
City of Spirit Lake (No. _____, St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Gus Johnson

If death occurred in a hospital, institution or camp give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX Male 4. COLOR OR RACE White 5. SINGLE, MARRIED, WIDOWED OR DIVORCED. Single
(Write the word.)

6. DATE OF BIRTH do not know
(Month) (Day) (Year)

7. AGE about 45 yrs old IF LESS than 1 day
how many hrs. or min?

8. OCCUPATION
(a) Trade, profession or particular kind of work. Common labor
(b) General nature of industry business or establishment in which employed (or employer)

9. BIRTHPLACE Sweden
(State or Country)

10. NAME OF FATHER ?

11. BIRTHPLACE OF FATHER ?
(State or Country)

12. MAIDEN NAME OF MOTHER ?

13. BIRTHPLACE OF MOTHER ?
(State or Country)

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) E. Smith
(Address) Spirit Lake

15. 10/10 1913 S. S. Brennan
Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH September 20 1913
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from July 1913, to Sept. 20 1913
that I last saw him alive on Sept 19 1913
and that death occurred on the date stated above, at 2 P M.
The CAUSE OF DEATH* was as follows:

Pulmonary Phthisis
(Duration) yrs. 9 mos. — ds.
Contributory (Secondary)
(Duration) yrs. 1 mos. — ds.
(Signed) Earl S. Smith M. D.
19 (Address)

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place In the
of death yrs. mos. ds. State yrs. mos. ds.
Where was disease contracted,
If not at place of death?
Former or
usual residence.

19. PLACE OF BURIAL OR REMOVAL Spirit Lake DATE OF BURIAL Sept 2 1913
20. UNDERTAKER Klopf ADDRESS Paterson St

Form V. S. No. 5 20M.1-16-12

CERTIFICATE OF DEATH

 State of Idaho
 BOARD OF HEALTH
 Bureau of Vital Statistics

 1. PLACE OF DEATH. Registration District No. 17
 County of Boatwin Primary Registration District No. 1003
 City of Boatwin (No. _____ St.)

 File No. 5959
 Registered No. 338

If death occurs away from usual residence, give facts called for under special information.

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

 3. SEX Male 4. COLOR OR RACE White 5. SINGLE, MARRIED, WIDOWED OR DIVORCED. Widowed (Write the word.)

6. DATE OF BIRTH

Jan 1 1844
 (Month) (Day) (Year)

7. AGE

69 yrs. 10 mos. 21 ds.

 IF LESS than 1 day
 how many hrs. or
 mins.?

8. OCCUPATION

(a) Trade, profession or particular kind of work

Farmer

(b) General nature of industry business, or establishment in which employed (or employer)

9. BIRTHPLACE

(State or Country)

Quebec

10. NAME OF FATHER

John B. Foster

11. BIRTHPLACE OF FATHER

(State or Country)

Ireland

12. MAIDEN NAME OF MOTHER

Mason

13. BIRTHPLACE OF MOTHER

(State or Country)

Canada

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

J. B. Foster

(Address)

Boatwin

15.

Filed

10/101913
J. B. Foster
 Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH

Sept 21 1913
 (Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from

1913, to 1913,
 that I last saw him alive on Sept 21 1913,
and that death occurred on the date stated above, at M.

The CAUSE OF DEATH* was as follows:

Arterio Sclerosis

(Duration) yrs. mos. ds.

Contributory
(Secondary)

(Duration) yrs. mos. ds.

(Signed) Max Doan M. D.9/22/13 (Address) O. O. A.

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death. yrs. mos. days. In the State. yrs. mos. days.

Where was disease contracted if not at place of death?

Former or usual residence.

19. PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

Boatwin 9/22 1913

20. UNDERTAKER

ADDRESS

Boatwin Boatwin

WRITE PLAINLY, WITH UNFADING INK--THIS IS A PERMANENT RECORD. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Form V. S. No. 5. 12½ M. 7-24-11

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH.

Registration District No. 12County of NeenahPrimary Registration District No. 1003

City of _____

(No. _____)

St.) _____

File No. 5960Registered No. 239

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

Margaret Jane Robertson

If death occurred in a hospital, institution or camp give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX

Female

4. COLOR OR RACE

White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED.

Widow
(Write the word.)

6. DATE OF BIRTH

March171836

(Month)

(Day)

(Year)

7. AGE

77 yrs. 6 mos. 4 ds.

IF LESS than 1 day
how many hrs. or
..... min?

8. OCCUPATION

(a) Trade, profession or particular kind of work.

House work

(b) General nature of industry business or establishment in which employed (or employer)

9. BIRTHPLACE

(State or Country)

Missouri

10. NAME OF FATHER

Wm. Bredding

11. BIRTHPLACE OF FATHER

(State or Country)

Not known

12. MAIDEN NAME OF MOTHER

Not known

13. BIRTHPLACE OF MOTHER

(State or Country)

Not known

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

(Address)

J. E. Wood
Neenah, Idaho.

15.

Filed 10/101913L. S. Brennan
Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH

Sept211913

(Month)

(Day)

(Year)

17. I HEREBY CERTIFY, That I attended deceased from

Sept 11 1913, to Sept. 21 1913that I last saw her alive on Sept 20 1913and that death occurred on the date stated above, at 3 P. M.

The CAUSE OF DEATH* was as follows:

Ulcers on neck.(Duration) yrs. mos. 18 ds.Contributory
(Secondary)

(Duration) yrs. mos. ds.

(Signed)

Sept. 21 1913 (Address) Chas. E. Jones Ida

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place

In the

of death yrs. mos. ds. State yrs. mos. ds.

Where was disease contracted,

If not at place of death?

Former or

usual residence.

19. PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

Idaho. work.9/23/13 1913

20. UNDERTAKER

ADDRESS

E. W. WhiteNeenah

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Form V. S. No. 5 20M.1-16-12

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH.

Registration District No. 17

County of Rushia

Primary Registration District No. 1003

City of Everett

(No. Infant Ward of St.)

File No. 5961

Registered No. 340

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME A. J. Jellum

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX male 4. COLOR OR RACE white 5. SINGLE, MARRIED, WIDOWED OR DIVORCED. single
(Write the word.)

6. DATE OF BIRTH 1913
2 (Month) 1 (Day) 1 (Year)

7. AGE 1 yrs. 2 mos. ds.
IF LESS than 1 day how many hrs. or mins.?

8. OCCUPATION
(a) Trade, profession or particular kind of work
(b) General nature of industry, business, or establishment in which employed (or employer)

9. BIRTHPLACE
(State or Country) San Francisco Wash

10. NAME OF FATHER A. Jellum

11. BIRTHPLACE OF FATHER
(State or Country) Russia

12. MAIDEN NAME OF MOTHER Lygia Jellum

13. BIRTHPLACE OF MOTHER
(State or Country) Russia

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) A. Jellum

(Address) Everett

15. Filed 10/10 1913 Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH September 26 1913
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from Sept 21 1913, to Sept 24 1913, that I last saw him alive on Sept 24 1913, and that death occurred on the date stated above, at 3 A. M.

The CAUSE OF DEATH* was as follows:
Pneumonia (Broncho)

(Duration) 1 yrs. 6 mos. ds.
Contributory Whooping Cough
(Secondary)

(Duration) 1 yrs. 30 mos. ds.
(Signed) W. H. Stodden M. D.
Sept 26 1913 (Address) Everett, Idaho

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death. yrs. mos. days. In the State. yrs. mos. days.
Where was disease contracted if not at place of death?
Former or usual residence.

19. PLACE OF BURIAL OR REMOVAL San Francisco Wash DATE OF BURIAL 1913

20. UNDERTAKER S. J. Jellum ADDRESS Everett

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Form V. S. No. 5 20M.1-16-12

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH. Registration District No. 17
County of Bortemai Primary Registration District No. 1003
City of Coeur D'Alene (No. _____ St.)

File No. 5962

Registered No. 0341

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Admie Geise

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX Female 4. COLOR OR RACE White 5. SINGLE, MARRIED, WIDOWED OR DIVORCED. Married
(Write the word.)

6. DATE OF BIRTH Apr. 14 1865
(Month) (Day) (Year)

7. AGE 48 yrs. 5 mos. 14 ds. IF LESS than 1 day how many hrs. or mins.?

8. OCCUPATION
(a) Trade, profession or particular kind of work House wife
(b) General nature of industry business, or establishment in which employed (or employer)

9. BIRTHPLACE
(State or Country) Mo.

10. NAME OF FATHER James Rice

11. BIRTHPLACE OF FATHER
(State or Country) Mo.

12. MAIDEN NAME OF MOTHER M. Bledsoe

13. BIRTHPLACE OF MOTHER
(State or Country) Mo.

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Jacob Geise

(Address) Coeur D'Alene

15. Filed 10/10 1913 M. Newman
Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH Sept. 28 1913
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from Sept 24 1913, to Sept 28 1913, that I last saw him alive on Sept 28 1913, and that death occurred on the date stated above, at 10 P. M.

The CAUSE OF DEATH* was as follows:

Endocarditis

(Duration) 15 yrs. mos. ds.

Contributory (Secondary)

(Duration) 15 yrs. mos. ds.

(Signed) J. D. Wagon M. D.

Sept 28 1913 (Address) Coeur d'Alene Idaho

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death yrs. mos. days. In the State yrs. mos. days.

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL Forest Cem. DATE OF BURIAL Sept. 30 1913

20. UNDERTAKER Cassedy & Nelson ADDRESS Coeur D'Alene

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Form V. S. No. 5 20M.1-16-12

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH.

Registration District No. 17

County of Kootenai

Primary Registration District No. 2051

City of Rathdrum

(No. _____, _____ St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

Kerna J. Hebert

File No. 5963

Registered No. 343

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX

4. COLOR OR RACE

5. SINGLE, MARRIED, WIDOWED OR DIVORCED.

(Write the word.)

6. DATE OF BIRTH

May 28, 1913
(Month) (Day) (Year)

7. AGE

4 yrs. 2 mos. 2 ds.

IF LESS than 1 day
how many _____ hrs. or
_____ mins.?

8. OCCUPATION

(a) Trade, profession or particular kind of work

(b) General nature of industry business, or establishment in which employed (or employer)

9. BIRTHPLACE

(State or Country)

Spokane, Wash

10. NAME OF FATHER

Raymond Hebert

11. BIRTHPLACE OF FATHER

(State or Country)

Ill.

12. MAIDEN NAME OF MOTHER

Rennie Larsen

13. BIRTHPLACE OF MOTHER

(State or Country)

Sweden

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

Raymond Hebert

(Address)

Garnwood

15.

Filed

10/10

1913

J. D. Drumm

Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH

Sep. 30, 1913
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from

Sep. 30, 1913, to Sep. 1913,

that I last saw him alive on 1913

and that death occurred on the date stated above, at 9:30 A.M.

The CAUSE OF DEATH* was as follows:

acute pneumonia with atelectasis of right lung

(Duration) yrs. mos. 1 ds.

Contributory (Secondary)

(Duration) yrs. mos. 14 ds.

(Signed)

Frank Henry M. D.

9/30 1913. (Address) Rathdrum, Id.

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death.....yrs.....mos.....days. In the State.....yrs.....mos.....days.

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

Garnwood

Oct. 1913

20. UNDERTAKER

ADDRESS

Robb's

Rathdrum

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Form V. S. No. 5 20M.1-16-12

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH.

Registration District No. 14County of KootenaiPrimary Registration District No. 1003City of Coeur d'Alene

(No. _____)

St.)

File No. 5964Registered No. 343

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Maud Callis

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX

4. COLOR OR RACE

5. SINGLE, MARRIED, WIDOWED OR DIVORCED.

FemaleWhiteMarried

(Write the word.)

6. DATE OF BIRTH

Oct231894

(Month)

(Day)

(Year)

7. AGE

18 yrs. 11 mos. 7 ds.IF LESS than 1 day
how many hrs. or
..... mins.?

8. OCCUPATION

(a) Trade, profession or particular kind of work

Housewife

(b) General nature of industry business, or establishment in which employed (or employer)

9. BIRTHPLACE

(State or Country)

Arkansas

10. NAME OF FATHER

Nels Bishop

11. BIRTHPLACE OF FATHER

(State or Country)

Mo

12. MAIDEN NAME OF MOTHER

Nettie Harold

13. BIRTHPLACE OF MOTHER

(State or Country)

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Clare Callis(Address) Coeur d'Alene

15.

Filed 10/101918J. S. Freeman
Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH

September 301913

(Month)

(Day)

(Year)

17. I HEREBY CERTIFY, That I attended deceased from

Sept 19 1913, to Sept 30 1913,that I last saw him alive on Sept 20 1913,and that death occurred on the date stated above, at 11:50 P.M.

The CAUSE OF DEATH* was as follows:

Septic Peritonitis
(Pneumonia & Sepsis)(Duration) 4 yrs. 4 mos. 7 ds.Contributory Peritonitis
(Secondary)(Duration) 4 yrs. 4 mos. 7 ds.(Signed) W. H. Hoedem

M. D.

Sept 19/13 (Address) Coeur d'Alene Idaho

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death yrs. mos. days. In the State yrs. mos. days.

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

Forest CemeteryOct 3 1913

20. UNDERTAKER

ADDRESS

Cassidy & Nelson209-2nd

-SUPPLEMENTARY DEATH CERTIFICATE-

(Please reply on this sheet to
the registrar of Vital Statistics)

Death Certificate No. _____

Name Maudie Leallis

Date of Death Sept 30 - 1913

Cause of Death Puerperal septicemia

Contributory Cause of death Tonitritis

(Sign here) W. H. Holman M.D.

Coroner of Allen
Idaho

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Form V. S. No. 5 20M.1-16-12

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH

Registration District No. 10

County of Idaho

Primary Registration District No. 2044

File No. 5965

City of Grangeville

(No. , St.)

Registered No. 164

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

James Marion Adkison

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX

Male

4. COLOR OR RACE

White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED.

(Write the word.)

6. DATE OF BIRTH

September 26 1853
(Month) (Day) (Year)

7. AGE

29 yrs. 11 mos. 10 ds.

IF LESS than 1 day
how many hrs. or
mins.?

8. OCCUPATION

(a) Trade, profession or particular kind of work

Farmer

(b) General nature of industry business, or establishment in which employed (or employer)

9. BIRTHPLACE

(State or Country)

Illinois

10. NAME OF FATHER

Elijah Adkison

11. BIRTHPLACE OF FATHER

(State or Country)

Indiana

12. MAIDEN NAME OF MOTHER

Mary Eckles

13. BIRTHPLACE OF MOTHER

(State or Country)

Illinois

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

J. Royal Adkison

(Address)

Grangeville, Ida

15.

Filed

Sept 1 1913

3

Geo L Harris
Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

Sept 6 1913
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from

Sept 3 1913, to Sept 6 1913,

that I last saw him alive on Sept 5 1913,

and that death occurred on the date stated above, at 10:22 P.M.

The CAUSE OF DEATH* was as follows:

General
Gastric Hemorrhage

(Duration) yrs. mos. 3 ds.

Contributory
(Secondary)

(Duration) yrs. mos. ds.

(Signed) G. S. Strickland M. D.

Sept 6 1913 (Address) Grangeville, Ida

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL OR HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death yrs. mos. days. In the State yrs. mos. days.

Where was disease contracted if not at place of death?

Former or usual residence.

19. PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

Mairie View Cemetery

Sept 7 1913

20. UNDERTAKER

ADDRESS

W. E. Graham

Grangeville

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Form V. S. No. 5. 12½M

Idaho

1. PLACE OF DEATH.

Registration District No. 2042 10BOARD OF HEALTH
Bureau of Vital StatisticsCounty of IdahoPrimary Registration District No. 10 2042File No. 5966City of Westlake

(No. _____, _____ St.)

Registered No. 165

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

Westley Everett Tolmson

If death occurred in a hospital, institution or camp give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX

male

4. COLOR OR RACE

white

5. SINGLE, MARRIED, WIDOWED OR DIVORCED.

Single
(Write the word.)

6. DATE OF BIRTH

Sept 23 1913
(Month) (Day) (Year)

7. AGE

4 yrs. 4 mos. 4 ds.IF LESS than 1 day
how many _____ hrs. or
_____ min?

8. OCCUPATION

(a) Trade, profession or particular kind of work
(b) General nature of industry business or establishment in which employed (or employer)Infant

9. BIRTHPLACE

(State or Country) Westlake, Idaho.

10. NAME OF FATHER

Everett G. Tolmson

11. BIRTHPLACE OF FATHER

(State or Country) Shelbyville Ill

12. MAIDEN NAME OF MOTHER

Minnie Davis

13. BIRTHPLACE OF MOTHER

(State or Country) Walla Walla Wash

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) E. G. Tolmson(Address) Kenterville, Idaho.

15.

Filed Sept 28 1913John E. Rains
per Blair Local Registrar
Sub Reg

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH

Sept 27 1913
(Month) (Day) (Year)17. I HEREBY CERTIFY, That I attended deceased from
Sept 23 1913, to Sept 27 1913that I last saw him alive on Sept 27 1913
and that death occurred on the date stated above, at 1:00 P.M.

The CAUSE OF DEATH* was as follows:

Premature birth
(8 mo utero)

(Duration) _____ yrs. _____ mos. _____ ds.

Contributory
(Secondary)

(Duration) _____ yrs. _____ mos. _____ ds.

(Signed) H. C. Parrish M. D.9-28 1913 (Address) Idaho

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place _____ In the _____
of death _____ yrs. _____ mos. _____ ds. State _____ yrs. _____ mos. _____ ds.

Where was disease contracted,

If not at place of death?

Former or

usual residence.

19. PLACE OF BURIAL OR REMOVAL DATE OF BURIAL

Ido Cemetery Lewis Co Sept 29 1913

20. UNDERTAKER

A H Ham

ADDRESS

Cottonwood Idaho

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Form V. S. No. 5 20M.1-16-12

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH.

Registration District No. 10County of IdahoPrimary Registration District No. 2044City of Thresh

(No. _____, _____ St.)

File No. 596Registered No. 166

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME John Henry Von Berg

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX

4. COLOR OR RACE

5. SINGLE, MARRIED, WIDOWED OR DIVORCED.

Male white(Write the word.) Married

6. DATE OF BIRTH

January 6th 1839
(Month) (Day) (Year)

7. AGE

74 yrs. 8 mos. 5 ds.IF LESS than 1 day
how many _____ hrs. or
_____ mins.?

8. OCCUPATION

(a) Trade, profession or particular kind of work

(b) General nature of industry, business, or establishment in which employed (or employer)

Harmon

9. BIRTHPLACE

(State or Country)

Hanover, Germany

10. NAME OF FATHER

Friedrich Von Berg

11. BIRTHPLACE OF FATHER

(State or Country)

Hanover, Germany

12. MAIDEN NAME OF MOTHER

Magdalena Rodenhorn

13. BIRTHPLACE OF MOTHER

(State or Country)

Hanover, Germany

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

(Address)

Frank McBray
Grangeville, Ida

15.

Filed

Sept. 15 1913 Geo L Rains
Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH

Sept 14 1913
(Month) (Day) (Year)17. I HEREBY CERTIFY, That I attended deceased from Sept 13 1913 to Sept 14 1913 that I last saw him alive on Sept 14 1913 and that death occurred on the date stated above, at 2 A. M.

The CAUSE OF DEATH* was as follows:

myocarditis(Duration) not known yrs. mos. ds.

Contributory (Secondary)

Epilepsy, Arteriosclerosis(Duration) 13 yrs. mos. ds.

(Signed)

G. B. Stockton M. D.Sept. 13 (Address) Grangeville, Idaho

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death _____ yrs. _____ mos. _____ days. In the State _____ yrs. _____ mos. _____ days.

Where was disease contracted if not at place of death?

Former or usual residence.

19. PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

Denver Sept. 16, 1913

20. UNDERTAKER

ADDRESS

McCabe & Granger

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Form V. S. No. 5 20M.1-16-12

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH

Registration District No. 10

County of Idaho

Primary Registration District No. 2044

City of Harpster

(No. , St.)

File No. 5962

Registered No. 167

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Mary Elizabeth Myers

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX

Female

4. COLOR OR RACE

White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED.

Married (Write the word.)

6. DATE OF BIRTH

Eight Fifty Two

March (Month)

12 (Day)

1852 (Year)

7. AGE

61 yrs. 6 mos. 17 ds.

IF LESS than 1 day how many hrs. or mins.?

8. OCCUPATION

(a) Trade, profession or particular kind of work

House Wife

(b) General nature of industry business, or establishment in which employed (or employer)

9. BIRTHPLACE

(State or Country)

Missouri Lawrence County

10. NAME OF FATHER

George Myers

11. BIRTHPLACE OF FATHER

(State or Country)

Missouri Lawrence County

12. MAIDEN NAME OF MOTHER

Esther

13. BIRTHPLACE OF MOTHER

(State or Country)

Missouri Lawrence County

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

Madison Myers

(Address)

Grangeville Ida

15.

Filed

Sept 29 1913

Israel Rains

Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

Sept 24 (Month) (Day)

1913 (Year)

17. I HEREBY CERTIFY, That I attended deceased from

191, to 191,

that I last saw h alive on 191,

and that death occurred on the date stated above, at M.

The CAUSE OF DEATH* was as follows:

accidentally killed by team running to grave,

(Duration) yrs. mos. ds.

Contributory (Secondary)

(Duration) yrs. mos. ds.

(Signed) G S Sheth M. D.

Sept 29 1913 (Address) Grangeville Ida

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death yrs. mos. days. In the State yrs. mos. days.

Where was disease contracted if not at place of death?

Former or usual residence.

19. PLACE OF BURIAL OR REMOVAL DATE OF BURIAL

Fairview Oct 1 1913

20. UNDERTAKER ADDRESS

W E Graham Grangeville

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Form V. S. No. 5 20M.1-16-12

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH

Registration District No. 10

County of Idaho

Primary Registration District No. 2044

City of Harvester

(No. , St.)

File No. 5969

Registered No. 168

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Charles Anthony Myers

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX Male 4. COLOR OR RACE White 5. SINGLE, MARRIED, WIDOWED OR DIVORCED. Single

(Write the word.)

6. DATE OF BIRTH Eighteen Eighty eight

December 3 1888
(Month) (Day) (Year)

7. AGE

24 yrs. 9 mos. 26 ds.

IF LESS than 1 day
how many hrs. or mins.?

8. OCCUPATION

(a) Trade, profession or particular kind of work
(b) General nature of industry business, or establishment in which employed (or employer)

Farmer

9. BIRTHPLACE

(State or Country)

Missouri
Lawrence county

10. NAME OF FATHER

11. BIRTHPLACE OF FATHER

(State or Country)

Missouri
Lawrence county

12. MAIDEN NAME OF MOTHER

Cortley

13. BIRTHPLACE OF MOTHER

(State or Country)

Missouri
Lawrence county

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Madison Myers

(Address) Grangerville Idaho

15.

Filed Sept 29 1913

Joe L. Davis
Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

Sept 29 1913
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from

191, to 191,

that I last saw him alive on 191,

and that death occurred on the date stated above, at M.

The CAUSE OF DEATH* was as follows:

accidentally killed by
team running off grade

(Duration) yrs. mos. ds.

Contributory
(Secondary)

(Duration) yrs. mos. ds.

(Signed) E. S. Stetson M. D.

Sept 29 1913 (Address) Grangerville Ida.

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death yrs. mos. days. In the State yrs. mos. days.

Where was disease contracted if not at place of death?

Former or usual residence.

19. PLACE OF BURIAL OR REMOVAL DATE OF BURIAL

Fairview Oct 1 1913

20. UNDERTAKER ADDRESS

W. E. Graham Grangerville

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Form V. S. No. 5 20M.1-16-12

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH. Registration District No. 10
County of Idaho Primary Registration District No. 1001
City of Grangerville (No. _____, St.)

File No. 5977
Registered No. 169

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Oakley Frank VanMatre
If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX male 4. COLOR OR RACE white 5. SINGLE, MARRIED, WIDOWED OR DIVORCED. married
(Write the word.)

6. DATE OF BIRTH May 7 1887
(Month) (Day) (Year)

7. AGE 26 yrs. 5 mos. 10 ds.
IF LESS than 1 day how many _____ hrs. or _____ mins.?

8. OCCUPATION
(a) Trade, profession or particular kind of work laborer
(b) General nature of industry business, or establishment in which employed (or employer)

9. BIRTHPLACE Virginia
(State or Country)

10. NAME OF FATHER John VanMatre

11. BIRTHPLACE OF FATHER } Not obtainable
(State or Country)

12. MAIDEN NAME OF MOTHER

13. BIRTHPLACE OF MOTHER
(State or Country)

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Mrs. Ethel Melbus

(Address) Grangerville Idaho

15. Filed Sept. 27 1913 Jose L. Rains
Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH Sept 27 1913
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from Sept 2 1913, to Sept 27 1913, that I last saw him alive on Sept 26 1913, and that death occurred on the date stated above, at 2 A.M.
The CAUSE OF DEATH* was as follows:

Typhoid Fever
(Duration) _____ yrs. _____ mos. 25 ds.

Contributory (Secondary)

(Duration) _____ yrs. _____ mos. _____ ds.
(Signed) A. S. Stockton M. D.
Sept 27 1913 (Address) Grangerville Ida

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death _____ yrs. _____ mos. _____ days. In the State _____ yrs. _____ mos. _____ days.

Where was disease contracted if not at place of death?

Former or usual residence _____

19. PLACE OF BURIAL OR REMOVAL Pravie View Cemetery DATE OF BURIAL Sept. 28 1913
20. UNDERTAKER W. E. Graham ADDRESS Grangerville

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.—
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Form V. S. No. 5 20M-1-16-12

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH.

Registration District No. 10

County of Idaho

Primary Registration District No. 1001

City of Grangerville

(No. _____ St.)

File No. 5971

Registered No. 170

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME William Faust

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX Male 4. COLOR OR RACE White 5. SINGLE, MARRIED, WIDOWED OR DIVORCED. Married (Write the word.)

6. DATE OF BIRTH Aug 6 1897 (Month) (Day) (Year)

7. AGE 26 yrs. 1 mos. 23 ds. IF LESS than 1 day how many _____ hrs. or _____ mins.?

8. OCCUPATION (a) Trade, profession or particular kind of work. Housewife (b) General nature of industry, business, or establishment in which employed (or employer).

9. BIRTHPLACE Kan (State or Country)

10. NAME OF FATHER Richard Johnson

11. BIRTHPLACE OF FATHER Kan (State or Country)

12. MAIDEN NAME OF MOTHER Annie Anderson

13. BIRTHPLACE OF MOTHER Kan (State or Country)

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE (Informant) W. Faust (Address) _____

15. Filed Oct. 6 1913 John L. Rains Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH Sept 4 1913 (Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from Sept 30 1913, to Oct 4 1913 that I last saw her alive on Oct 4 1913 and that death occurred on the date stated above, at 11 A.M.

The CAUSE OF DEATH* was as follows:

Pneumonia (Duration) yrs. mos. 14 ds.

Contributory (Secondary)

(Duration) yrs. mos. ds.

(Signed) J. S. Stricklin M. D.

Oct 6 1913 (Address) Grangerville Ida

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death _____ yrs. _____ mos. _____ days. In the State _____ yrs. _____ mos. _____ days.

Where was disease contracted if not at place of death?

Former or usual residence _____

19. PLACE OF BURIAL OR REMOVAL DATE OF BURIAL

Hatchers Colorado 1913

20. UNDERTAKER ADDRESS

W. E. Graham Grangerville

-SUPPLEMENTARY DEATH CERTIFICATE-

(Please reply on this sheet to
the registrar of Vital Statistics)

Death Certificate No.

Name Minnie Faust

Date of Death Oct 4 - 1913

Cause of Death Lobar Pneumonia

Contributory Cause of death

(Sign here) G. S. Stratton M.D.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
N. B.—Every item of information should be carefully supplied. AGE should be state EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Form V. S. No. 5. 10M. 6-20-11.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH.

Registration District No. 10

County of Idaho

Primary Registration District No. 2042

City of Coltonwood

(No. _____ St.)

File No. 5972

Registered No. 171

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Theodore Schmitt

If death occurred in a hospital, institution or camp give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX

male

4. COLOR OR RACE

white

5. SINGLE, MARRIED, WIDOWED OR DIVORCED.

married
(Write the word.)

6. DATE OF BIRTH

April

14 1840

(Month)

(Day)

(Year)

7. AGE

73

5

16

IF LESS than 1 day

how many 8 hrs. or

yrs. mos. ds.

min.

8. OCCUPATION

(a) Trade, profession or particular kind of work

Farmer

(b) General nature of industry business or establishment in which employed (or employer)

9. BIRTHPLACE

(State or Country)

Germany

10. NAME OF FATHER

11. BIRTHPLACE OF FATHER

(State or Country)

Not obtainable

12. MAIDEN NAME OF MOTHER

13. BIRTHPLACE OF MOTHER

(State or Country)

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

Mathew Schmitt

(Address)

Coltonwood

15.

Filed

Oct. 4

1913

Jose L. Tains

Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

Oct. 1

1st

1913

(Month)

(Day)

(Year)

17. I HEREBY CERTIFY, That I attended deceased from

Sept 30th

1913

to Sept 30th

1913

that I last saw him alive on Sept 30th

1913

and that death occurred on the date stated above, at 9 a. m.

The CAUSE OF DEATH* was as follows:

Arterio Sclerosis

(Duration)

Indefinite

yrs.

mos.

ds.

Contributory (Secondary)

(Duration)

Mitral Insufficiency

yrs.

mos.

ds.

(Signed)

10-2-1913

(Address)

Coltonwood, Ida.

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place

In the

of death..... yrs..... mos..... ds. State..... yrs..... mos..... ds.

Where was disease contracted,

If not at place of death?

Former or

usual residence.

19. PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

Catholic Cemetery, Coltonwood

Oct. 3 1913

20. UNDERTAKER

ADDRESS

C. S. Hancock

Grangeville

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Form V. S. No. 5 20M.1-16-12

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH.

Registration District No. 26

County of Oneida

Primary Registration District No. 2069

City of Malad

(No. _____ St.)

File No. 5979

Registered No. 76

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME William Albert Dalton

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX

4. COLOR OR RACE

5. SINGLE, MARRIED, WIDOWED OR DIVORCED.

Male

White

Married

6. DATE OF BIRTH

June

21

1853

(Month)

(Day)

(Year)

7. AGE

60 yrs. 2 mos. 18 ds.

IF LESS than 1 day
how many _____ hrs. or
_____ mins.?

8. OCCUPATION

(a) Trade, profession or particular kind of work
(b) General nature of industry, business, or establishment in which employed (or employer)

Farmer

9. BIRTHPLACE

(State or Country)

Ogden Utah

10. NAME OF FATHER

Mathew William Dalton

11. BIRTHPLACE OF FATHER

(State or Country)

Ireland

12. MAIDEN NAME OF MOTHER

Rozilla Whittaker

13. BIRTHPLACE OF MOTHER

(State or Country)

North Carolina

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

Erwin Dalton

(Address)

Malad Ida

15.

Filed 9-5 1913

D. C. Ray
Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

Sept

3

1913

(Month)

(Day)

(Year)

17. I HEREBY CERTIFY, That I attended deceased from

Aug 1

1913

to Sept 3

1913

that I last saw him alive on Sept 3 1913

and that death occurred on the date stated above, at 8:15 AM

The CAUSE OF DEATH* was as follows:

Cancer of Stomach

(Duration) _____ yrs. _____ mos. _____ ds.

Contributory

(Secondary)

(Duration) _____ yrs. _____ mos. _____ ds.

(Signed)

D. C. Ray

M. D.

9-5 1913

(Address) Malad City Idaho

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place

of death.....yrs.....mos.....days.

In the

State.....yrs.....mos.....days.

Where was disease contracted if not at place of death?

Former or

usual residence.

19. PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

Malad Ida

Sept 6 1913

20. UNDERTAKER

ADDRESS

D. S. Johnson

Malad Ida

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Form V. S. No. 5 20M.1-16-12

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH.

Registration District No. 26

County of *Blaine*

Primary Registration District No. 2069

City of *Malad*

(No. St.)

File No. 5974

Registered No. 77

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

William Evans

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX

4. COLOR OR RACE

5. SINGLE, MARRIED, WIDOWED OR DIVORCED.

Male White Single

6. DATE OF BIRTH

October 13 1909
(Month) (Day) (Year)

7. AGE

3 yrs. 11 mos. 4 ds.

IF LESS than 1 day
how many hrs. or mins.?

8. OCCUPATION

(a) Trade, profession or particular kind of work

(b) General nature of industry, business, or establishment in which employed (or employer)

None

9. BIRTHPLACE

(State or Country)

Malad Idaho

10. NAME OF FATHER

Evans Evans

11. BIRTHPLACE OF FATHER

(State or Country)

Malad Idaho

12. MAIDEN NAME OF MOTHER

Sarah Bolingbroke

13. BIRTHPLACE OF MOTHER

(State or Country)

Malad Idaho

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

Ervin J. Evans

(Address)

Malad Idaho

15.

Filed

Sept 17 1913

D. C. Ray
Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH

Sep 17 1913
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from

191... to 191...

that I last saw h... alive on 191...

and that death occurred on the date stated above, at *5:30 P.M.*

The CAUSE OF DEATH* was as follows:

*glycemia
infected in attendance*
(Duration) yrs. mos. ds.

Contributory (Secondary)

(Duration) 2 yrs. 4 mos. ds.

(Signed) *D. C. Ray* M. D.

19 (Address) *Malad City Idaho*

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death... yrs... mos... days. In the State... yrs... mos... days.

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

Malad Ida Sep 19 1913

20. UNDERTAKER

ADDRESS

D. S. Johnson Malad Ida

1. PLACE OF DEATH. County of <u>Oneida</u> City of <u>Malad</u>		Registration District No. <u>2069</u> (No. _____, _____ St.)		BOARD OF HEALTH Bureau of Vital Statistics File No. <u>5975</u> Registered No. <u>78</u>	
If death occurs away from usual residence, give facts called for under special information.					
2. FULL NAME <u>Rees J. Thomas</u>					
PERSONAL AND STATISTICAL PARTICULARS					
3. SEX <u>Male</u>		4. COLOR OR RACE <u>White</u>		5. SINGLE, MARRIED, WIDOWED OR DIVORCED. <u>Married</u>	
6. DATE OF BIRTH <u>April 7 1851</u> (Month) (Day) (Year)					
7. AGE <u>62 yrs. 5 mos. 16 ds.</u>		IF LESS than 1 day how many.....hrs. or.....min?			
8. OCCUPATION (a) Trade, profession or particular kind of work. (b) General nature of industry business or establishment in which employed (or employer). <u>Carpenter</u>					
9. BIRTHPLACE (State or Country) <u>Utah</u>					
10. NAME OF FATHER <u>Rees J. Thomas</u>					
11. BIRTHPLACE OF FATHER (State or Country) <u>Wales</u>					
12. MAIDEN NAME OF MOTHER <u>Mary Evans</u>					
13. BIRTHPLACE OF MOTHER (State or Country) <u>Wales</u>					
14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE (Informant) <u>Eph Thomas</u> (Address) <u>Malad Idaho.</u>					
15. Filed <u>Sept 20 1913</u>		<u>D. C. Ray</u> Local Registrar			
MEDICAL CERTIFICATE OF DEATH.					
16. DATE OF DEATH <u>9 23 1913</u> (Month) (Day) (Year)					
17. I HEREBY CERTIFY, That I attended deceased from <u>7/13 1913</u> , to <u>9/21 1913</u> , that I last saw him alive on <u>9/21 1913</u> and that death occurred on the date stated above, at <u>4 AM</u> . The CAUSE OF DEATH* was as follows: <u>Apoplexy</u>					
..... (Duration) yrs. mos. <u>10</u> ds.					
Contributory (Secondary)					
..... (Duration) yrs. mos. ds.					
(Signed) <u>J. M. Turner</u> M. D. <u>9/23 1913</u> (Address) <u>Malad Idaho</u>					
*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.					
18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.) At place yrs. mos. ds. In the State yrs. mos. ds. Where was disease contracted, If not at place of death? Former or usual residence.....					
19. PLACE OF BURIAL OR REMOVAL <u>Malad Ida</u>					
DATE OF BURIAL <u>Sep 25 1913</u>					
20. UNDERTAKER <u>W. E. Johnson</u>					
ADDRESS <u>Malad Ida.</u>					

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Form V. S. No. 5. 12½ M. 7-24-11

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH. Registration District No. 26
County of Oneida Primary Registration District No. 2069
City of Malad (No. _____, St.)

File No. 597
Registered No. 80

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

Everett L Plunkett

If death occurred in a hospital, institution or camp give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX Male 4. COLOR OR RACE white 5. SINGLE, MARRIED, WIDOWED OR DIVORCED. married
(Write the word.)

6. DATE OF BIRTH Apr 20 1881
(Month) (Day) (Year)

7. AGE 32 yrs. 4 mos. 23 ds. IF LESS than 1 day how many _____ hrs. or _____ min?

8. OCCUPATION

(a) Trade, profession or particular kind of work. Merchant
(b) General nature of industry business or establishment in which employed (or employer)

9. BIRTHPLACE

(State or Country) Illinois

10. NAME OF FATHER

Union Plunkett

11. BIRTHPLACE OF FATHER

(State or Country) Tenn.

12. MAIDEN NAME OF MOTHER

Mary Farmer

13. BIRTHPLACE OF MOTHER

(State or Country) Ill

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Mrs. Mary Plunkett
(Address) Malad City Idaho

15. Filed Sept 20 1913 D C Ray
Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH

Sept 13 1913
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from June 17 1912, to Sept 13 1913

that I last saw him alive on Sept 13 1913 and that death occurred on the date stated above, at 11³⁰ A. M.

The CAUSE OF DEATH* was as follows:

pulmonary tuberculosis

(Duration) 2 yrs. mos. _____ ds. _____

Contributory (Secondary)

(Duration) _____ yrs. _____ mos. _____ ds. _____

(Signed) D C Ray M. D.

Sept 15 1913 (Address) Malad City Idaho

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place _____ yrs. _____ mos. _____ ds. _____ In the

of death _____ yrs. _____ mos. _____ ds. _____ State _____ yrs. _____ mos. _____ ds. _____

Where was disease contracted,

If not at place of death?

Former or usual residence.

19. PLACE OF BURIAL OR REMOVAL DATE OF BURIAL

Malad City Ida Sept 15 1913

20. UNDERTAKER ADDRESS

D E Johnson Malad City
Idaho

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
N. B.—Every item of information should be carefully supplied. AGE must be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Form V. S. No. 5. 1274 M. 7-24-11

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH.

Registration District No. 63

County of Idaho

Primary Registration District No. 2143

City of Kendrick

(No. _____ St.)

File No. 5978

Registered No. 1

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

Joseph H. Huffman

If death occurred in a hospital, institution or camp give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX

M

4. COLOR OR RACE

White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED.

Married
(Write the word.)

6. DATE OF BIRTH

June71862

(Month)

(Day)

(Year)

7. AGE

51 yrs. 3 mos. 10 ds.

IF LESS than 1 day

how many.....hrs. or
.....min?

8. OCCUPATION

(a) Trade, profession or particular kind of work

farmer

(b) General nature of industry business or establishment in which employed (or employer)

9. BIRTHPLACE

(State or Country)

Iowa

10. NAME OF FATHER

Wm. Huffman

11. BIRTHPLACE OF FATHER

(State or Country)

N. Jersey

12. MAIDEN NAME OF MOTHER

Lucinda Steele

13. BIRTHPLACE OF MOTHER

(State or Country)

New Jersey

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

James Huffman

(Address)

Kendrick, Ida

15.

Filed Sept 12 1913J. E. Hoyt

Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH

Sept123

(Month)

(Day)

(Year)

17. I HEREBY CERTIFY, That I attended deceased from

men1912

to

Sept 121913

that I last saw him alive on

Sept 121913and that death occurred on the date stated above, at 10 M.

The CAUSE OF DEATH* was as follows:

dilatation of heart
valvular disease(Duration) did suddenly yrs. mos. ds.

Contributory (Secondary)

interstitial nephritis(Duration) 2+ yrs. mos. ds.

(Signed)

J. E. Hoyt

M. D.

Sept 12 1913 (Address) Kendrick, Ida

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place

In the

of death.....yrs.....mos.....ds. State.....yrs.....mos.....ds.

Where was disease contracted,

If not at place of death?

Former or

usual residence.

19. PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

Wood Rose Cemetery9-141913

20. UNDERTAKER

ADDRESS

D. J. RowlandsKendrick, Ida

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Form V, S. No. 5. 12½ M. 7-24-11

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics
File No. 5977
Registered No. 2

1. PLACE OF DEATH. Registration District No. 63
County of Latah Primary Registration District No. 2143
City of Kendrick (No. _____, _____ St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

Ole Olson

If death occurred in a hospital, institution or camp give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX Male 4. COLOR OR RACE white 5. SINGLE, MARRIED, WIDOWED OR DIVORCED. Married (Write the word.)

6. DATE OF BIRTH March 13 1880
(Month) (Day) (Year)

7. AGE 63 yrs. 6 mos. - ds. IF LESS than 1 day how many _____ hrs. or _____ min?

8. OCCUPATION

(a) Trade, profession or particular kind of work Retired Farmer
(b) General nature of industry business or establishment in which employed (or employer)

9. BIRTHPLACE

(State or Country) Sweden

10. NAME OF FATHER

Don't know

11. BIRTHPLACE OF FATHER

(State or Country) Sweden

12. MAIDEN NAME OF MOTHER

Don't know

13. BIRTHPLACE OF MOTHER

(State or Country) Sweden

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) O Erickson
(Address) Kendrick Ida

15.

Filed Sep 13 1913 J. E. Hayf Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH Sep 13 1913
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from Sep 7 1913, to Sep 13 1913 that I last saw him alive on Sep 13 1913 and that death occurred on the date stated above, at 2:09 P.M.

The CAUSE OF DEATH* was as follows:

peritonitis

(Duration) _____ yrs. _____ mos. 7 ds.

Contributory (Secondary) tuberculosis

(Duration) one + yrs. _____ mos. _____ ds.

(Signed) J. E. Hayf M. D.
Sep 13 1913 (Address) Kendrick

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place In the
of death _____ yrs. _____ mos. _____ ds. State _____ yrs. _____ mos. _____ ds.
Where was disease contracted,
If not at place of death?
Former or
usual residence _____

19. PLACE OF BURIAL OR REMOVAL DATE OF BURIAL

little Bear cemetery Sep 14 1913

20. UNDERTAKER ADDRESS

D. J. Rowlands Kendrick

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK.—THIS IS A PERMANENT RECORD.
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Form V. S. No. 5. 10M. 6-20-11.

CERTIFICATE OF DEATH

1. PLACE OF DEATH

Registration District No.

County of Monmouth

Primary Registration District No.

City of Rupert

(No. St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

Mary Jane Everett

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics
File No. 5980

Registered No.
If death occurred in a hospital, institution or camp give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX

4. COLOR OR RACE

5. SINGLE, MARRIED, WIDOWED OR DIVORCED.

Female White

(Write the word.)

6. DATE OF BIRTH

Mar 5 1870
(Month) (Day) (Year)

7. AGE

83 yrs. 6 mos. 21 ds.
IF LESS than 1 day how many hrs. or min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work

(b) General nature of industry business or establishment in which employed (or employer)

house wife

9. BIRTHPLACE

(State or Country)

Kentucky

10. NAME OF FATHER

11. BIRTHPLACE OF FATHER
(State or Country)

12. MAIDEN NAME OF MOTHER

13. BIRTHPLACE OF MOTHER
(State or Country)

Kentucky

Kentucky

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Stella M. Wilson

(Address) Burley, R. 2, Id.

15.

Filed 191

Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

Sept 25 1913
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from Sept. 19 1913, to Sept 22 1913

that I last saw her alive on Sept 22 1913, and that death occurred on the date stated above, at 3 A. M.

The CAUSE OF DEATH* was as follows:

Monobromismia

(Duration) yrs. mos. 10 ds.

Contributory (Secondary)

(Duration) yrs. mos. ds.

(Signed) J. H. Scott M. D.
Sept 30 1913 (Address) Rupert, Id.

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death yrs. mos. ds. In the State yrs. mos. ds.
Where was disease contracted.
If not at place of death?
Former or usual residence.

19. PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

Rupert Cemetery

Sept 26 1913

20. UNDERTAKER

ADDRESS

W. G. Goodman

Rupert

-SUPPLEMENTARY DEATH CERTIFICATE-

(Please reply on this sheet to
the registrar of Vital Statistics)

Death Certificate No.

Name *Mary Jane Everts*

Date of Death *Sept. 22, 1913*

Cause of Death *Broncho Pneumonia*

Contributory Cause of death

(Sign here)

C. H. Scott

M.D.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Form V. S. No. 5. 10M. 6-20-11.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH.

Registration District No. 19County of Blaine

Primary Registration District No. _____

City of Rupert

(No. _____, St.)

File No. 5981

Registered No. _____

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Irvin O. Nickerson

If death occurred in a hospital, institution or camp give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX

Male

4. COLOR OR RACE

White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED.

Married
(Write the word.)

6. DATE OF BIRTH

Mar

(Month)

26

(Day)

1865

(Year)

7. AGE

48 yrs. 6 mos. 3 ds.

IF LESS than 1 day
how many hrs. or
min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work

(b) General nature of industry business or establishment in which employed (or employer)

Painter

9. BIRTHPLACE

(State or Country)

Maine

10. NAME OF FATHER

Hiram Nickerson

11. BIRTHPLACE OF FATHER

(State or Country)

Maine

12. MAIDEN NAME OF MOTHER

13. BIRTHPLACE OF MOTHER

(State or Country)

Maine

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

Mrs I. O. Nickerson

(Address)

Rupert Idaho

15.

Filed

191

Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

Sept

(Month)

29

(Day)

1913

(Year)

17. I HEREBY CERTIFY, That I attended deceased from

191

to

191

that I last saw h..... alive on..... 191

and that death occurred on the date stated above, at 11 A. M.

The CAUSE OF DEATH* was as follows:

Accident. Sudden death

(Duration) yrs. mos. ds.

Contributory (Secondary)

(Duration) yrs. mos. ds.

(Signed) P. H. Scott M. D.Sept 29 1913 (Address) Rupert Idaho

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place

In the

of death..... yrs. mos. ds. State..... yrs. mos. ds.

Where was disease contracted,

If not at place of death?

Former or

usual residence

19. PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

Rupert CemeteryOct 1 191

20. UNDERTAKER

ADDRESS

W. G. GordonRupert

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Form V. S. No. 5. 10M. 6-20-11.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics
File No. **5982**

1. PLACE OF DEATH.

Registration District No.

County of Minnehaha

Primary Registration District No.

City of Rupert

(No., St.)

Registered No.

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

Margaret R. Alenslager

If death occurred in a hospital, institution or camp give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX

F

4. COLOR OR RACE

White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED.

Infant
(Write the word.)

6. DATE OF BIRTH

March 8 1913
(Month) (Day) (Year)

7. AGE

0 yrs. 5 mos. 22 ds.

IF LESS than 1 day
how many.....hrs. or
min.?

8. OCCUPATION

- (a) Trade, profession or particular kind of work
(b) General nature of industry business or establishment in which employed (or employer)

Infant

9. BIRTHPLACE

(State or Country)

Utah

10. NAME OF FATHER

Ben Alenslager

11. BIRTHPLACE OF FATHER

(State or Country)

Warship Utah

12. MAIDEN NAME OF MOTHER

Wilson Margaret R

13. BIRTHPLACE OF MOTHER

(State or Country)

Utah

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

Ben Alenslager

(Address)

Rupert

15.

Filed.....191.....

C. H. Scott
Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

Sept 1 1913
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from

Aug 20 1913, to Sept 1 1913
that I last saw her alive on Aug 23 1913,
and that death occurred on the date stated above, at 10 P.M.

The CAUSE OF DEATH* was as follows:

Septicemia(Duration) yrs. mos. 10 ds.Contributory
(Secondary)

(Duration) yrs. mos. ds.

(Signed) C. H. Scott M. D.
Sept. 30 1913 (Address) Rupert Id.

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death..... yrs. mos. ds. State..... yrs. mos. ds.
Where was disease contracted,
If not at place of death?
Former or usual residence.....

19. PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

Rupert Cemetery Sept. 3 1913

20. UNDERTAKER

ADDRESS

W. G. Goodman Rupert

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

5983

File No.

Registered No.

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PLACE OF DEATH

Registration District No. 5-5

County of Bear Lake

Primary Registration District No. 2134

City of Mt. Charles

(No. , St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Annie May Linford

PERSONAL AND STATISTICAL PARTICULARS

3. SEX Female 4. COLOR OR RACE White 5. SINGLE, MARRIED, WIDOWED OR DIVORCED Single (Write the word.)

6. DATE OF BIRTH

March 23 1913
(Month) (Day) (Year)

7. AGE

yrs. 2 mos. 24 ds.

IF LESS than 1 day
how many hrs. or mins.?

8. OCCUPATION

(a) Trade, profession or particular kind of work
(b) General nature of industry, business, or establishment in which employed (or employer)

None

9. BIRTHPLACE

(State or Country)

Mt. Charles

10. NAME OF FATHER

Georg Christian Linford

11. BIRTHPLACE OF FATHER

(State or Country)

Paris Idaho

12. MAIDEN NAME OF MOTHER

Alice May Peterson

13. BIRTHPLACE OF MOTHER

(State or Country)

Mt. Charles

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

Christian Linford

(Address)

Mt. Charles

15.

Filed August 8 1913

John Mattson
Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

June 23 1913
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from

May 26 1913, to June 29 1913,

that I last saw her alive on June 19 1913,

and that death occurred on the date stated above, at 10 M.

The CAUSE OF DEATH* was as follows:

Uremia

(Duration) yrs. mos. 4 ds.

Contributory acute at. media
(Secondary)

(Duration) yrs. mos. 19 ds.

(Signed) Wm. L. Rish M. D.

19 (Address) Paris Id.

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death yrs. mos. days. In the State yrs. mos. days.

Where was disease contracted if not at place of death?

Former or usual residence.

19. PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

John A. Blade June 27 1913

20. UNDERTAKER

ADDRESS

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIAN should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Form V. S. No. 5. 12½ M. 7-24-11

CERTIFICATE OF DEATH

1. PLACE OF DEATH.

County of IdahoCity of Indian ValleyRegistration District No. 88Primary Registration District No. 2164

(No. _____, _____ St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME _____

State of Idaho
BOARD OF HEALTH
Bureau of Vital StatisticsFile No. 5984

Registered No. _____

If death occurred in a hospital, institution or camp give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX

Female

4. COLOR OR RACE

White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED.

Single
(Write the word.)

6. DATE OF BIRTH

Sept
(Month)26
(Day)1913
(Year)

7. AGE

_____ yrs. _____ mos. _____ ds.

IF LESS than 1 day
how many... 3... hrs. or
_____ min?

8. OCCUPATION

- (a) Trade, profession or particular kind of work.
(b) General nature of industry business or establishment in which employed (or employer)

9. BIRTHPLACE

(State or Country)

Indian Valley

10. NAME OF FATHER

Robert Dunham

11. BIRTHPLACE OF FATHER

(State or Country)

Mo

12. MAIDEN NAME OF MOTHER

Minnie Anderson

13. BIRTHPLACE OF MOTHER

(State or Country)

Washington

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

C. E. Schumacher

(Address)

Cambodge Ida

15.

Filed Sept 30 1913C. E. Schumacher

Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH

Sept
(Month)26
(Day)1913
(Year)

17. I HEREBY CERTIFY, That I attended deceased from

Sept 261913to Sept 261913that I last saw her alive on Sept 26 1913and that death occurred on the date stated above, at 1 P M.

The CAUSE OF DEATH* was as follows:

Innumeration

(Duration) _____ yrs. _____ mos. _____ ds.

Contributory
(Secondary)

(Duration) _____ yrs. _____ mos. _____ ds.

(Signed)

Sept 30 1913C. E. Schumacher

M. D.

(Address) Cambodge Ida

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place

In the

of death _____ yrs. _____ mos. _____ ds. State _____ yrs. _____ mos. _____ ds.

Where was disease contracted,

If not at place of death?

Former or

usual residence.

19. PLACE OF BURIAL OR REMOVAL DATE OF BURIAL

Medvale IdahoSept 28 1913

20. UNDERTAKER

ADDRESS

Joe HudsonCambodge Ida

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. PHYSICIANS should be stated EXACTLY. Exact statement of CAUSE OF DEATH in plain terms, so that it may be properly classified. See instructions on back of certificate.

Form V. S. No. 5. 10M. 6-20-11.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics
File No. **5985**

1. PLACE OF DEATH.
County of Bonner
City of Priest River

Registration District No. 81st
Primary Registration District No. 2158
(No. _____, St.)

Registered No. _____

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

Johanna Hagmann

If death occurred in a hospital, institution or camp give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX Female 4. COLOR OR RACE white 5. SINGLE, MARRIED, WIDOWED OR DIVORCED. married
(Write the word.)

6. DATE OF BIRTH March 18 1834
(Month) (Day) (Year)

7. AGE 79 yrs. 6 mos. 16 ds. IF LESS than 1 day how many hrs. or min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work House wife
(b) General nature of industry business or establishment in which employed (or employer)

9. BIRTHPLACE

(State or Country) Sweden

10. NAME OF FATHER

John Magnusen

11. BIRTHPLACE OF FATHER

(State or Country) Sweden

12. MAIDEN NAME OF MOTHER

Don't know

13. BIRTHPLACE OF MOTHER

(State or Country) Sweden

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Albert Hagman
(Address) Priest River Idaho

15.

Filed Sept 26 1913 ED McPart
Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH Sept 26 1913
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from Sept 24 1913, to Sept 26 1913, that I last saw her alive on Sept 25 1913, and that death occurred on the date stated above, at 11:30 AM.

The CAUSE OF DEATH* was as follows:

Cerebral hemorrhage

(Duration) yrs. mos. 1 1/2 ds.

Contributory (Secondary)

(Duration) yrs. mos. ds.

(Signed) E. Weston McCash M. D.
Sept 26 1913 (Address) Priest River Idaho

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death. yrs. mos. ds. State. yrs. mos. ds.
Where was disease contracted.
If not at place of death?
Former or usual residence.

19. PLACE OF BURIAL OR REMOVAL Priest River Idaho DATE OF BURIAL Sept 30 1913

20. UNDERTAKER, Harding & Harding ADDRESS Idaho

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Form V. S. No. 5 20M.1-16-12

CERTIFICATE OF DEATH

 State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

 1. PLACE OF DEATH. Registration District No. 22th
County of Gowebury Primary Registration District No. 2018
City of Mendell (No. _____, St.)
If death occurs away from usual residence, give facts called for under special information. 2. FULL NAME Mike Eichen

 File No. _____
Registered No. _____
If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

 3. SEX Male 4. COLOR OR RACE White 5. SINGLE, MARRIED, WIDOWED OR DIVORCED. Single
(Write the word.)

 6. DATE OF BIRTH _____
(Month) _____ (Day) 49 (Year) 1864

 7. AGE 49 yrs. _____ mos. _____ ds.
IF LESS than 1 day how many _____ hrs. or _____ mins.?

 8. OCCUPATION
(a) Trade, profession or particular kind of work Farmer
(b) General nature of industry business, or establishment in which employed (or employer) _____

 9. BIRTHPLACE
(State or Country) Malden, Ill.

 10. NAME OF FATHER Thannas Eichen

 11. BIRTHPLACE OF FATHER
(State or Country) Ireland

 12. MAIDEN NAME OF MOTHER Catherine O'Connor

 13. BIRTHPLACE OF MOTHER
(State or Country) Ireland

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

 (Informant) John Eichen
(Address) Base, Idaho

 15. Filed Sept 30 1913 H E Lamb
Local Registrar

MEDICAL CERTIFICATE OF DEATH.

 16. DATE OF DEATH
_____ 1913
(Month) 9 (Day) 26 (Year)

 17. I HEREBY CERTIFY, That I attended deceased from _____ 1913, to _____ 1913,
that I last saw him alive on Sept 25 1913,
and that death occurred on the date stated above, at 4 P.M.
The CAUSE OF DEATH was as follows:

apoplexy
(Duration) _____ yrs. 30 mos. _____ ds.

Contributory (Secondary) _____

(Duration) _____ yrs. _____ mos. _____ ds.

 (Signed) H. E. Lamb M. D.

 19 (Address) Mendell

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death _____ yrs. _____ mos. _____ days. In the State _____ yrs. _____ mos. _____ days.

Where was disease contracted if not at place of death? _____

Former or usual residence. _____

19. PLACE OF BURIAL OR REMOVAL DATE OF BURIAL

Pacatella Idaho Sept 28 1913

20. UNDERTAKER ADDRESS

A T Thompson Gowebury

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Form V. S. No. 5 20M.1-16-12

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH.

Registration District No.

County of Twin Falls

Primary Registration District No.

City of

(No., St.)

Registered No.

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

Margaret Deftter

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX

4. COLOR OR RACE

5. SINGLE, MARRIED, WIDOWED OR DIVORCED.

GirlWhiteSingle
(Write the word.)

6. DATE OF BIRTH

Dec
(Month)2
(Day)1901
(Year)

7. AGE

11 yrs. 9 mos. 20 ds.IF LESS than 1 day
how many hrs. or
..... mins.?

8. OCCUPATION

(a) Trade, profession or particular kind of work

(b) General nature of industry business, or establishment in which employed (or employer)

9. BIRTHPLACE

(State or Country)

Walla Walla, Wash.

10. NAME OF FATHER

Ernest Hefter

11. BIRTHPLACE OF FATHER

(State or Country)

Canada

12. MAIDEN NAME OF MOTHER

Alice York

13. BIRTHPLACE OF MOTHER

(State or Country)

Nebraska

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

Ernest Hefter

(Address)

Filer Idaho.

15.

Filed

191

A. A. Newberry
Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH

Sept221913

(Month)

(Day)

(Year)

17. I HEREBY CERTIFY, That I attended deceased from Sept 17 1913, to Sept 22 1913that I last saw him alive on Sept 21 1913and that death occurred on the date stated above, at 7¹⁰ M.

The CAUSE OF DEATH* was as follows:

Meuritis

(Duration) yrs. mos. ds.

Contributory
(Secondary)

(Duration) yrs. mos. ds.

(Signed)

A. A. Newberry M. D.

19

(Address)

Filer

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL OR HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death yrs. mos. days. In the State yrs. mos. days.

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

Filer Ida9-23 1913

20. UNDERTAKER

ADDRESS

A. J. CrosbyTwin Falls

1. PLACE OF DEATH County of <u>Sagin Falls</u> City of <u>Filer</u>		2. REGISTRATION DISTRICT NO. <u>2086</u> (No. _____, St. _____)		BOARD OF HEALTH Bureau of Vital Statistics File No. <u>5988</u> Registered No. _____	
If death occurs away from usual residence, give facts called for under special information. 2. FULL NAME <u>Margaret M Elligott</u> If death occurred in a hospital, institution or camp give its NAME instead of street and number.					
PERSONAL AND STATISTICAL PARTICULARS			MEDICAL CERTIFICATE OF DEATH.		
3. SEX <u>Fe.</u>	4. COLOR OR RACE <u>W.</u>	5. SINGLE, MARRIED, WIDOWED OR DIVORCED <u>Married</u> (Write the word.)	16. DATE OF DEATH <u>Sept 28</u> 191 <u>3</u> (Month) (Day) (Year)		
6. DATE OF BIRTH <u>Apr 14</u> 188 <u>7</u> (Month) (Day) (Year)			17. I HEREBY CERTIFY, That I attended deceased from <u>Sept 28</u> 191 <u>3</u> , to <u>Sept 28</u> 191 <u>3</u> that I last saw <u>h</u> alive on <u>Sept 28</u> 191 <u>3</u> and that death occurred on the date stated above, at _____ M.		
7. AGE <u>36</u> yrs. <u>5</u> mos. <u>14</u> ds. IF LESS than 1 day how many _____ hrs. or _____ min?			The CAUSE OF DEATH* was as follows: <u>Pulmonary Tuberculosis</u>		
8. OCCUPATION (a) Trade, profession or particular kind of work (b) General nature of industry business or establishment in which employed (or employer) <u>Housewife</u>			(Duration) _____ yrs. _____ mos. _____ ds.		
9. BIRTHPLACE (State or Country) <u>Iowa</u>			Contributory (Secondary) _____		
10. NAME OF FATHER <u>J J McCarty</u>			(Duration) _____ yrs. _____ mos. _____ ds.		
11. BIRTHPLACE OF FATHER (State or Country) <u>Ill</u>			(Signed) <u>A A Newberry</u> M. D.		
12. MAIDEN NAME OF MOTHER <u>Margaret Harkin</u>			_____ 19 _____ (Address) _____		
13. BIRTHPLACE OF MOTHER (State or Country) <u>Ill</u>			*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; (2) whether ACCIDENTAL, SUICIDAL OR HOMICIDAL.		
14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE (Informant) <u>J S M E Elligott</u> (Address) _____			18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.) At place _____ In the _____ of death _____ yrs. _____ mos. _____ ds. State _____ yrs. _____ mos. _____ ds. Where was disease contracted, If not at place of death? _____ Former or usual residence _____		
15. _____ Filed _____ 191 <u>3</u>			19. PLACE OF BURIAL OR REMOVAL <u>Filer Ida</u> DATE OF BURIAL <u>9-30</u> 191 <u>3</u>		
Local Registrar _____			20. UNDERTAKER <u>A A Newberry</u> ADDRESS <u>Sagin Falls</u>		

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Form V. S. No. 5 20M.1-16-12		CERTIFICATE OF DEATH		State of Idaho BOARD OF HEALTH Bureau of Vital Statistics	
1. PLACE OF DEATH County of <u>Bear Lake</u> City of <u>St Charles</u>		Registration District No. _____ Primary Registration District No. <u>5-5-</u> (No. _____, St.)		File No. <u>5989</u> Registered No. _____	
If death occurs away from usual residence, give facts called for under special information.		2. FULL NAME <u>Ida Mares Nelson Clark</u> If death occurred in a hospital, institution or camp, give its NAME instead of street and number.			
PERSONAL AND STATISTICAL PARTICULARS				MEDICAL CERTIFICATE OF DEATH	
3. SEX <u>Female</u>		4. COLOR OR RACE <u>White</u>		5. SINGLE, MARRIED, WIDOWED OR DIVORCED. <u>Married</u> (Write the word.)	
6. DATE OF BIRTH <u>October 29 1913</u> (Month) (Day) (Year)				16. DATE OF DEATH <u>Oct 6 1913</u> (Month) (Day) (Year)	
7. AGE <u>26</u> yrs. _____ mos. _____ ds.		IF LESS than 1 day how many _____ hrs. or _____ mins.?		17. I HEREBY CERTIFY, That I attended deceased from <u>Sept 1913</u> to <u>Oct 6 1913</u> that I last saw her alive on <u>Oct 5 1913</u> and that death occurred on the date stated above, at _____ M.	
8. OCCUPATION (a) Trade, profession or particular kind of work <u>House Wife.</u> (b) General nature of industry business, or establishment in which employed (or employer) _____		The CAUSE OF DEATH* was as follows: <u>Pneumonia (Lobar Right Lower)</u>			
9. BIRTHPLACE (State or Country) <u>St Charles</u>		(Duration) _____ yrs. _____ mos. <u>6</u> ds.			
10. NAME OF FATHER <u>Rasmus P. Nelson</u>		Contributory <u>Pneumonia</u> (Secondary)			
11. BIRTHPLACE OF FATHER (State or Country) <u>Denmark Urop</u>		(Duration) <u>Don't know</u> yrs. _____ mos. _____ ds.			
12. MAIDEN NAME OF MOTHER <u>Wilhelmina Andersen</u>		(Signed) <u>A. P. Cooler</u> M. D.			
13. BIRTHPLACE OF MOTHER (State or Country) <u>Malmo Sweden</u>		19. (Address) <u>Paris Idaho</u>			
14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE (Informant) <u>Wilhelmina Nelson</u> (Address) <u>St Charles Id.</u>				*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.	
15. Filed <u>Oct 25 1913</u> <u>John Mattson</u> <u>St Charles</u> Local Registrar		18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.) At place of death _____ yrs. _____ mos. _____ days. In the State _____ yrs. _____ mos. _____ days. Where was disease contracted if not at place of death? Former or usual residence <u>St Charles Id.</u>			
		19. PLACE OF BURIAL OR REMOVAL <u>St Charles Id.</u>		DATE OF BURIAL _____ 191__	
		20. UNDERTAKER <u>John E. Bladen</u>		ADDRESS _____	

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Form V. S. No. 5 20M.1-16-12

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics
File No. 3990

1. PLACE OF DEATH. Registration District No. 39
County of Twin Falls Primary Registration District No. 2087
City of Bune (No. St.)

Registered No. If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

If death occurs away from usual residence, give facts called for under special information. 2. FULL NAME Jessie Nightengale

PERSONAL AND STATISTICAL PARTICULARS

3. SEX F 4. COLOR OR RACE White 5. SINGLE, MARRIED, WIDOWED OR DIVORCED. Infant (Write the word)

6. DATE OF BIRTH 10 4 1911 (Month) (Day) (Year)

7. AGE 1 yrs. 10 mos. 29 ds. IF LESS than 1 day how many hrs. or mins.?

8. OCCUPATION (a) Trade, profession or particular kind of work (b) General nature of industry business, or establishment in which employed (or employer) Infant

9. BIRTHPLACE (State or Country) Bune

10. NAME OF FATHER W. M. Nightengale

11. BIRTHPLACE OF FATHER Waua Waua (State or Country)

12. MAIDEN NAME OF MOTHER Nora Phillips

13. BIRTHPLACE OF MOTHER Grinnese Ida. (State or Country)

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE (Informant) W. M. Buffington (Address)

15. Filed 9-3 1913 J. H. Murphy Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH 9 2 1913 (Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from 8/14/1913, to 9/1/1913, that I last saw her alive on 8/31/1913, and that death occurred on the date stated above, at M.

The CAUSE OF DEATH* was as follows: Acute military tuberculosis

(Duration) About 2 yrs. 2 mos. ds. Contributory (Secondary) Typhoid fever (Duration) about 1 yrs. 6 mos. ds. (Signed) H. G. P. M. D. 9/2/1913 (Address) Twin Falls, Ida.

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death. yrs. mos. days. In the State. yrs. mos. days. Where was disease contracted if not at place of death? Former or usual residence.

19. PLACE OF BURIAL OR REMOVAL DATE OF BURIAL Waua Waua Wash. 1913

20. UNDERTAKER ADDRESS H. B. Evans Bule

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Form V. S. No. 5 20M.1-16-12

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics
File No. **5991**

1. PLACE OF DEATH.

Registration District No. **3**County of **Canyon**Primary Registration District No. **1005**City of **Caldwell**

(No. _____)

St. _____

Registered No. **89**

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME **James William Van Lennep**

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX

M

4. COLOR OR RACE

W.

5. SINGLE, MARRIED, WIDOWED OR DIVORCED.

(Write the word.)

6. DATE OF BIRTH

Feb. 26
Sept
(Month) (Day) (Year)**26**
8
(Day) (Year)**1913**
(Year)

7. AGE

7 yrs. **10** mos. **10** ds.IF LESS than 1 day
how many hrs. or
..... mins.?

8. OCCUPATION

- (a) Trade, profession or particular kind of work
(b) General nature of industry business, or establishment in which employed (or employer)

9. BIRTHPLACE

(State or Country) **Caldwell Idaho**

10. NAME OF FATHER

Sam'l J. Van Lennep

11. BIRTHPLACE OF FATHER

(State or Country) **Ohio**

12. MAIDEN NAME OF MOTHER

Esther Wilkin

13. BIRTHPLACE OF MOTHER

(State or Country) **Kentucky**

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) **Sam'l J. Van Lennep**(Address) **Caldwell, Ida**

15.

Filed **Sept. 9 - 1913****J. H. Meyer**
Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH

Sept
(Month)**8**
(Day)**1913**
(Year)

17. I HEREBY CERTIFY, That I attended deceased from

Aug 25 1913, to **Sept 8 1913**,that I last saw him alive on **Sept 8 1913**,and that death occurred on the date stated above, at **11:45 A.M.**

The CAUSE OF DEATH* was as follows:

Enterocolitis ulcerative(Duration) yrs. **1** mos. **3** ds.Contributory
(Secondary)

(Duration) yrs. _____ mos. _____ ds.

(Signed) **J. H. Meyer**

M. D.

Sept 8 1913 (Address) **Caldwell Idaho**

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death yrs. mos. days. In the State yrs. mos. days.

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL

Canyon Hills

DATE OF BURIAL

Sept 9 1913

20. UNDERTAKER

W. C. Dyer **Caldwell, Idaho**

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Form V. S. No. 5 20M.1-16-12

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics
File No. 5992
Registered No. 90

1. PLACE OF DEATH.

Registration District No. 3County of CampPrimary Registration District No. 2.005City of Caldwell

(No. _____, _____ St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Leopold Ribbald

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX Girl4. COLOR OR RACE White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED.

(Write the word.)

6. DATE OF BIRTH Sept. 18th 1913

(Month)

(Day)

(Year)

7. AGE _____ yrs. _____ mos. 5 hrs.IF LESS than 1 day
how many _____ hrs. or
_____ mins.

8. OCCUPATION

(a) Trade, profession or particular kind of work

(b) General nature of industry business, or establishment in which employed (or employer)

9. BIRTHPLACE

(State or Country)

10. NAME OF FATHER Walter Scott Ribbald11. BIRTHPLACE OF FATHER California

(State or Country)

12. MAIDEN NAME OF MOTHER Kathryn E Frank13. BIRTHPLACE OF MOTHER California

(State or Country)

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) W. S. Ribbald(Address) Caldwell

15.

Filed Sept. 19- 1913 J. H. Meyer

Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH Sept 18th 1913

(Month)

(Day)

(Year)

17. I HEREBY CERTIFY, That I attended deceased from Sept 18 1913 to Sept 18 1913that I last saw her alive on 18 1913and that death occurred on the date stated above, at 11 P.M.

The CAUSE OF DEATH* was as follows:

Premature Birth

(Duration) _____ yrs. _____ mos. _____ ds.

Contributory
(Secondary)

(Duration) _____ yrs. _____ mos. _____ ds.

(Signed) R. E. Shuck M. D.19. (Address) Boise, Ida.

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death _____ yrs. _____ mos. _____ days. In the State _____ yrs. _____ mos. _____ days.

Where was disease contracted if not at place of death?

Former or usual residence _____

19. PLACE OF BURIAL OR REMOVAL Camp HillDATE OF BURIAL 9/19 191320. UNDERTAKER W. E. DyerADDRESS Caldwell

Idaho

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Form V. S. No. 5 20M.1-16-12

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics
File No. **5993**
Registered No. **91**

1. PLACE OF DEATH. Registration District No. **3**
County of **Canyon** Primary Registration District No. **2005-**
City of **Caldwell** (No. _____, St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME **Infant Sibbald**

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX **girl** 4. COLOR OR RACE **white** 5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.)

6. DATE OF BIRTH **Sept 15 1913**
(Month) (Day) (Year)

7. AGE _____ yrs. _____ mos. **3 hrs**
IF LESS than 1 day how many _____ hrs. or _____ mins.?

8. OCCUPATION
(a) Trade, profession or particular kind of work
(b) General nature of industry business, or establishment in which employed (or employer)

9. BIRTHPLACE
(State or Country)

10. NAME OF FATHER **Shaver Scott Sibbald**

11. BIRTHPLACE OF FATHER **California**
(State or Country)

12. MAIDEN NAME OF MOTHER **Kathryn E Frank**

13. BIRTHPLACE OF MOTHER **California**
(State or Country)

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) **W. S. Sibbald**
(Address) **Caldwell**

15. Filed **Sept. 19-** 1913 **John Meyer**
Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH **Sept 18 1913**
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from **Sept 18 1913** to **Sept 18 1913**
that I last saw her alive on **Sept 18 1913**
and that death occurred on the date stated above, at **8 P.** M.

The CAUSE OF DEATH* was as follows:
Premature Birth

(Duration) _____ yrs. _____ mos. _____ ds.
Contributory (Secondary) _____
(Duration) _____ yrs. _____ mos. _____ ds.
(Signed) **R. E. Smith** M. D.
19 _____ (Address) **Boise Ida**

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death _____ yrs. _____ mos. _____ days. In the State _____ yrs. _____ mos. _____ days.

Where was disease contracted if not at place of death? _____

Former or usual residence _____

19. PLACE OF BURIAL OR REMOVAL **Canyon Hill** DATE OF BURIAL **9/19 1913**

20. UNDERTAKER **W. B. Dyer** ADDRESS **Caldwell Idaho.**

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Form V. S. No. 5. 12½ M. 7-24-11

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH.
County of Canyon
City of Caldwell

Registration District No. 3
Primary Registration District No. 1005
(No. _____, St.)

File No. 599
Registered No. 92

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Theodore W. Merritt

If death occurred in a hospital, institution or camp give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX male 4. COLOR OR RACE white 5. SINGLE, MARRIED, WIDOWED OR DIVORCED. single
(Write the word.)

6. DATE OF BIRTH Nov. 22 1901
(Month) (Day) (Year)

7. AGE 12 yrs. 10 mos. 2 ds. IF LESS than 1 day how many _____ hrs. or _____ min?

8. OCCUPATION School boy
(a) Trade, profession or particular kind of work.
(b) General nature of industry business or establishment in which employed (or employer)

9. BIRTHPLACE Boise Idaho
(State or Country)

10. NAME OF FATHER Geo. Merritt

11. BIRTHPLACE OF FATHER Indiana
(State or Country)

12. MAIDEN NAME OF MOTHER Miss May Dorman

13. BIRTHPLACE OF MOTHER Illinois
(State or Country)

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Geo. Merritt
(Address) Caldwell Ida

15. Filed Sept. 26 1913 J. H. Meyer
Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH Sept 24 1913
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from Sept 10 1913, to Sept 24 1913
that I last saw him alive on Sept 24 1913
and that death occurred on the date stated above, at 6 P. M.

The CAUSE OF DEATH* was as follows:

Diphtheria given with throat complication

(Duration) _____ yrs. _____ mos. 4 ds.

Contributory (Secondary)

(Duration) _____ yrs. _____ mos. _____ ds.

(Signed) J. H. Meyer M. D.
Sept 25 1913 (Address) Caldwell Ida

State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; (2) whether ACCIDENTAL, SUICIDAL OR HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place _____ yrs. _____ mos. _____ ds. State _____ yrs. _____ mos. _____ ds.
of death
Where was disease contracted,
If not at place of death?
Former or
usual residence.

19. PLACE OF BURIAL OR REMOVAL Boise Idaho DATE OF BURIAL Sept 26 1913

20. UNDERTAKER Platt Reedman ADDRESS Caldwell Idaho

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly identified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Form V. S. No. 5 20M.1-16-12

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics
File No. 5995
Registered No. 93

1. PLACE OF DEATH.

Registration District No. 3

County of Canyon

Primary Registration District No. 2005

City of Caldwell

(No. _____, _____ St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Elizabeth Grider

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX Female

4. COLOR OR RACE white

5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.)

6. DATE OF BIRTH Aug 30 1853

(Month)

(Day)

(Year)

7. AGE 60 yrs. 28 mos. 28 ds.

IF LESS than 1 day
how many hrs. or
..... mins.

8. OCCUPATION

(a) Trade, profession or particular kind of work Housewife

(b) General nature of industry business, or establishment in which employed (or employer)

9. BIRTHPLACE

(State or Country) Kentucky

10. NAME OF FATHER Grider

11. BIRTHPLACE OF FATHER

(State or Country) dont know

12. MAIDEN NAME OF MOTHER Elizabeth Grider

13. BIRTHPLACE OF MOTHER

(State or Country) dont know

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Gora Hancock

(Address) Caldwell Idaho

15.

Filed Sept. 30 - 1913

John D. Meyer
Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH Sept. 28 1913

(Month)

(Day)

(Year)

17. I HEREBY CERTIFY, That I attended deceased from Sept 22 1913 to Sept. 28 1913

that I last saw her alive on Sept 28 1913

and that death occurred on the date stated above, at 4 P.M.

The CAUSE OF DEATH* was as follows:

Pneumonia (Bronch)

(Duration) yrs. mos. 3 ds.

Contributory (Secondary)

(Duration) yrs. mos. ds.

(Signed) J. M. Cole M. D.

9/30/1913 (Address) Caldwell Idaho

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death yrs. mos. days. In the State yrs. mos. days.

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

Canyon Hill

9/30 1913

20. UNDERTAKER

ADDRESS

W. B. Dyer

Caldwell

-SUPPLEMENTARY DEATH CERTIFICATE-

(Please reply on this sheet to
the registrar of Vital Statistics)

Death Certificate No.

Name Elizabeth Criden

Date of Death Sept. 28 - 1913

Cause of Death Bronchopneumonia

Contributory Cause of death

(Sign here) J. W. Cole M.D.

1. PLACE OF DEATH. —		Registration District No. <u>2005</u>		Bureau of Vital Statistics	
County of <u>Caldwell</u>		Primary Registration District No. <u>2005</u>		File No. <u>5996</u>	
City of <u>Caldwell, Rural</u>		(No., St.)		Registered No. <u>94</u>	
If death occurs away from usual residence, give facts called for under special information.		2. FULL NAME <u>Maria Blessinger</u>		If death occurred in a hospital, institution or camp give its NA instead of street and number.	
PERSONAL AND STATISTICAL PARTICULARS					
3. SEX <u>FM</u>		4. COLOR OR RACE <u>W</u>		5. SINGLE, MARRIED, WIDOWED OR DIVORCED. <u>M</u> (Write the word.)	
6. DATE OF BIRTH <u>Sept 30 1913</u> (Month) (Day) (Year)					
7. AGE <u>66</u> yrs. <u>2</u> mos. <u>1</u> ds. IF LESS than 1 day how many hrs. or min.?					
8. OCCUPATION <u>Housewife</u> (a) Trade, profession, or particular kind of work (b) General nature of industry, business, or establishment in which employed (or employer)					
9. BIRTHPLACE <u>Illinois</u> (State or Country)					
10. NAME OF FATHER <u>James A. Mc. Cadden</u>					
11. BIRTHPLACE OF FATHER <u>Nova Scotia</u> (State or Country)					
12. MAIDEN NAME OF MOTHER <u>Manda Reed</u>					
13. BIRTHPLACE OF MOTHER <u>New York</u> (State or Country)					
14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE (Informant) <u>Alexander Blessinger</u> (Address) <u>Caldwell</u>					
15. Filed <u>Sept. 30 - 1913</u> <u>John D. Meyer</u> Local Registrar					
MEDICAL CERTIFICATE OF DEATH					
16. DATE OF DEATH <u>Sept 3</u> (Month) (Day) (Year)					
17. I HEREBY CERTIFY, That I attended deceased from <u>Sept 1</u> 191 <u>3</u> , to <u>Sept 3</u> 191 <u>3</u> , that I last saw him alive on <u>Sept 2</u> 191 <u>3</u> , and that death occurred on the date stated above, at <u>4300</u> The CAUSE OF DEATH* was as follows: <u>Cancer, Liver, Kidney & Lungs</u> (Duration) <u>one</u> yrs. — mos. —					
Contributory (Secondary) _____ (Duration) _____ yrs. _____ mos. _____					
(Signed) <u>W. H. Hall</u> 19 _____ (Address) <u>Star & Hal</u>					
*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.					
18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.) At place _____ In the _____ of death. yrs. mos. ds. State. yrs. mos. Where was Disease contracted, If not at place of death? _____ Former or usual residence. _____					
19. PLACE OF BURIAL OR REMOVAL <u>Star & Hal</u>				DATE OF BURIAL <u>Oct 1</u> 19 <u>13</u>	
20. UNDERTAKER <u>W. H. Dyer</u>				ADDRESS <u>Caldwell</u>	

-SUPPLEMENTARY DEATH CERTIFICATE-

(Please reply on this sheet to
the registrar of Vital Statistics)

Death Certificate No.

Maria Blessinger

Name

Date of Death

Sept 30 1913

Cause of Death

Cancer Liver, Kidney, & Face

Contributory Cause of death

*Don't know which one was primary
probably the face*

(Sign here)

Oliver Hall M.D.

M.D.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Form V. S. No. 5 20M.1-16-12

CERTIFICATE OF DEATH

 State of Idaho
 BOARD OF HEALTH
 Bureau of Vital Statistics

 1. PLACE OF DEATH. Registration District No. 3
 County of Canyon Primary Registration District No. 1005
 City of Caldwell (No. Rumbaker Ave. St.)

 File No. 599
 Registered No. 951

If death occurs away from usual residence, give facts called for under special information.

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Karrieth Newell Oakes

PERSONAL AND STATISTICAL PARTICULARS

3. SEX 4. COLOR OR RACE 5. SINGLE, MARRIED, WIDOWED OR DIVORCED.

Female White (Write the word.)

6. DATE OF BIRTH

 May 13 1828
 (Month) (Day) (Year)

7. AGE

85 yrs. 4 mos. 19 ds.

 IF LESS than 1 day
 how many hrs. or mins.?

8. OCCUPATION

 (a) Trade, profession or particular kind of work
 (b) General nature of industry business, or establishment in which employed (or employer)

Housewife

9. BIRTHPLACE

(State or Country)

Oneida Co. New York

10. NAME OF FATHER

Unknown

11. BIRTHPLACE OF FATHER

(State or Country)

"

12. MAIDEN NAME OF MOTHER

"

13. BIRTHPLACE OF MOTHER

(State or Country)

"

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

Chas Oakes

(Address)

Caldwell Idaho

15.

Filed Oct 5 1913

John F. Meyer

Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH

 Oct 2 1913
 (Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from

Aug 5 1913, to Oct 3 1913

that I last saw her alive on Oct 2 1913

and that death occurred on the date stated above, at M.

The CAUSE OF DEATH* was as follows:

General debility & pneumonia

(Duration) yrs. mos. ds.

Contributory

(Secondary)

(Duration) yrs. mos. ds.

(Signed)

J. M. Cole M. D.

Oct 4 1913 (Address) Caldwell

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death yrs. mos. days. In the State yrs. mos. days.

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL DATE OF BURIAL

W. C. Dyer Hill

10/5 1913

20. UNDERTAKER

W. C. Dyer

ADDRESS

Caldwell

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Form V. S. No. 5 20M.1-16-12

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH

Registration District No.

County of

Primary Registration District No.

City of

(No. 633 1st Ave. St.)

File No. 5993

Registered No. 97

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX

4. COLOR OR RACE

5. SINGLE, MARRIED, WIDOWED OR DIVORCED.

Male

White

Single (Write the word.)

6. DATE OF BIRTH

Sept

22

1913

(Month)

(Day)

(Year)

7. AGE

yrs. mos. ds.

IF LESS than 1 day
how many hrs. or
mins.

8. OCCUPATION

(a) Trade, profession or particular kind of work

(b) General nature of industry business, or establishment in which employed (or employer)

None

9. BIRTHPLACE

(State or Country)

Pocatello Idaho

10. NAME OF FATHER

Francis James Nason

11. BIRTHPLACE OF FATHER

(State or Country)

Ogden Utah

12. MAIDEN NAME OF MOTHER

Rose Amelia Lundquist

13. BIRTHPLACE OF MOTHER

(State or Country)

Hooper Utah

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

(Address)

Mrs Francis James Nason

Pocatello

15.

Filed

1913

O. B. Steele

Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH

Sept

22

1913

(Month)

(Day)

(Year)

17. I HEREBY CERTIFY, That I attended deceased from Sept 22 1913, to Oct 22 1913

that I last saw him alive on Sept 22 1913, and that death occurred on the date stated above, at 12 P.M.

The CAUSE OF DEATH* was as follows:

Lesion of heart of indeterminate nature

(Duration) yrs. mos. ds.

Contributory (Secondary)

Asphyxiation

(Duration) yrs. mos. ds.

(Signed)

J. M. Nason

M. D.

19 (Address)

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL OR HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death yrs. mos. days. In the State yrs. mos. days.

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

Pocatello Idaho

Apr 23 1913

20. UNDERTAKER

ADDRESS

J. M. Nason Pocatello

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Form V. S. No. 5 20M.1-16-12

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH

Registration District No.

County of

Primary Registration District No.

City of

(No. Baggage Room O.S. St.)

File No. 3 5999

Registered No. 98

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX

4. COLOR OR RACE

5. SINGLE, MARRIED, WIDOWED OR DIVORCED.

6. DATE OF BIRTH

7. AGE

IF LESS than 1 day
how many hrs. or
..... mins.?

8. OCCUPATION

(a) Trade, profession or particular kind of work
(b) General nature of industry business, or establishment in which employed (or employer)

9. BIRTHPLACE

(State or Country)

10. NAME OF FATHER

11. BIRTHPLACE OF FATHER

(State or Country)

12. MAIDEN NAME OF MOTHER

13. BIRTHPLACE OF MOTHER

(State or Country)

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

(Address)

15.

Filed

191. 3

Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH

17. I HEREBY CERTIFY, That I attended deceased from

191. to 191.
that I last saw h. alive on

and that death occurred on the date stated above, at

The CAUSE OF DEATH* was as follows:

(Duration) yrs. mos. ds.

Contributory (Secondary)

(Duration) yrs. mos. ds.

(Signed)

191. 3

(Address)

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death yrs. mos. days. In the State yrs. mos. days.

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

20. UNDERTAKER

ADDRESS

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Form V. S. No. 5 20M.1-16-12

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

File No. 2 600Registered No. 91

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

1. PLACE OF DEATH.

Registration District No.

County of Sanborn

Primary Registration District No.

City of Young Lake(No. Young Lake St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Nazel Apgar

PERSONAL AND STATISTICAL PARTICULARS

3. SEX Female4. COLOR OR RACE White5. SINGLE, MARRIED, WIDOWED OR DIVORCED Married
(Write the word)

6. DATE OF BIRTH

(Month)

(Day)

(Year) 1892

7. AGE

21

yrs.

mos.

ds.

IF LESS than 1 day
how many hrs. or
..... mins.

8. OCCUPATION

(a) Trade, profession or particular kind of work Nurse

(b) General nature of industry, business, or establishment in which employed (or employer)

9. BIRTHPLACE

(State or Country) Ogden Utah10. NAME OF FATHER Chas Reed

11. BIRTHPLACE OF FATHER

(State or Country)

12. MAIDEN NAME OF MOTHER

13. BIRTHPLACE OF MOTHER

(State or Country)

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) N. Apgar(Address) Pocatello IdahoFiled 9-19-

191

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH

(Month) Sept(Day) 17

191

(Year)

17. I HEREBY CERTIFY, That I attended deceased from

191, to

191

that I last saw him alive on

191

and that death occurred on the date stated above, at 5:15 M.

The CAUSE OF DEATH* was as follows:

Accidental drowning

(Duration) yrs. mos. ds.

Contributory

(Secondary)

(Duration) yrs. mos. ds.

(Signed) Off Duty

M. D.

Address) Pocatello Idaho

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place

of death yrs. mos. days.

In the

State yrs. mos. days.

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL DATE OF BURIAL

Ogden Utah Sept 19 191

20. UNDERTAKER

PLACE OF DEATH.

Registration District No. 28

County of Bannock

Primary Registration District No.

City of Pracatello

(No. Gen Hospital St.)

File No. 2 600

Registered No. 90

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

Emily Alice Balista

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX

4. COLOR OR RACE

5. SINGLE, MARRIED, WIDOWED OR DIVORCED

Female

White

Married
(Write the word)

6. DATE OF BIRTH

Jan
(Month)

6
(Day)

1891
(Year)

7. AGE

39 yrs. 8 mos. 10 ds.

IF LESS than 1 day
how many hrs. or mins.?

8. OCCUPATION

(a) Trade, profession or particular kind of work
(b) General nature of industry, business, or establishment in which employed (or employer)

Nurse

9. BIRTHPLACE

(State or Country)

Bountiful Utah

10. NAME OF FATHER

James Hadley

11. BIRTHPLACE OF FATHER

(State or Country)

England

12. MAIDEN NAME OF MOTHER

Marion Coltrian

13. BIRTHPLACE OF MOTHER

(State or Country)

English

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

(Address)

David Gurgley
Pracatello

15.

Filed

Sep 18 1913

Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH

Sept
(Month)

16
(Day)

1913
(Year)

17. I HEREBY CERTIFY, That I attended deceased from

Sept 5 1913 to Sept 16 1913

that I last saw her alive on Sept 16 1913

and that death occurred on the date stated above, at 9:15 M.

The CAUSE OF DEATH* was as follows:

metabolism following operation (3 days after) Carcinoma Cervix

(Duration) yrs. mos. ds.

Contributory (Secondary) Carcinoma Cervix

(Duration) yrs. mos. ds.

(Signed) W. H. Howard M. D.

9/17 1913 (Address) Pracatello Idaho

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death.....yrs.....mos.....days. In the State.....yrs.....mos.....days.

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

Mountain View Sept 18 1913

20. UNDERTAKER

ADDRESS

W. H. Howard Pracatello

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY.
CLANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified.
ment of OCCUPATION is very important. See instructions on back of certificate.

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Form V. S. No. 5 20M.1-16-12

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH.

Registration District No.

County of

Primary Registration District No.

City of

(No.

St.)

File No.

Registered No.

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX

4. COLOR OF RACE

5. SINGLE, MARRIED, WIDOWED OR DIVORCED.

(Write the word.)

6. DATE OF BIRTH

7. AGE

IF LESS than 1 day
how many hrs. or mins.?

8. OCCUPATION

(a) Trade, profession or particular kind of work
(b) General nature of industry, business, or establishment in which employed (or employer)

9. BIRTHPLACE

(State or Country)

10. NAME OF FATHER

11. BIRTHPLACE OF FATHER

(State or Country)

12. MAIDEN NAME OF MOTHER

13. BIRTHPLACE OF MOTHER

(State or Country)

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

(Address)

15.

Filed

191

Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH

17. I HEREBY CERTIFY, That I attended deceased from

that I last saw him alive on

and that death occurred on the date stated above, at

The CAUSE OF DEATH* was as follows:

(Duration) yrs. mos. ds.

Contributory
(Secondary)

(Duration) yrs. mos. ds.

(Signed) M. D.

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death yrs. mos. days. In the State yrs. mos. days.

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

20. UNDERTAKER

ADDRESS

Form V. S. No. 5 20M.1-16-12

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH.

Registration District No.

County of *Bainrock*

Primary Registration District No.

City of *Pocatello*(No. *Main street* St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

*Catherine Schmitt*File No. *2 6002*Registered No. *88*

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX

female

4. COLOR OR RACE

White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED.

Married
(Write the word.)

6. DATE OF BIRTH

Sept 9th 1848
(Month) (Day) (Year)

7. AGE

65 years
yrs. mos. ds.IF LESS than 1 day
how many hrs. or
mins.?

8. OCCUPATION

- (a) Trade, profession or particular kind of work
-
- (b) General nature of industry, business, or establishment in which employed (or employer)

Retired

9. BIRTHPLACE

(State or Country)

Europe

10. NAME OF FATHER

Gabriel Betz

11. BIRTHPLACE OF FATHER

(State or Country)

Europe

12. MAIDEN NAME OF MOTHER

Unknown

13. BIRTHPLACE OF MOTHER

(State or Country)

Europe

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

Frank Schmitt
Pocatello Idaho

(Address)

15.

Sep 15, 1913
OB Stealy
Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH

Sept 14th 1913
(Month) (Day) (Year)17. I HEREBY CERTIFY, That I attended deceased from
Nov. 27th 1912, to *Sept. 14th 1913*that I last saw her alive on *Sept. 14th 1913*
and that death occurred on the date stated above, at *5:00 P.M.*

The CAUSE OF DEATH* was as follows:

Carcinoma of Pancreas.(Duration) *2* yrs. mos. ds.Contributory *Glycosuric Langrene*
(Secondary)(Duration) *7* yrs. mos. ds.(Signed) *W. A. Wright* M. D.
9/15 1913 - (Address) *Pocatello, Idaho*

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death.....yrs.....mos.....days. In the State.....yrs.....mos.....days.

Where was disease contracted if not at place of death?

Former or usual residence.....

19. PLACE OF BURIAL OR REMOVAL DATE OF BURIAL

Mountain View *Sept 17 1913*

20. UNDERTAKER ADDRESS

W. A. Wright
W. A. Wright

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Form V. S. No. 5 20M.1-16-12

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
 Bureau of Vital Statistics
 File No. 2,600
 Registered No. 87
 If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

1. **PLACE OF DEATH** Idaho
 County of Idaho
 City of Idaho
 Registration District No. _____
 Primary Registration District No. _____
 (No. Idaho Idaho St.)
 If death occurs away from usual residence, give facts called for under special information. 2. **FULL NAME** Mrs. Lee Drollinger

PERSONAL AND STATISTICAL PARTICULARS

3. **SEX** Male 4. **COLOR OR RACE** White 5. **SINGLE, MARRIED, WIDOWED OR DIVORCED.** Single
 (Write the word.)

6. **DATE OF BIRTH** Aug 26 1891
 (Month) (Day) (Year)

7. **AGE** 22 yrs. 8 mos. 18 ds.
 IF LESS than 1 day how many hrs. or mins.?

8. **OCCUPATION**
 (a) Trade, profession or particular kind of work School Teacher
 (b) General nature of industry, business, or establishment in which employed (or employer)

9. **BIRTHPLACE** Arizona
 (State or Country)

10. **NAME OF FATHER** C. L. Drollinger

11. **BIRTHPLACE OF FATHER** Utah
 (State or Country)

12. **MAIDEN NAME OF MOTHER** Mary E. Drollinger

13. **BIRTHPLACE OF MOTHER** Utah
 (State or Country)

14. **THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE**
 (Informant) L. Drollinger
 (Address) Marysville Idaho

15. Sept 13 1913
 Local Registrar O. J. Healy

MEDICAL CERTIFICATE OF DEATH.

16. **DATE OF DEATH** Sept 13 1913
 (Month) (Day) (Year)

17. **I HEREBY CERTIFY**, That I attended deceased from 1913, to 1913,
 that I last saw h. alive on 1913,
 and that death occurred on the date stated above, at 9:15 A.M.
 The CAUSE OF DEATH* was as follows:

Railroad Accident Killed by Train

(Duration) yrs. mos. ds.

Contributory (Secondary)

(Duration) yrs. mos. ds.

(Signed) _____ M. D.

19 (Address) _____

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. **LENGTH OF RESIDENCE** (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death. yrs. mos. days. In the State. yrs. mos. days.

Where was disease contracted if not at place of death?

Former or usual residence.

19. **PLACE OF BURIAL OR REMOVAL** Marysville Idaho **DATE OF BURIAL** Sept 14 1913

20. **UNDERTAKER** N. J. Racker **ADDRESS** Idaho

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Form V. S. No. 5 20M.1-16-12

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH.

Registration District No. 28

County of Blaine

Primary Registration District No.

City of Pocatello

(No. 946, W. Lewis)

St.)

File No. 2 6005

Registered No. 86

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

Aduel Gray

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX

Female

4. COLOR OR RACE

White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED.

Single (Write the word.)

6. DATE OF BIRTH

January 1st 1913

(Month)

(Day)

(Year)

7. AGE

8 yrs. 8 mos. 12 ds.

IF LESS than 1 day how many hrs. or mins.?

8. OCCUPATION

(a) Trade, profession or particular kind of work

None

(b) General nature of industry business, or establishment in which employed (or employer)

9. BIRTHPLACE

(State or Country)

Pocatello Idaho

10. NAME OF FATHER

Roy L. Gray

11. BIRTHPLACE OF FATHER

(State or Country)

Iowa

12. MAIDEN NAME OF MOTHER

Daisy Hawthorne

13. BIRTHPLACE OF MOTHER

(State or Country)

Nebraska

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

Roy L. Gray

(Address)

Pocatello Idaho

15.

Sept 3 1913

W. Lewis

Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH

Sept 12 1913

(Month)

(Day)

(Year)

17. I HEREBY CERTIFY, That I attended deceased from

Sept. 7th 1913, to Sept 12 1913

that I last saw him alive on Sept 12 1913

and that death occurred on the date stated above, at 10:30 P. M.

The CAUSE OF DEATH* was as follows:

Enteritis

(Duration) yrs. mos. ds.

Contributory (Secondary)

(Duration) yrs. mos. ds.

(Signed) W. Lewis M. D.

Sept. 13 1913 (Address) Pocatello Idaho

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death yrs. mos. days. In the State yrs. mos. days.

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL DATE OF BURIAL

Put Row

Sept 14 1913

20. UNDERTAKER

W. Lewis Pocatello

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Form V. S. No. 5 20M.1-16-12

CERTIFICATE OF DEATH

1. PLACE OF DEATH.

Registration District No. 28

County of

Primary Registration District No. 1

City of

No. 343, Do 9 Ave. St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

Judeviska For Eichholz

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

File No.

2 600

Registered No.

85

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX

Female

4. COLOR OR RACE

White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED.

Widow (Write the word.)

6. DATE OF BIRTH

April 14 1849 (Month) (Day) (Year)

7. AGE

64 yrs. 4 mos. 27 ds.

IF LESS than 1 day
how many hrs. or
..... mins.?

8. OCCUPATION

(a) Trade, profession or particular kind of work

(b) General nature of industry business, or establishment in which employed (or employer)

Retired Housewife

9. BIRTHPLACE

(State or Country)

Germany

10. NAME OF FATHER

11. BIRTHPLACE OF FATHER

(State or Country)

12. MAIDEN NAME OF MOTHER

13. BIRTHPLACE OF MOTHER

(State or Country)

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

(Address)

15.

Sept 11 1913

Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH

Sept 11 1913 (Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from

August 1st 1913, to Sept 11 1913,

that I last saw her alive on Sept 11 1913,

and that death occurred on the date stated above, at 10th AM.

The CAUSE OF DEATH* was as follows:

Sarcoma of Sept. junction

(Duration) yrs. mos. ds.

Contributory (Secondary)

(Duration) yrs. mos. ds.

(Signed) R. Smith W. Agency M. D.

(Address) Prater's Building

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death yrs. mos. days. In the State yrs. mos. days.

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL DATE OF BURIAL

Schuyler. Neb. 1913

20. UNDERTAKER

ADDRESS

W. Macken Pocatello

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Form V. S. No. 5 20M.1-16-12

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH.

Registration District No. 28County of BlainePrimary Registration District No. 723City of Pocatello(No. 723)

St.)

File No. 2 600Registered No. 84

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Duffield A. Steffen

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX Male 4. COLOR OR RACE White 5. SINGLE, MARRIED, WIDOWED OR DIVORCED. Single6. DATE OF BIRTH Sept 6 1913

(Month)

(Day)

(Year)

7. AGE 30 yrs. 1 mos. 1 ds.

IF LESS than 1 day
how many hrs. or
mins.?

8. OCCUPATION

- (a) Trade, profession or particular kind of work
(b) General nature of industry business, or establishment in which employed (or employer)

None

9. BIRTHPLACE

(State or Country)

Pocatello Idaho10. NAME OF FATHER A. Steffen

11. BIRTHPLACE OF FATHER

(State or Country)

Sweden12. MAIDEN NAME OF MOTHER Annie Lundgren

13. BIRTHPLACE OF MOTHER

(State or Country)

Sweden

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) A. Steffen(Address) Pocatello Idaho15. Sept 6 1913

1913

O B Steffy

Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH Sept 6 1913

(Month)

(Day)

(Year)

17. I HEREBY CERTIFY, That I attended deceased from Sept 6 1913, to Sept 6 1913, that I last saw him alive on Sept 6 1913, and that death occurred on the date stated above, at 8:30 A.M.

The CAUSE OF DEATH* was as follows:

Stroke

(Duration) yrs. mos. ds.

Contributory (Secondary)

(Duration) yrs. mos. ds.

(Signed) O B Steffy M. D.

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death yrs. mos. days. In the State yrs. mos. days.

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL Back of Ida DATE OF BURIAL Sept 7 191320. UNDERTAKER H. R. WalkerADDRESS Pocatello

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. PHYSI-
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. Exact state-
CENS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. See instructions on back of certificate.

Form V. S. No. 5 20M.1-16-12

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH.

Registration District No. _____

County of _____

Primary Registration District No. _____

City of _____

(No. _____ St.)

File No. _____

Registered No. _____

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME _____

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX

4. COLOR OR RACE

5. SINGLE, MARRIED, WID-
OWED OR DIVORCED.

Male

White

Single
(Write the word.)

6. DATE OF BIRTH

Sept 3 1913
(Month) (Day) (Year)

7. AGE

____ yrs. ____ mos. ____ ds.

IF LESS than 1 day
how many ____ hrs. or
____ mins.?

8. OCCUPATION

- (a) Trade, profession or particular kind of work
(b) General nature of industry business, or establishment in which employed (or employer)

None.

9. BIRTHPLACE

(State or Country)

Pocatello Idaho.

10. NAME OF FATHER

A. P. Day

11. BIRTHPLACE OF FATHER

(State or Country)

Nebraska.

12. MAIDEN NAME OF MOTHER

Annie E. Bauer

13. BIRTHPLACE OF MOTHER

(State or Country)

Sweden

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

(Address)

A. P. Day
Pocatello Idaho.

15.

do

Sept 4th 1913

3

A. P. Day

Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH

Sept 3 1913
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from

Sept 3 1913, to Sept 3 1913

that I last saw him alive on Sept 3 1913

and that death occurred on the date stated above, at 3:30 P. M.

The CAUSE OF DEATH* was as follows:

Premature birth (7 mos.)

(Duration) ____ yrs. ____ mos. ____ ds.

Contributory
(Secondary)

(Duration) ____ yrs. ____ mos. ____ ds.

(Signed)

7/4/1913 (Address) W. J. Howard, M. P.
Pocatello Idaho

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death ____ yrs. ____ mos. ____ days. In the State ____ yrs. ____ mos. ____ days.

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

Mountain View

Sept 4 1913

20. UNDERTAKER

ADDRESS

M. M. Rader Pocatello Idaho

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Form V. S. No. 5 20M.1-16-12

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics
File No. 3 6009
Registered No. 604

1. PLACE OF DEATH.

County of Bannock
City of Pocatello

Registration District No.
Primary Registration District No.
(No. 110 N. Johnson St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

Laura J. Whitaker

PERSONAL AND STATISTICAL PARTICULARS

3. SEX

Female

4. COLOR OR RACE

White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED.

Single
(Write the word.)

6. DATE OF BIRTH

Dec 4th

1904

(Month)

(Day)

(Year)

7. AGE

8 yrs. 11 mos. 2 ds.

IF LESS than 1 day
how many hrs. or
..... mins.

8. OCCUPATION

(a) Trade, profession or particular kind of work
(b) General nature of industry, business, or establishment in which employed (or employer)

Child

9. BIRTHPLACE

(State or Country)

Utah

10. NAME OF FATHER

J. E. Whitaker

11. BIRTHPLACE OF FATHER

(State or Country)

Utah

12. MAIDEN NAME OF MOTHER

Lucy Reed

13. BIRTHPLACE OF MOTHER

(State or Country)

Idaho

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

(Address)

Mrs. Lucy Albred
110 N. Johnson

15.

Filed

Nov 6

1913

Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH

Oct 28

1913

(Month)

(Day)

(Year)

17. I HEREBY CERTIFY, That I attended deceased from

191 to 191

191

that I last saw him alive on 191

and that death occurred on the date stated above, at M.

The CAUSE OF DEATH* was as follows:

accidental
drowning, due to overside, collision
of foot bridge, and approaches and
it is recommended to the City authorities
that they cause all bridges and approaches
be made safe or removed.

(Duration) yrs. mos. ds.

Contributory

(Secondary)

(Duration) yrs. mos. ds.

(Signed)

O. B. Stealy M. D.

19..... (Address)

Pocatello, Idaho

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death yrs. mos. days. In the State yrs. mos. days.

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

Mountain View Cem

Nov 7 1913

20. UNDERTAKER

ADDRESS

Stanford & Chumacher

Pocatello

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIAN should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Form V. S. No. 5 20M.1-16-12

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH.

Registration District No. 44

County of Owyhee

Primary Registration District No. 2121

City of Bruneau

(No. _____, St.)

File No. 6019

Registered No. 6-

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

Mila Kidd

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX

Female

4. COLOR OR RACE

White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED.

Single
(Write the word.)

6. DATE OF BIRTH

October 26th 1911
(Month) (Day) (Year)

7. AGE

2 yrs. 0 mos. 28 ds.

IF LESS than 1 day
how many _____ hrs. or
_____ mins.?

8. OCCUPATION

- (a) Trade, profession or particular kind of work
(b) General nature of industry business, or establishment in which employed (or employer)

At Home

9. BIRTHPLACE

(State or Country)

Idaho

10. NAME OF FATHER

John Kidd

11. BIRTHPLACE OF FATHER

(State or Country)

Utah

12. MAIDEN NAME OF MOTHER

Grace Bailey

13. BIRTHPLACE OF MOTHER

(State or Country)

Utah

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

Granville Deming

(Address)

Bruneau Idaho

15.

Filed

Nov. 26 1913

Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH

Nov 24 1913
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from

Nov 24 1913, to 1913

that I last saw her alive on Nov. 24 1913

and that death occurred on the date stated above, at 5 P. M.

The CAUSE OF DEATH* was as follows:

Accidentally burned by fire. Playing with matches

(Duration) _____ yrs. _____ mos. _____ ds.

Contributory

(Secondary)

(Duration) _____ yrs. _____ mos. _____ ds.

(Signed)

11/25 1913 J. C. Bartlett M. D.
(Address) Bruneau Idaho

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death _____ yrs. _____ mos. _____ days. In the State _____ yrs. _____ mos. _____ days.

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

Bruneau Idaho Nov. 26 1913

20. UNDERTAKER

ADDRESS

1. PLACE OF DEATH. County of Casper Registration District No. 118 File No. 6011
City of Albion (No. _____ St.) Registered No. _____
If death occurs away from usual residence, give facts called for under special information. 2. FULL NAME Archie Lorenzo Howell
If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX Male 4. COLOR OR RACE white 5. SINGLE, MARRIED, WIDOWED OR DIVORCED. Single
6. DATE OF BIRTH Sept 28 1862
(Month) (Day) (Year)
7. AGE 51 yrs 0 mos 20 ds.
IF LESS than 1 day how many hrs. or mins.?
8. OCCUPATION (a) Trade, profession or particular kind of work Miner
(b) General nature of industry business, or establishment in which employed (or employer)
9. BIRTHPLACE (State or Country) Unknown
10. NAME OF FATHER
11. BIRTHPLACE OF FATHER (State or Country)
12. MAIDEN NAME OF MOTHER
13. BIRTHPLACE OF MOTHER (State or Country)
14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Walter Powell
(Address) Albion Ida
15. Filed _____ 191 _____
Local Registrar W. L. Leman

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH Oct 19 1913
(Month) (Day) (Year)
17. I HEREBY CERTIFY, That I attended deceased from 191____, to 191____,
that I last saw h. alive on 191____,
and that death occurred on the date stated above, at _____ M.
The CAUSE OF DEATH* was as follows:
Burned to death in Hotel fire
(Duration) _____ yrs. _____ mos. _____ ds.
Contributory (Secondary)
(Duration) _____ yrs. _____ mos. _____ ds.
(Signed) L. B. Gallagher Coroner M. B.
Oct 21 1913 (Address) Albion Ida
*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.
18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death _____ yrs. _____ mos. _____ days. In the State _____ yrs. _____ mos. _____ days.
Where was disease contracted if not at place of death?
Former or usual residence _____
19. PLACE OF BURIAL OR REMOVAL Albion Ida DATE OF BURIAL Oct 20 1913
20. UNDERTAKER Walter Powell ADDRESS Albion Ida

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Form V. S. No. 5, 20M.1-16-12

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics
File No. **6012**

1. PLACE OF DEATH.

Registration District No. **145**

County of **Boise**

Primary Registration District No. **2203**

City of **Roseberry**

(No. _____, _____ St.)

Registered No. _____

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME **Walter Conrad Ruuska**

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX

Male

4. COLOR OR RACE

White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED
Married
(Write the word.)

6. DATE OF BIRTH

December 30 1887
(Month) **12** (Day) (Year)

7. AGE

55 yrs. 9 mos. 14 ds.

IF LESS than 1 day
how many _____ hrs. or
_____ mins?

8. OCCUPATION

(a) Trade, profession or particular kind of work

(b) General nature of industry business, or establishment in which employed (or employer)

Farmer

9. BIRTHPLACE

(State or Country)

Finland

10. NAME OF FATHER

Samuel Ruuska

11. BIRTHPLACE OF FATHER

(State or Country)

Finland

12. MAIDEN NAME OF MOTHER

Kaisa Moosio

13. BIRTHPLACE OF MOTHER

(State or Country)

Finland

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

Mrs. Walter Ruuska

(Address)

Roseberry, Idaho

15.

Filed

Nov. 15

1913

G. H. Compton
Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

Oct 13 1913
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from **Oct 13 1913** to **Oct 13 1913** that I last saw him alive on **Oct 13 1913** and that death occurred on the date stated above, at **M.**

The CAUSE OF DEATH* was as follows:

Myocardial degeneration

(Duration) **10** yrs. **10** mos. **10** ds.

Contributory (Secondary)

Arteriosclerosis

(Duration) _____ yrs. _____ mos. _____ ds.

(Signed)

Houston B. Rydman, D.

19

(Address) **McCall Idaho**

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death _____ yrs. _____ mos. _____ days. In the State _____ yrs. _____ mos. _____ days.

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

Roseberry Idaho

191

20. UNDERTAKER

ADDRESS

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Form V. S. No. 5 20M.1-16-12

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

File No. 3 6013
Registered No. 106

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

1. PLACE OF DEATH

Registration District No. _____

County of Bannock

Primary Registration District No. _____

City of Pocatello

(No. Paul Norpatal St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

Benj. M. Iverson

PERSONAL AND STATISTICAL PARTICULARS

3. SEX

Male

4. COLOR OR RACE

White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED

Married
(Write the words)

6. DATE OF BIRTH

Nov.

5

1854

(Month)

(Day)

(Year)

7. AGE

58

11

25

ds.

IF LESS than 1 day
how many hrs. or
..... mins.?

8. OCCUPATION

(a) Trade, profession or particular kind of work

(b) General nature of industry, business, or establishment in which employed (or employer)

Rancher

9. BIRTHPLACE

(State or Country)

Norway

10. NAME OF FATHER

Nave. Iverson

11. BIRTHPLACE OF FATHER

(State or Country)

Norway

12. MAIDEN NAME OF MOTHER

Maria Johanson

13. BIRTHPLACE OF MOTHER

(State or Country)

Norway

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

Mrs. Hannah Christensen

(Address)

Pocatello Ida

15.

Filed

191

of Pocatello

Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

Oct

30

1913

(Month)

(Day)

(Year)

17. I HEREBY CERTIFY, That I attended deceased from Oct 23 1913, to Oct 30 1913

that I last saw him alive on Oct 30 1913

and that death occurred on the date stated above, at 7 A.M.

The CAUSE OF DEATH* was as follows:

Lobar pneumonia

(Duration)

yrs.

mos.

ds.

Contributory
(Secondary)

(Duration)

yrs.

mos.

ds.

(Signed)

Oct 31 1913

(Address)

Pocatello

M. D.

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death

.....yrs.....mos.....days.

In the State

.....yrs.....mos.....days.

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

Blackfoot Idaho

191

20. UNDERTAKER

ADDRESS

M. Wacker Pocatello Ida

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Form V. S. No. 5 20M.1-16-12

1. PLACE OF DEATH.

County of *Bannock*City of *Idaho Falls*

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

Registration District No. _____

Primary Registration District No. _____

(No. *544*, *Do Arthur* St.)State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

File No. _____

Registered No. _____

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX

Female

4. COLOR OR RACE

White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED.

Married
(Write the word.)

6. DATE OF BIRTH

July
(Month)*8*
(Day)*1870*
(Year)

7. AGE

43 yrs. *2* mos. *30* ds.IF LESS than 1 day
how many hrs. or
..... mins.?

8. OCCUPATION

(a) Trade, profession or particular kind of work

(b) General nature of industry, business, or establishment in which employed (or employer)

Housewife

9. BIRTHPLACE

(State or Country)

Shelby Ohio

10. NAME OF FATHER

Michael Sullivan

11. BIRTHPLACE OF FATHER

(State or Country)

Ireland

12. MAIDEN NAME OF MOTHER

Mary Mead

13. BIRTHPLACE OF MOTHER

(State or Country)

Ireland

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

(Address)

Mr. Paul Roberts
Idaho Falls

15.

Filed

Oct 7 191*3**Of Idaho Falls*

Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH

Oct

(Month)

7
(Day)

191

(Year)

17. I HEREBY CERTIFY, That I attended deceased from *Sept 20th* 191*3*, to *Oct 7* 191*3*,that I last saw him alive on *Oct 7* 191*3*,and that death occurred on the date stated above, at *5:25* P. M.

The CAUSE OF DEATH* was as follows:

Myocarditis

(Duration)

yrs.

mos.

ds.

Contributory

(Secondary)

(Duration)

yrs.

mos.

ds.

(Signed)

Oct 7 191*3*

(Address)

Dr. Smith & Wadley, M.D.
Practicing Idaho

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place

of death

yrs.

mos.

days.

In the

State

yrs.

mos.

days.

Where was disease contracted
if not at place of death?Former or
usual residence

19. PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

*At Newbury**Oct 9* 191*3*

20. UNDERTAKER

ADDRESS

W. H. MacKay
Idaho Falls Idaho

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
 N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Form V. S. No. 5 20M.1-16-12

CERTIFICATE OF DEATH

 State of Idaho
 BOARD OF HEALTH
 Bureau of Vital Statistics

1. PLACE OF DEATH

Registration District No. 24

County of

Primary Registration District No.

City of

(No.

St.)

File No.

Registered No.

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX

4. COLOR OR RACE

5. SINGLE, MARRIED, WIDOWED OR DIVORCED.

6. DATE OF BIRTH

7. AGE

 IF LESS than 1 day
 how many hrs. or
 mins.?

8. OCCUPATION

- (a) Trade, profession or particular kind of work
 (b) General nature of industry, business, or establishment in which employed (or employer)

9. BIRTHPLACE

(State or Country)

10. NAME OF FATHER

11. BIRTHPLACE OF FATHER

(State or Country)

12. MAIDEN NAME OF MOTHER

13. BIRTHPLACE OF MOTHER

(State or Country)

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

(Address)

15.

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH

17. I HEREBY CERTIFY, That I attended deceased from

that I last saw him alive on

and that death occurred on the date stated above, at

The CAUSE OF DEATH* was as follows:

Contributory (Secondary)

(Signed)

19

(Address)

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death. yrs. mos. days. In the State. yrs. mos. days.

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

20. UNDERTAKER

ADDRESS

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
 Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Form V. S. No. 5 20M.1-16-12

CERTIFICATE OF DEATH

 State of Idaho
 BOARD OF HEALTH
 Bureau of Vital Statistics

1. PLACE OF DEATH

Registration District No.

County of

Primary Registration District No.

City of

(No. 436 S. Hayes St.)

File No.

Registered No.

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX

4. COLOR OR RACE

5. SINGLE, MARRIED, WIDOWED OR DIVORCED

6. DATE OF BIRTH

7. AGE

 IF LESS than 1 day
 how many hrs. or
 mins.?

8. OCCUPATION

(a) Trade, profession or particular kind of work

(b) General nature of industry business, or establishment in which employed (or employer)

9. BIRTHPLACE

(State or Country)

10. NAME OF FATHER

11. BIRTHPLACE OF FATHER

(State or Country)

12. MAIDEN NAME OF MOTHER

13. BIRTHPLACE OF MOTHER

(State or Country)

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

(Address)

15.

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

17. I HEREBY CERTIFY, That I attended deceased from

that I last saw her alive on

and that death occurred on the date stated above, at M.

The CAUSE OF DEATH* was as follows:

(Duration)

Contributory (Secondary)

(Signed)

Oct 13 1913 (Address)

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death yrs. mos. days. In the State yrs. mos. days.

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

20. UNDERTAKER

ADDRESS

Filed Oct 14 1913

Local Registrar

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Form V. S. No. 5 20M.1-16-12

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics
File No. 3 6017
Registered No. 99
If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

1. PLACE OF DEATH
County of Sanborn
City of Procatillo
Registration District No. _____
Primary Registration District No. _____
(No. Genl Hospital St.)
If death occurs away from usual residence, give facts called for under special information. 2. FULL NAME Henry Day

PERSONAL AND STATISTICAL PARTICULARS

3. SEX Male 4. COLOR OR RACE Negro 5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.)
6. DATE OF BIRTH _____
(Month) _____ (Day) _____ (Year) _____

7. AGE _____ yrs. _____ mos. _____ ds.
IF LESS than 1 day how many _____ hrs. or _____ mins.?

8. OCCUPATION
(a) Trade, profession or particular kind of work Laborer
(b) General nature of industry business, or establishment in which employed (or employer) _____

9. BIRTHPLACE
(State or Country) _____

10. NAME OF FATHER _____

11. BIRTHPLACE OF FATHER
(State or Country) _____

12. MAIDEN NAME OF MOTHER _____

13. BIRTHPLACE OF MOTHER
(State or Country) _____

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) M. M. Macker
(Address) Procatillo Ida

15. Filed Oct 28 1913 OP Stee
Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH
10 21 1913
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from 10 - 21 1913, to 10 - 21 1913, that I last saw him alive on Oct. 21 1913, and that death occurred on the date stated above, at 6:30 P.M.

The CAUSE OF DEATH* was as follows:
Shock

(Duration) _____ yrs. _____ mos. _____ ds.
Contributory Double amputation
(Secondary) both legs
(Duration) _____ yrs. _____ mos. _____ ds.
(Signed) Dr. Roberts M. D.
10/25 1913 (Address) _____

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death _____ yrs. _____ mos. _____ days. In the State _____ yrs. _____ mos. _____ days.
Where was disease contracted if not at place of death? _____

Former or usual residence _____

19. PLACE OF BURIAL OR REMOVAL St. Hew Cemetery DATE OF BURIAL Oct 28 1913

20. UNDERTAKER M. M. Macker ADDRESS Procatillo

Form V. S. No. 5 20M.1-16-12

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH

Registration District No.

County of *Blainville*

Primary Registration District No.

City of *Procatello*(No. *Ranch* St.)File No. *3 601*Registered No. *100*

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME *Geo Gordon*

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX

Male

4. COLOR OR RACE

White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED.

Married
(Write the words)

6. DATE OF BIRTH

Aug 2 1856
(Month) (Day) (Year)

7. AGE

*57 yrs 2 mos 20 ds.*IF LESS than 1 day
how many hrs. or
..... mins.?

8. OCCUPATION

(a) Trade, profession or particular kind of work

Rancher

(b) General nature of industry business, or establishment in which employed (or employer)

9. BIRTHPLACE

(State or Country)

Wisconsin

10. NAME OF FATHER

Thomas Gordon

11. BIRTHPLACE OF FATHER

(State or Country)

Norway

12. MAIDEN NAME OF MOTHER

13. BIRTHPLACE OF MOTHER

(State or Country)

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

(Address)

Geo Gordon
Procatello

15.

Filed

Oct 22 1913
O. B. Steeg
Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH

Oct 22 1913
(Month) (Day) (Year)17. I HEREBY CERTIFY, That I attended deceased from *Oct 6th* 191*3*, to *Oct 22* 191*3*,
that I last saw him alive on *Oct 22* 191*3*,
and that death occurred on the date stated above, at *7:30* P. M.

The CAUSE OF DEATH* was follows:

Typhoid fever.

(Duration) yrs. mos. ds.

Contributory
(Secondary)

(Duration) yrs. mos. ds.

(Signed) *Wm H. Wadley* M. D.*Oct 22 1913* (Address) *Procatello Idaho*

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death yrs. mos. days. In the State yrs. mos. days.

Where was disease contracted if not at place of death?

Former or usual residence.

19. PLACE OF BURIAL OR REMOVAL DATE OF BURIAL

At New Cuckin *Oct 26* 191*3*

20. UNDERTAKER ADDRESS

P. H. Walker *Procatello*

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Form V. S. No. 5 20M.1-16-12

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH

Registration District No.

County of

Primary Registration District No.

City of

(No.

St.)

File No.

Registered No.

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX

4. COLOR OR RACE

5. SINGLE, MARRIED, WIDOWED OR DIVORCED.

6. DATE OF BIRTH

7. AGE

IF LESS than 1 day
how many hrs. or
..... mins.?

8. OCCUPATION

(a) Trade, profession or particular kind of work
(b) General nature of industry, business, or establishment in which employed (or employer)

9. BIRTHPLACE

(State or Country)

10. NAME OF FATHER

11. BIRTHPLACE OF FATHER

(State or Country)

12. MAIDEN NAME OF MOTHER

13. BIRTHPLACE OF MOTHER

(State or Country)

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

(Address)

15.

Filed

1913

Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH

(Month)

(Day)

191

(Year)

17. I HEREBY CERTIFY, That I attended deceased from

that I last saw him alive on

and that death occurred on the date stated above, at

The CAUSE OF DEATH* was as follows

(Duration)

yrs.

mos.

ds.

Contributory
(Secondary)

(Duration)

yrs.

mos.

ds.

(Signed)

(Address)

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place

of death yrs. mos. days.

In the

State yrs. mos. days.

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

20. UNDERTAKER

ADDRESS

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Form V. S. No. 5 20M.1-16-12

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH

Registration District No.

County of

Primary Registration District No.

City of

(No.

St.)

File No.

Registered No.

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX

4. COLOR OR RACE

5. SINGLE, MARRIED, WIDOWED OR DIVORCED

6. DATE OF BIRTH

7. AGE

IF LESS than 1 day how many hrs. or mins.?

8. OCCUPATION

(a) Trade, profession or particular kind of work
(b) General nature of industry business, or establishment in which employed (or employer)

9. BIRTHPLACE

(State or Country)

10. NAME OF FATHER

11. BIRTHPLACE OF FATHER

(State or Country)

12. MAIDEN NAME OF MOTHER

13. BIRTHPLACE OF MOTHER

(State or Country)

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

(Address)

15.

Filed

191

Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

17. I HEREBY CERTIFY, That I attended deceased from

that I last saw him alive on

and that death occurred on the date stated above, at

The CAUSE OF DEATH* was as follows:

(Duration) yrs. mos. ds.

Contributory (Secondary)

(Duration) yrs. mos. ds.

(Signed)

(Address)

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death yrs. mos. days. In the State yrs. mos. days.

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL DATE OF BURIAL

20. UNDERTAKER

ADDRESS

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Form V. S. No. 5 20M.1-16-12

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics
File No. 6021
Registered No. 91

1. PLACE OF DEATH.

Registration District No. 73

County of

Primary Registration District No. 2150

City of

(No.)

St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

Infant Fowler

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX

4. COLOR OR RACE

5. SINGLE, MARRIED, WIDOWED OR DIVORCED.

Female White

Single
(Write the word.)

6. DATE OF BIRTH

Nov. 16 1913
(Month) (Day) (Year)

7. AGE

.....yrs.mos. 2 ds.

IF LESS than 1 day
how manyhrs. or
.....mins.?

8. OCCUPATION

(a) Trade, profession or particular kind of work

None

(b) General nature of industry business, or establishment in which employed (or employer)

9. BIRTHPLACE

(State or Country)

Bonneville

10. NAME OF FATHER

John Fowler

11. BIRTHPLACE OF FATHER

(State or Country)

Ill.

12. MAIDEN NAME OF MOTHER

Ellen Moore

13. BIRTHPLACE OF MOTHER

(State or Country)

Utah

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

(Address)

Idaho Falls Idaho

15.

Filed

2015 1913

Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

Nov 18 1913
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from

Nov 16 1913, to Nov 17 1913,
that I last saw her alive on Nov 17 1913

and that death occurred on the date stated above, at 3:45 A.M.

The CAUSE OF DEATH* was as follows:

Malformation heart

(Duration)yrs.mos.ds.

Contributory

(Secondary)

(Duration)yrs.mos.ds.

(Signed)

Nov 18 1913

(Address) Idaho Falls Idaho

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of deathyrs.mos.days. In the Stateyrs.mos.days.

Where was disease contracted if not at place of death?.....

Former or usual residence.....

19. PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

Idaho Falls

Nov. 18 1913

20. UNDERTAKER

ADDRESS

Idaho Falls

Idaho Falls

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Form V. S. No. 5 20M.1-16-12

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH.

Registration District No. 73

County of Bannock

Primary Registration District No. 210

City of Idaho Falls

(No. _____, St.)

File No. 6023

Registered No. 89

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

Geo. Butler

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX

Male

4. COLOR OR RACE

White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED.

Single
(Write the word.)

6. DATE OF BIRTH

May
(Month)

24
(Day)

1880
(Year)

7. AGE

33 yrs. 6 mos. 2 ds.

IF LESS than 1 day
how many hrs. or
..... mins.?

8. OCCUPATION

(a) Trade, profession or particular kind of work
(b) General nature of industry, business, or establishment in which employed (or employer)

Painter

9. BIRTHPLACE

(State or Country)

Nebraska

10. NAME OF FATHER

G. W. Butler

11. BIRTHPLACE OF FATHER

(State or Country)

Ill.

12. MAIDEN NAME OF MOTHER

P. Dungan

13. BIRTHPLACE OF MOTHER

(State or Country)

Ind.

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

Mr. M. Brocksome

(Address)

Idaho Falls

15.

Filed

Nov 25 1913 C. J. ...
Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH

Nov
(Month)

26
(Day)

1913
(Year)

17. I HEREBY CERTIFY, That I attended deceased from

11-15-13 1913, to 11-25-13 1913,

that I last saw him alive on 11-25-13 1913,

and that death occurred on the date stated above, at A M.

The CAUSE OF DEATH* was as follows:

Typhoid fever.

(Duration) 6 yrs. 1 mos. 0 ds.

Contributory
(Secondary)

(Duration) _____ yrs. _____ mos. _____ ds.

(Signed) J. M. Bridges M. D.

11-25-13 (Address) Idaho Falls, Idaho.

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death yrs. mos. days. In the State yrs. mos. days.

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL DATE OF BURIAL

Idaho Falls 11/28 1913

20. UNDERTAKER ADDRESS

C. E. Hinwood Idaho Falls

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Form V. S. No. 5 20M.1-16-12

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH.

Registration District No. 73

County of Bonner

Primary Registration District No. 2150

City of Idaho Falls

(No. _____, _____ St.)

File No. 6024

Registered No. 88

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

Q. B. Jones

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX

Male

4. COLOR OR RACE

White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED.

Single
(Write the word.)

6. DATE OF BIRTH

? _____ 1 _____
(Month) (Day) (Year)

7. AGE

53 yrs. _____ mos. _____ ds.

IF LESS than 1 day
how many _____ hrs. or
_____ mins.?

8. OCCUPATION

(a) Trade, profession or particular kind of work
(b) General nature of industry, business, or establishment in which employed (or employer)

Employed in
City State

9. BIRTHPLACE

(State or Country) ?

10. NAME OF FATHER

?

11. BIRTHPLACE OF FATHER

(State or Country) ?

12. MAIDEN NAME OF MOTHER

?

13. BIRTHPLACE OF MOTHER

(State or Country) ?

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) W. J. Jones

(Address) Idaho Falls, Idaho

15.

Filed Nov 25 1913

1913

W. J. Jones
Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH

Nov 24 1913
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from

August 15 1913, to Sept 15 1913

that I last saw him alive on Sept 15 1913

and that death occurred on the date stated above, at 10 P.M.

The CAUSE OF DEATH* was as follows:

Carcinoma of stomach

(Duration) ? yrs. _____ mos. _____ ds.

Contributory
(Secondary)

(Duration) _____ yrs. _____ mos. _____ ds.

(Signed) W. J. Jones M. D.

125 1913 (Address) Idaho Falls, Idaho

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death _____ yrs. _____ mos. _____ days. In the State _____ yrs. _____ mos. _____ days.

Where was disease contracted if not at place of death?

Former or usual residence _____

19. PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

Idaho Falls

11-28 1913

20. UNDERTAKER

ADDRESS

Idaho Falls

Idaho Falls

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Form V. S. No. 5 20M.1-16-12

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH.

Registration District No. 73

County of Bannock

Primary Registration District No. 214-0

City of Idaho Falls

(No. —, 8 St. St.)

File No. 6025

Registered No. 87

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Augustus W. Pearson Jr.

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX Male 4. COLOR OR RACE White 5. SINGLE, MARRIED, WIDOWED OR DIVORCED. Child
(Write the word.)

6. DATE OF BIRTH

Nov 13 1918
(Month) (Day) (Year)

7. AGE

x yrs. x mos. 8 ds.

IF LESS than 1 day
how many hrs. or
..... mins.?

8. OCCUPATION

(a) Trade, profession or particular kind of work
(b) General nature of industry, business, or establishment in which employed (or employer)

Baby

9. BIRTHPLACE

(State or Country)

Idaho

10. NAME OF FATHER

Augustus W. Pearson

11. BIRTHPLACE OF FATHER

(State or Country)

Idaho

12. MAIDEN NAME OF MOTHER

Ada B. Jensen

13. BIRTHPLACE OF MOTHER

(State or Country)

Idaho

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

A. W. Pearson

(Address)

Idaho Falls

15.

Filed

Apr 22 1913

E. G. Denwood
Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH

Nov 21 1918
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from

Nov 13 1918, to Nov 21 1918,

that I last saw him alive on Nov 21 1918,

and that death occurred on the date stated above, at 4 P. M.

The CAUSE OF DEATH* was as follows:

Premature Birth

(Duration) yrs. mos. ds.

Contributory
(Secondary)

(Duration) yrs. mos. ds.

(Signed) E. M. Blinn M. D.

1122 1913 (Address) Idaho Falls, Ida

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death.....yrs.....mos.....days. In the State.....yrs.....mos.....days.

Where was disease contracted if not at place of death?.....

Former or usual residence.....

19. PLACE OF BURIAL OR REMOVAL DATE OF BURIAL

Idaho Falls 11/23 1918

20. UNDERTAKER

ADDRESS

E. G. Denwood Idaho Falls

MARGIN RESERVED FOR BINDING
WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Form V. S. No. 5 20M.1-16-12

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH.

Registration District No. 73

County of Bonner

Primary Registration District No. 2157

City of Idaho Falls

(No. _____ St.)

File No. 6025

Registered No. 76

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

Charles Marshfield

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX

Male

4. COLOR OR RACE

White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED.

Single
(Write the word.)

6. DATE OF BIRTH

?

(Month)

(Day)

(Year)

7. AGE

..... yrs. mos. ds.

IF LESS than 1 day
how many hrs. or
..... mins.?

8. OCCUPATION

(a) Trade, profession or particular kind of work
(b) General nature of industry business, or establishment in which employed (or employer)

Farm hand

9. BIRTHPLACE

(State or Country)

10. NAME OF FATHER

11. BIRTHPLACE OF FATHER

(State or Country)

12. MAIDEN NAME OF MOTHER

13. BIRTHPLACE OF MOTHER

(State or Country)

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

B. E. Dimwooder

(Address)

Idaho Falls

15.

Filed

Nov 6

1913

[Signature]

Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH

Nov

1

1913

(Month)

(Day)

(Year)

17. I HEREBY CERTIFY, That I attended deceased from

Oct 31 1913, to Nov 1 1913,

that I last saw him alive on Nov. 12 1913,

and that death occurred on the date stated above, at 2 a.m.

The CAUSE OF DEATH* was as follows:

mercurial poisoning
accidental

(Duration) yrs. mos. ds.

Contributory

(Secondary)

(Duration) yrs. mos. ds.

(Signed)

E. M. Cline, A. M. D.

11/6 1913 (Address) Idaho Falls, Ida

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place

of death yrs. mos. days.

In the

State yrs. mos. days.

Where was disease contracted if not at place of death?

Former or

usual residence.

19. PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

Idaho Falls

11/6 1913

20. UNDERTAKER

ADDRESS

B. E. Dimwooder, Idaho Falls

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Form V. S. No. 5 20M.1-16-12

CERTIFICATE OF DEATH

 State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

 1. PLACE OF DEATH
 County of Bonneville
 City of Idaho Falls
 Registration District No. 73
 Primary Registration District No. 2150
 (No. _____, _____ St.)

 File No. 602
 Registered No. 70

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Belzora King

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

 3. SEX Female 4. COLOR OR RACE White 5. SINGLE, MARRIED, WID-
 OWED OR DIVORCED. Married
 (Write the word.)

6. DATE OF BIRTH

Jan. 17, 1853
 (Month) (Day) (Year)

7. AGE

60 yrs 8 mos 17 ds.

 IF LESS than 1 day
 how many _____ hrs., or
 _____ mins.?

8. OCCUPATION

 (a) Trade, profession or particular kind of work Housewife
 (b) General nature of industry business, or establishment in which employed (or employer)

9. BIRTHPLACE

(State or Country)

Missouri
Wm. S. Siple
Frank S. Siple

10. NAME OF FATHER

11. BIRTHPLACE OF FATHER

(State or Country)

12. MAIDEN NAME OF MOTHER

Mauda Wilson

13. BIRTHPLACE OF MOTHER

(State or Country)

Missouri

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

David King

(Address)

Idaho

15.

 Filed Oct. 10 1913

Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

October 4 1913
 (Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from

191, to 191,

 that I last saw him alive on 191,

 and that death occurred on the date stated above, at 7 A. M.

The CAUSE OF DEATH* was as follows:

Paralysis and
diabetes - no medical
attendance

(Duration) _____ yrs. _____ mos. _____ ds.

Contributory

(Secondary)

(Duration) _____ yrs. _____ mos. _____ ds.

(Signed)

Wm. S. Siple M. D.
Oct. 10 1913 (Address) Idaho Falls

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death.....yrs.....mos.....days. In the State.....yrs.....mos.....days.

Where was disease contracted if not at place of death?

Former or usual residence.

19. PLACE OF BURIAL OR REMOVAL DATE OF BURIAL

Iona, Ida. Oct. 5 1913

20. UNDERTAKER

ADDRESS

M.T. Peck & SonsRigby, Ida.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Form V. S. No. 5 20M.1-16-12

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH. Registration District No. 121
County of Blaine Primary Registration District No. 1007 File No. 6028
City of Blackfoot (No. Hospital Trans St.) Registered No. 115
If death occurs away from usual residence, give facts called for under special information. 2. FULL NAME George F. Buechner
If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX M 4. COLOR OR RACE W 5. SINGLE, MARRIED, WIDOWED OR DIVORCED. Single
(Write the word.)

6. DATE OF BIRTH Sept 26 1890
(Month) (Day) (Year)

7. AGE 23 yrs. 2 mos. 3 ds. IF LESS than 1 day how many hrs. or mins.?

8. OCCUPATION
(a) Trade, profession or particular kind of work Machinist
(b) General nature of industry business, or establishment in which employed (or employer)

9. BIRTHPLACE Chicago Ill
(State or Country)

10. NAME OF FATHER Wm. Buechner

11. BIRTHPLACE OF FATHER Germany
(State or Country)

12. MAIDEN NAME OF MOTHER Katharine Atzl

13. BIRTHPLACE OF MOTHER Chicago Ill
(State or Country)

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Chas Buechner
(Address) 1238 E. 13th Ave

15. Filed Nov 3 1913 M. E. Patrice
Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH Nov 29 1913
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from Nov 27 1913, to Nov 29 1913
that I last saw him alive on Nov 28 1913
and that death occurred on the date stated above, at 3 A. M.

The CAUSE OF DEATH* was as follows:
Septic Peritonitis following operation for appendicitis
(Duration) yrs. mos. 1 ds.

Contributory (Secondary)
(Duration) yrs. mos. ds.
(Signed) R. Davis M. D.
(Address) Blackfoot Ida

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death yrs. mos. 2 days. In the State yrs. 2 mos. days.

Where was disease contracted if not at place of death?
Former or usual residence Denver Colo.

19. PLACE OF BURIAL OR REMOVAL Shinn Coal DATE OF BURIAL 191.....

20. UNDERTAKER E. F. Rich ADDRESS Blackfoot Idaho

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Form V. S. No. 5 20M.1-16-12

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH.

Registration District No. 121

County of Bingham

Primary Registration District No. 2196

City of Fort Hall

(No. _____, _____ St.)

File No. 6029

Registered No. 114

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Benjamin Olson

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX

4. COLOR OR RACE

5. SINGLE, MARRIED, WIDOWED OR DIVORCED.

Male

White

Married
(Write the word.)

6. DATE OF BIRTH

_____. 1. _____
(Month) (Day) (Year)

7. AGE

37 yrs. _____ mos. _____ ds.

IF LESS than 1 day
how many _____ hrs. or
_____ mins.?

8. OCCUPATION

(a) Trade, profession or particular kind of work

Laborer

(b) General nature of industry business, or establishment in which employed (or employer)

9. BIRTHPLACE

(State or Country)

Unknown

10. NAME OF FATHER

Unknown

11. BIRTHPLACE OF FATHER

(State or Country)

Unknown

12. MAIDEN NAME OF MOTHER

Unknown

13. BIRTHPLACE OF MOTHER

(State or Country)

Unknown

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Rosa Olson

(Address) Fort Hall, E. J. Park

15.

Filed Dec 2 1913

M. E. O'Leary
Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH

Nov 28 1913
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from

191____, to 191____,
that I last saw h_____ alive on 191____,

and that death occurred on the date stated above, at 10 AM.

The CAUSE OF DEATH* was as follows:

Gunshot Wound in heart
Suicidal

(Duration) _____ yrs. _____ mos. _____ ds.

Contributory
(Secondary)

(Duration) _____ yrs. _____ mos. _____ ds.

(Signed) E. J. Park M.D.
19____ (Address) Blackfoot

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death _____ yrs. _____ mos. _____ days. In the State _____ yrs. _____ mos. _____ days.

Where was disease contracted if not at place of death?

Former or usual residence _____

19. PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

Green City cemetery

Dec 2 1913

20. UNDERTAKER

ADDRESS

E. J. Park

Blackfoot

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Form V. S. No. 5 20M.1-16-12

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH.

Registration District No. 121

County of

Primary Registration District No. 219H

City of

(No. _____, _____ St.)

File No. 6039

Registered No. 113

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

George S. Glover (Glover)

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX

Male

4. COLOR OR RACE

White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED.

Widowed
(Write the word.)

6. DATE OF BIRTH

(Month)

(Day)

(Year)

7. AGE

52 yrs.

mos.

ds.

IF LESS than 1 day
how many hrs. or
..... mins.?

8. OCCUPATION

(a) Trade, profession or particular kind of work

Carpenter

(b) General nature of industry business, or establishment in which employed (or employer)

9. BIRTHPLACE

(State or Country)

Canada

10. NAME OF FATHER

Unknown

11. BIRTHPLACE OF FATHER

(State or Country)

Unknown

12. MAIDEN NAME OF MOTHER

Unknown

13. BIRTHPLACE OF MOTHER

(State or Country)

Unknown

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

George E. Hyde

(Address)

Blackfoot, Idaho

15.

Filed

Nov 13 1913

M. E. Postrie

Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH

November

30

1913

(Month)

(Day)

(Year)

17. I HEREBY CERTIFY, That I attended deceased from

July 1st 1913, to Nov 30th 1913,

that I last saw him alive on Nov 30th 1913

and that death occurred on the date stated above, at 6 AM.

The CAUSE OF DEATH* was as follows:

General Paralysis of Insane

(Duration)

Unknown

yrs.

mos.

ds.

Contributory (Secondary)

Unknown

(Duration)

Unknown

yrs.

mos.

ds.

(Signed)

Dec 12 1913

(Address)

Blackfoot

M. D.

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place

5 yrs.

2 mos.

10 days.

In the

30 yrs.

mos.

days.

Where was disease contracted if not at place of death?

Don't know

Former or usual residence

Boise, Idaho

19. PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

Boise Idaho

Dec 12 1913

20. UNDERTAKER

ADDRESS

E. F. Hick

Blackfoot

CERTIFICATE OF DEATH.

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH.

Registration District No. 121County of BlainePrimary Registration District No. 2194City of Blackfoot

(No. _____ St.)

File No. 6031Registered No. 112

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

Margie Lee

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX

4. COLOR OR RACE

5. SINGLE, MARRIED, WIDOWED OR DIVORCED.

FemaleWhite6
(Write the word.)

6. DATE OF BIRTH.

Oct.
(Month)14.
(Day)1913
(Year)

7. AGE

1 Yrs. 12 Mos. 2 ds.IF LESS than 1 day
how many hrs. or
..... min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work...
(b) General nature of industry, business, or establishment in which employed (or employer).....

9. BIRTHPLACE

(State or Country)

Tabor Idaho

10. NAME OF FATHER

John Lee

11. BIRTHPLACE OF FATHER

(State or Country)

Kennett

12. MAIDEN NAME OF MOTHER

Edna Bailey
Madison Monroe

13. BIRTHPLACE OF MOTHER

(State or Country)

Kennett

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant)

Ira Lee

(Address)

Tabor Idaho

15.

Filed

Nov. 27th 1913W.E. Patie

Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

Nov.
(Month)26th
(Day)1913
(Year)17. I HEREBY CERTIFY, That I investigated
death attended deceased from 191 to 191that I last saw him alive on 191
and that death occurred on the date stated above, at 5:30 P.M.

The CAUSE OF DEATH* was as follows:

Broncho - Pneumonia.(Duration) _____ Yrs. _____ mos. 10 ds.Contributory
(Secondary)

(Duration) _____ Yrs. _____ mos. _____ ds.

(Signed)

W.E. Patie M. D.

(Address)

Blackfoot Ida.

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death.....yrs.....mos.....days In the State.....yrs.....mos.....days

Where was disease contracted if not at place of death?.....

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

Mountain IdahoNov 28 1913

20. UNDERTAKER

ADDRESS

Ira LeeTabor Ida.

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Form V. S. No. 5. 12½M.7-24-11

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics
File No. 6032
Registered No. 111

1. PLACE OF DEATH. Registration District No. 121
County of Bingham Primary Registration District No. 2194
City of Blackfoot R.F.D. No. 1 (No. , St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

Alphon R. Kelley

If death occurred in a hospital, institution or camp give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX Male 4. COLOR OR RACE White 5. SINGLE, MARRIED, WIDOWED OR DIVORCED. Single
(Write the word.)

6. DATE OF BIRTH March 19 1892
(Month) (Day) (Year)

7. AGE 21 yrs. 9 mos. 24 ds. IF LESS than 1 day
how many.....hrs. or.....min?

8. OCCUPATION

(a) Trade, profession or particular kind of work
(b) General nature of industry business or establishment in which employed (or employer)

Farmer

9. BIRTHPLACE
(State or Country)

Utah

10. NAME OF FATHER

Russel S. Kelley

11. BIRTHPLACE OF FATHER
(State or Country)

Utah

12. MAIDEN NAME OF MOTHER

Abigail Bingham

13. BIRTHPLACE OF MOTHER
(State or Country)

Iowa

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) R. S. Kelley
(Address) Blackfoot R.F.D. No. 1

15. Filed Nov 24 1913 W. G. Lattie
Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH

Nov 13 1913
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from Nov 3 1913, to Nov 12 1913.

that I last saw him alive on Nov 12 1913 and that death occurred on the date stated above, at 10 A.M.

The CAUSE OF DEATH* was as follows:

Typhoid Fever
3 week

(Duration) yrs. mos. ds.

Contributory
(Secondary)

(Duration) yrs. mos. ds.

(Signed) John B. Cooper M. D.
19 (Address) Blackfoot

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place In the
of death yrs. mos. ds. State yrs. mos. ds.

Where was disease contracted,

If not at place of death?

Former or
usual residence.

19. PLACE OF BURIAL OR REMOVAL DATE OF BURIAL

Goodland Ida Nov 14 1913

20. UNDERTAKER

ADDRESS

R. S. Kelley Blackfoot
R.F.D. No. 4

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Form V. S. No. 5 20M.1-16-12

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics
File No. 6034

1. PLACE OF DEATH.

Registration District No. 121County of BinghamPrimary Registration District No. 2194City of Blackfoot (No. Thomson) (St.)Registered No. 108

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

Isaac Robert Johnson

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX

4. COLOR OR RACE

5. SINGLE, MARRIED, WIDOWED OR DIVORCED.

MaleWhitemarried
(Write the word.)

6. DATE OF BIRTH

March211870

(Month)

(Day)

(Year)

7. AGE

43 yrs. 7 mos. 25 ds.

IF LESS than 1 day
how many hrs. or
..... mins.?

8. OCCUPATION

(a) Trade, profession or particular kind of work

Farmer

(b) General nature of industry business, or establishment in which employed (or employer)

9. BIRTHPLACE

(State or Country)

North Carolina

10. NAME OF FATHER

Lewis Johnson

11. BIRTHPLACE OF FATHER

(State or Country)

North Carolina

12. MAIDEN NAME OF MOTHER

Nancy Whitley

13. BIRTHPLACE OF MOTHER

(State or Country)

North Carolina

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

I. Johnson

(Address)

Blackfoot Idaho R. 2 Box 44

15.

Filed

Nov. 191913M. E. Patric

Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH

Nov171913

(Month)

(Day)

(Year)

17. I HEREBY CERTIFY, That I attended deceased from

Nov 7 1913, to Nov 17 1913that I last saw him alive on Nov 17 1913and that death occurred on the date stated above, at 11:15 P.M.

The CAUSE OF DEATH* was as follows:

Croupous pneumonia(Duration) yrs. mos. 2 ds.

Contributory

(Secondary)

(Duration) yrs. mos. 24 ds.(Signed) H. J. Simmons M. D.117 1913 (Address) Blackfoot Idaho

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death yrs. mos. days. In the State yrs. mos. days.

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

Thomson, Bingham Co. Id.
E. J. Beck Cem.Nov 19 1913

20. UNDERTAKER

ADDRESS

E. J. BeckBlackfoot

CERTIFICATE OF DEATH.

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH.

Registration District No. 121County of Benjamin
City of BlackfootPrimary Registration District No. 1007
(No. 87 North Ash St.)File No. 6035Registered No. 107If death occurs away from
usual residence, give facts
called for under special
information.

2. FULL NAME

Nelson Henry KestnerIf death occurred in a hos-
pital, institution or camp,
give its NAME instead of
street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX Male 4. COLOR OR RACE White 5. SINGLE, MARRIED, WID-
OWED OR DIVORCED. Married
(Write the word.)

6. DATE OF BIRTH.

Feb. 2nd 1879
(Month) (Day) (Year)

7. AGE

34 Yrs. 9 Mos. 5 ds.IF LESS than 1 day
how many hrs. or
min.

8. OCCUPATION

(a) Trade, profession or
particular kind of work...
(b) General nature of in-
dustry, business, or estab-
lishment in which employ-
ed (or employer).....Barber

9. BIRTHPLACE

(State or Country)

Ohio10. NAME OF
FATHERHenry Kestner11. BIRTHPLACE
OF FATHER

(State or Country)

Germany12. MAIDEN NAME
OF MOTHERMary J. Howard13. BIRTHPLACE
OF MOTHER

(State or Country)

Ohio

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Eugene M. Smith
(Address) Blackfoot Idaho15. Nov. 8 1913
FiledW.E. Patrie
Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

Nov. 4th 1913
(Month) (Day) (Year)17. I HEREBY CERTIFY, That I attended deceased from
1911 to Nov. 7th 1913
that I last saw him alive on Nov. 7th 1913
and that death occurred on the date stated above, at Blackfoot M.

The CAUSE OF DEATH* was as follows:

Tuberculosis of lungs(Duration) 3 Yrs. mos. ds.Contributory Edema of legs
(Secondary) & heart. mitral(Duration) Yrs. mos. ds.(Signed) W.E. Patrie M. D.Nov. 8/13 (Address) Blackfoot*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1)
MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.18. LENGTH OF RESIDENCE (For Hospitals, Institutions,
Transients or Recent Residents.)At place of death Yrs. mos. days In the State Yrs. mos. daysWhere was disease contracted
if not at place of death?Former or
usual residence

19. PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

Cross City Am. Blackfoot Nov. 9 1913

20. UNDERTAKER

ADDRESS

Blackfoot

should state CAUSE OF DEATH in plain terms, so that it may be properly classified. See instructions on back of certificate.

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Form V. S. No. 5 20M.1-16-12

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH.

Registration District No. 4

County of Canyon

Primary Registration District No. 1008

City of Payette

(No. , (St.))

File No. 6039

Registered No. 105

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Harry J Cartwright

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX Male

4. COLOR OR RACE White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED Married
(Write the word.)

6. DATE OF BIRTH Aug 21 1888
(Month) (Day) (Year)

7. AGE 25 yrs. 3 mos. 8 ds.

IF LESS than 1 day
how many hrs. or
 mins.?

8. OCCUPATION

(a) Trade, profession or particular kind of work Electrician

(b) General nature of industry, business, or establishment in which employed (or employer)

9. BIRTHPLACE Iowa
(State or Country)

10. NAME OF FATHER J. H. Cartwright

11. BIRTHPLACE OF FATHER Iowa
(State or Country)

12. MAIDEN NAME OF MOTHER Maria E Setzer

13. BIRTHPLACE OF MOTHER Ill.
(State or Country)

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Geo M Wilson

(Address) Payette Ida

15.

Filed Dec 1 1913

Local Registrar J. C. Woodward

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH Nov. 29 1913
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from Nov 4 1913, to Nov 29 1913, that I last saw him alive on Nov 29 1913, and that death occurred on the date stated above, at 11⁵⁰ P. M.

The CAUSE OF DEATH* was as follows:

Typhoid fever

(Duration) 25 yrs. 6 mos. 8 ds.

Contributory (Secondary) Lobar pneumonia

(Duration) 6 yrs. 6 mos. 8 ds.

(Signed) O. H. Avery M. D.

19. (Address) Payette

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death yrs. mos. days. In the State yrs. mos. days.

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL Payette Ida DATE OF BURIAL Dec 1 1913

20. UNDERTAKER H. Eldair

ADDRESS Payette Ida

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Form V. S. No. 5 20M.1-16-12

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH

Registration District No. 4County of CanyonPrimary Registration District No. 1008City of Payette

(No. _____ St.)

File No. 6937Registered No. 104

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Archie Cannon

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX

4. COLOR OR RACE

5. SINGLE, MARRIED, WIDOWED OR DIVORCED.

6. DATE OF BIRTH

7. AGE

IF LESS than 1 day
how many _____ hrs. or
_____ mins.

8. OCCUPATION

(a) Trade, profession or particular kind of work

(b) General nature of industry business, or establishment in which employed (or employer)

9. BIRTHPLACE

(State or Country)

10. NAME OF FATHER

11. BIRTHPLACE OF FATHER

(State or Country)

12. MAIDEN NAME OF MOTHER

13. BIRTHPLACE OF MOTHER

(State or Country)

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

(Address)

15.

Filed

1913

Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

November 20 1913
(Month) (Day) (Year)17. I HEREBY CERTIFY, That I attended deceased from Nov 9 1913, to Nov 20 1913,that I last saw him alive on Nov 20 1913,and that death occurred on the date stated above, at 11 P.M.

The CAUSE OF DEATH* was as follows:

Pulmonary Tuberculosis(Duration) _____ yrs. 6 mos. _____ ds.Contributory obscure
(Secondary)(Duration) _____ yrs. 6 mos. 1 ds.(Signed) E. W. Barton M.D.11-21-1913 (Address) Payette, Ida

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death _____ yrs. _____ mos. _____ days. In the State _____ yrs. _____ mos. _____ days.

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

Payette, Ida Nov 22 1913

20. UNDERTAKER

ADDRESS

J. C. Woodward J. A. McAdair Payette, Ida

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Form V, S. No. 5 20M.1-16-12

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH

Registration District No. 4County of CanyonPrimary Registration District No. 1008File No. 6035City of Payette(No. 103)

St.)

Registered No. 103

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Sarah E. Williams

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX Female4. COLOR OR RACE White5. SINGLE, MARRIED, WIDOWED OR DIVORCED Married
(Write the word.)6. DATE OF BIRTH Dec 6 1851
(Month) (Day) (Year)7. AGE 62 yrs. 11 mos. 18 ds.IF LESS than 1 day
how many hrs. or
..... mins.?8. OCCUPATION Housewife(a) Trade, profession or particular kind of work
(b) General nature of industry, business, or establishment in which employed (or employer)9. BIRTHPLACE Georgia
(State or Country)10. NAME OF FATHER Jas Hutchesson11. BIRTHPLACE OF FATHER Not Known
(State or Country)12. MAIDEN NAME OF MOTHER Sarah E. Hutchesson13. BIRTHPLACE OF MOTHER Georgia
(State or Country)

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Ans L. Williams(Address) Payette Ida15. Filed Nov. 18 1913Local Registrar J. C. Woodward

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH Nov. 17 1913
(Month) (Day) (Year)17. I HEREBY CERTIFY, That I attended deceased from May 24 1913 to Nov. 17 1913that I last saw him alive on Nov. 16 1913and that death occurred on the date stated above, at 7⁰⁰ P. M.

The CAUSE OF DEATH* was as follows:

Gastric Carcinoma(Duration) yrs. 8 mos. ds.Contributory
(Secondary)

(Duration) yrs. mos. ds.

(Signed) J. C. Woodward M. D.Nov. 17 1913 (Address) Payette Idaho

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death yrs. mos. days. In the State yrs. mos. days.

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL Payette IdaDATE OF BURIAL Nov 19 191320. UNDERTAKER J. A. McLeanADDRESS Payette Ida

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Form V. S. No. 5 20M.1-16-12

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH.

Registration District No. 4County of CanyonPrimary Registration District No. 1008City of Payette(No. St.)File No. 6039Registered No. 103

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

Hiltha Hayne

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX

Female

4. COLOR OR RACE

White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED.

Single
(Write the word.)

6. DATE OF BIRTH

June 7 1909
(Month) (Day) (Year)

7. AGE

4 yrs. 5 mos. 1 ds.IF LESS than 1 day
how many hrs. or
..... mins.?

8. OCCUPATION

(a) Trade, profession or particular kind of work

(b) General nature of industry business, or establishment in which employed (or employer)

Infant

9. BIRTHPLACE

(State or Country)

Idaho

10. NAME OF FATHER

H. C. Hayne

11. BIRTHPLACE OF FATHER

(State or Country)

Wis

12. MAIDEN NAME OF MOTHER

Lou Hurlburt

13. BIRTHPLACE OF MOTHER

(State or Country)

Colo.

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

H. S. Hayne

(Address)

15.

Filed

Nov. 81913J. C. Woodward
Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH

Nov. 8 1913
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from

Nov 7 1913, to Nov 7 1913,that I last saw her alive on Nov. 7 191and that death occurred on the date stated above, at 1:30 A.M.

The CAUSE OF DEATH* was as follows:

Accidental burns(Duration) About 9 hours yrs. mos. ds.

Contributory

(Secondary)

(Duration) yrs. mos. ds.

(Signed)

O. H. Avery M. D.Nov 8 1913 (Address) Payette, Ida.

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death yrs. mos. days. In the State yrs. mos. days.

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL DATE OF BURIAL

Payette Ida Nov 9 1913

20. UNDERTAKER

ADDRESS

J. N. Adair Payette Ida

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Form V. S. No. 5. 10M. 6-20-11.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics
File No. **6040**

1. PLACE OF DEATH. Registration District No. **4**
County of **Canyon** Primary Registration District No. **1008**
City of **Payette** (No. _____, St.)

Registered No. **101**
If death occurred in a hospital, institution or camp give its NAME instead of street and number.

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME **Henry Lewis Gutz**

PERSONAL AND STATISTICAL PARTICULARS

3. SEX **Male** 4. COLOR OR RACE **White** 5. SINGLE, MARRIED, WIDOWED OR DIVORCED. **Married**
(Write the word.)

6. DATE OF BIRTH **March 20** 18**83**
(Month) (Day) (Year)

7. AGE **58** yrs. **7** mos. **11** ds. IF LESS than 1 day how many _____ hrs. or min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work **Farmer**
(b) General nature of industry business or establishment in which employed (or employer)

9. BIRTHPLACE (State or Country) **Buffalo, N.Y.**

10. NAME OF FATHER **Don't know**

11. BIRTHPLACE OF FATHER (State or Country) **Germany**

12. MAIDEN NAME OF MOTHER **Don't know**

13. BIRTHPLACE OF MOTHER (State or Country) **Germany**

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) **Mrs. H. L. Gutz**
(Address) **Payette, Idaho**

15. Filed **Nov 2** 191**3** **J. C. Woodward**
Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH **Nov. 1** 191**3**
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from **Nov. 1/1913** 191____, to **Nov. 1/1913** 191____
that I last saw him alive on **not at all** 191____,
and that death occurred on the date stated above, at **an M.**

The CAUSE OF DEATH* was as follows: **unknown**
Diseased was found
death probably from
alcohol & exposure
(Duration) _____ yrs. _____ mos. _____ ds.

Contributory (Secondary) _____
(Duration) _____ yrs. _____ mos. _____ ds.
(Signed) **J. C. Woodward** M. D.
Nov 2 191**3** (Address) **Payette**

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death. _____ yrs. _____ mos. _____ ds. State. _____ yrs. _____ mos. _____ ds.
Where was disease contracted, If not at place of death?
Former or usual residence _____

19. PLACE OF BURIAL OR REMOVAL **Vale, Oregon** DATE OF BURIAL **Nov. 5** 191**3**

20. UNDERTAKER **J. C. Landon** ADDRESS **Payette, Idaho**

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Form V. S. No. 5 20M.1-16-12

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH

Registration District No.

County of

Primary Registration District No.

City of

(No.)

St.)

File No.

Registered No.

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX

4. COLOR OR RACE

5. SINGLE, MARRIED, WIDOWED OR DIVORCED.

6. DATE OF BIRTH

7. AGE

IF LESS than 1 day
how many . hrs. or
mins.?

8. OCCUPATION

(a) Trade, profession or particular kind of work
(b) General nature of industry business, or establishment in which employed (or employer)

9. BIRTHPLACE

(State or Country)

10. NAME OF FATHER

11. BIRTHPLACE OF FATHER

(State or Country)

12. MAIDEN NAME OF MOTHER

13. BIRTHPLACE OF MOTHER

(State or Country)

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

(Address)

15.

Filed

1913

Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH

17. I HEREBY CERTIFY, That I attended deceased from

that I last saw him alive on

and that death occurred on the date stated above, at

The CAUSE OF DEATH* was as follows:

Information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Form V. S. No. 5 20M.1-16-12

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH

Registration District No. 62

County of Latah

Primary Registration District No. 242

City of Genesee

(No. St.)

File No. 6042

Registered No. 3

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

John Bernard Pleiman

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX

male

4. COLOR OR RACE

white

5. SINGLE, MARRIED, WIDOWED OR DIVORCED.

divorced

(Write the word.)

6. DATE OF BIRTH

September 11 1886

(Month)

(Day)

(Year)

7. AGE

57 yrs. 2 mos. 19 ds.

IF LESS than 1 day
how many hrs. or
mins.?

8. OCCUPATION

(a) Trade, profession or particular kind of work

farmer

(b) General nature of industry business, or establishment in which employed (or employer)

9. BIRTHPLACE

(State or Country)

Ohio

10. NAME OF FATHER

H. B. Pleiman

11. BIRTHPLACE OF FATHER

(State or Country)

Germany

12. MAIDEN NAME OF MOTHER

Catherine Kremer

13. BIRTHPLACE OF MOTHER

(State or Country)

Germany

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

J. B. Pleiman

(Address)

Genesee, Idaho

15.

Filed 12-2 1913

W. H. Pleiman

Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

November 30 1913

(Month)

(Day)

(Year)

17. I HEREBY CERTIFY, That I attended deceased from

Nov 16 1913, to Nov 29 1913

that I last saw him alive on Nov 29 1913

and that death occurred on the date stated above, at P. M.

The CAUSE OF DEATH* was as follows:

Mitral Regurgitation
and myocarditis

(Duration) 5 yrs. - mos. - ds.

Contributory
(Secondary)

(Duration) yrs. mos. ds.

(Signed)

Wm. C. Call M. D.

Dec 1 1913

(Address) Genesee Idaho

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death yrs. mos. days. In the State yrs. mos. days.

Where was disease contracted if not at place of death?

Former or usual residence.

19. PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

1913

20. UNDERTAKER

ADDRESS

J. E. Lambert Genesee Idaho

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Form V. S. No. M. 7-24-11

CERTIFICATE OF DEATH

1. PLACE OF DEATH.

County of medialCity of BlackpineRegistration District No. Blackpine 26Primary Registration District No. 2071(No. , St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

Warda Montoya

State of Idaho

BOARD OF HEALTH
Bureau of Vital StatisticsFile No. 6013Registered No. 87

If death occurred in a hospital, institution or camp give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX

female

4. COLOR OR RACE

White
american

5. SINGLE, MARRIED, WIDOWED OR DIVORCED.

married
(Write the word.)

6. DATE OF BIRTH

March 23

(Month)

(Day)

1912
(Year)

7. AGE

43 yrs. 5 mos. 23 ds.IF LESS than 1 day
how many.....hrs. or
.....min?

8. OCCUPATION

(a) Trade, profession or particular kind of work.....
(b) General nature of industry business or establishment in which employed (or employer).....

9. BIRTHPLACE

(State or Country)

Kansas

10. NAME OF FATHER

Unknown

11. BIRTHPLACE OF FATHER

(State or Country)

Unknown

12. MAIDEN NAME OF MOTHER

Warda Ziehl

13. BIRTHPLACE OF MOTHER

(State or Country)

Kansas

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

J. W. Lynch

(Address)

Blackpine Idaho

15.

Filed

15 1913J. W. Lynch
Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH

Sept 16

(Month)

(Day)

1912
(Year)

17. I HEREBY CERTIFY, That I attended deceased from

Aug 10 1912, to Sept 16 1912that I last saw her alive on the 16 day 1912and that death occurred on the date stated above, at 12 M.

The CAUSE OF DEATH* was as follows:

first sickness confined on Sept 10 and died Sept 10. then typhoid fever seen

(Duration) yrs. mos. ds.

Contributory physician in attendance
(Secondary)

(Duration) yrs. mos. ds.

(Signed) J. C. Ray M. D.19 (Address) Malad city

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES state (1) MEANS OF INJURY; (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place yrs. mos. ds. State yrs. mos. ds.

Where was disease contracted,

If not at place of death?

Former or

usual residence Blackpine Idaho

19. PLACE OF BURIAL OR REMOVAL DATE OF BURIAL

Snoville Utah Sept 19 1912

20. UNDERTAKER

ADDRESS

Stahl funeral C. Brigham Utah

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Form V. S. No. 5. 12½ M. 7-24-11

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics
File No. 6048
Registered No. 81

1. PLACE OF DEATH. Registration District No. 26
County of Conda Primary Registration District No. 2071
City of Blackpine (No. _____ St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

Joseph Montoya

If death occurred in a hospital, institution or camp give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX _____ 4. COLOR OR RACE _____ 5. SINGLE, MARRIED, WIDOWED OR DIVORCED. _____

(Write the word.)

6. DATE OF BIRTH Joseph Montoya Nov. 16 1913
(Month) (Day) (Year)

7. AGE 11 yrs. 10 mos. 1 ds. IF LESS than 1 day how many _____ hrs. or _____ min?

8. OCCUPATION

- (a) Trade, profession or particular kind of work. _____
(b) General nature of industry business or establishment in which employed (or employer) _____

9. BIRTHPLACE

(State or Country)

Utah

10. NAME OF FATHER

Joseph Montoya

11. BIRTHPLACE OF FATHER

(State or Country)

Colorado

12. MAIDEN NAME OF MOTHER

Wanda Treace

13. BIRTHPLACE OF MOTHER

(State or Country)

Kansas

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) _____

(Address) _____

J. W. Lynch
Blackpine Idaho

15.

Filed

Oct 15 1913

J. C. Ray

Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH

Sept 11 1913
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from

Aug 14 1913, to Sept 11 1913

that I last saw him alive on Sept 11 1913

and that death occurred on the date stated above, at 2:30 AM

The CAUSE OF DEATH* was as follows:

Diphtheria

No physician in attendance

(Duration) _____ yrs. 1 mos. 3 ds.

Contributory (Secondary) _____

(Duration) _____ yrs. _____ mos. _____ ds.

(Signed) J. C. Ray County Physician

19 (Address) _____

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place _____ In the _____
of death _____ yrs. _____ mos. _____ ds. State _____ yrs. _____ mos. _____ ds.

Where was disease contracted, _____

If not at place of death? _____

Former or _____

usual residence. _____

19. PLACE OF BURIAL OR REMOVAL DATE OF BURIAL

Snouville Utah Sept 14 1913

20. UNDERTAKER

ADDRESS

Stahl Furniture Co Brigham City
Utah

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Form V. S. No. 5. 12½M.7-24-11

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics
File No. 6045
Registered No. _____

1. PLACE OF DEATH. Registration District No. _____
County of Myr Per Primary Registration District No. _____
City of Gifford (No. _____, _____ St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Louisa Hyatt

If death occurred in a hospital, institution or camp give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX Fi 4. COLOR OR RACE _____ 5. SINGLE, MARRIED, WIDOWED OR DIVORCED. _____
(Write the word.)

6. DATE OF BIRTH

June 22 1864
(Month) (Day) (Year)

7. AGE

57 yrs. 5 mos. 3 ds.

IF LESS than 1 day
how many.....hrs. or
min?

8. OCCUPATION

(a) Trade, profession or particular kind of work.
(b) General nature of industry business or establishment in which employed (or employer)

homwife

9. BIRTHPLACE

(State or Country)

Iowa

10. NAME OF FATHER

Riley Strait

11. BIRTHPLACE OF FATHER

(State or Country)

ny

12. MAIDEN NAME OF MOTHER

Sarah A Davis

13. BIRTHPLACE OF MOTHER

(State or Country)

N.Y.

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

(Address)

J. L. Bigh
Gifford

15.

Filed 11-25 1913E. E. Hyatt

Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH

Nov 25 1913
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from Nov 13th 1913, to Nov 25th 1913

that I last saw her alive on Nov 13th 1913

and that death occurred on the date stated above, at 7:30 P.M.

The CAUSE OF DEATH* was as follows:

Cancer of Stomach

(Duration) 4 yrs. in mos. in ds.
Contributory Valvular Insufficiency
(Secondary)

(Duration) Short time yrs. in mos. in ds.

(Signed) J. J. Huntington M. D.

19. (Address) Gifford, Ida.

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place _____ In the _____
of death.....yrs.....mos.....ds. State.....yrs.....mos.....ds.

Where was disease contracted,
If not at place of death?.....

Former or
usual residence.....

19. PLACE OF BURIAL OR REMOVAL DATE OF BURIAL

Myrth11-27- 1913

20. UNDERTAKER

ADDRESS

H. E. StoddardGifford

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

FORM V. S. No. 5-25 M. 1-16-13

CERTIFICATE OF DEATH.

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH *Lulu*
Whitman
County of *Pottawatch*
City of *Pottawatch*
Registration District No. *65*
Primary Registration District No. *2145*
(No. _____ St.)

File No. *6046*
Registered No. _____

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

not named

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX *Female* 4. COLOR OR RACE *White* 5. SINGLE, MARRIED, WID-
OWED OR DIVORCED. *Single*
(Write the word.)

6. DATE OF BIRTH.

Nov 10 1913
(Month) (Day) (Year)

7. AGE

IF LESS than 1 day
how many *3* hrs. or
min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work...
(b) General nature of industry, business, or establishment in which employed (or employer)

none

9. BIRTHPLACE

(State or Country)

Pottawatch Idaho

10. NAME OF FATHER

Cyrus C Berry

11. BIRTHPLACE OF FATHER

(State or Country)

Mo

12. MAIDEN NAME OF MOTHER

Essie Maica

13. BIRTHPLACE OF MOTHER

(State or Country)

Kansas

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant)

Essie Maica

(Address)

Pottawatch Idaho

15.

Filed

Nov 10 1913

D. J. Thompson
Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

Nov 10 1913
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from *5 a m to 8 a m - about 10*
that I last saw her alive on *Nov 10 - 1913*
and that death occurred on the date stated above, at *8 a m*.

The CAUSE OF DEATH* was as follows:

Premature birth during 6th month

(Duration) Yrs. mos. ds.

Contributory (Secondary)

(Duration) Yrs. mos. ds.

(Signed)

W. S. Darr

M. D.

Nov 10 1913 (Address) *Potlouse Iowa*

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death... yrs... mos... days In the State... yrs... mos... days

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

*Pottawatch**Nov 11 1913*

20. UNDERTAKER

ADDRESS

*Parents**Pottawatch*

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Form V. S. No. 5. 10M. 6-20-11.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH. Registration District No. _____
County of Canyon Primary Registration District No. _____
City of Naupho (No. _____, St.) _____

File No. 604
Registered No. _____

If death occurs away from usual residence, give facts called for under special information.

If death occurred in a hospital, institution or camp give its NAME instead of street and number.

2. FULL NAME Oscar Whitman

PERSONAL AND STATISTICAL PARTICULARS

3. SEX Male 4. COLOR OR RACE White 5. SINGLE, MARRIED, WIDOWED OR DIVORCED. Single
(Write the word.)

6. DATE OF BIRTH _____

(Month) (Day) (Year)

7. AGE 23 yrs. _____ mos. _____ ds. IF LESS than 1 day how many _____ hrs. or _____ min.?

8. OCCUPATION
(a) Trade, profession, or particular kind of work Book-keeper
(b) General nature of industry, business, or establishment in which employed (or employer) _____

9. BIRTHPLACE
(State or Country) Mo

10. NAME OF FATHER John Whitman

11. BIRTHPLACE OF FATHER
(State or Country) Don't know

12. MAIDEN NAME OF MOTHER _____

13. BIRTHPLACE OF MOTHER
(State or Country) _____

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) J. K. Robinson

(Address) Naupho Ida

15. Oct 30 1913 S. D. Calonge
Filed _____ Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH
Oct 27 1913
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from _____ 191____, to _____ 191____
that I last saw him _____ alive on _____ 191____,
and that death occurred on the date stated above, at _____ M.
The CAUSE OF DEATH* was as follows:

Gun shop Wound
(Suicide)

(Duration) _____ yrs. _____ mos. _____ ds.
Contributory (Secondary) _____

(Duration) _____ yrs. _____ mos. _____ ds.
(Signed) Fred V. Robinson Coroner
1029 1913 (Address) Naupho Ida

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place _____ In the _____
of death _____ yrs. _____ mos. _____ ds. State _____ yrs. _____ mos. _____ ds.
Where was Disease contracted, _____
If not at place of death? _____
Former or _____
usual residence _____

19. PLACE OF BURIAL OR REMOVAL Oakdale Calif DATE OF BURIAL _____ 191____

20. UNDERTAKER J. K. Robinson ADDRESS Naupho Ida

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Form V. S. No. 5. 10M. 6-20-11.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH.
County of Canyon
City of McCalla

Registration District No. 7
Primary Registration District No. 7
(No. _____ St.)

File No. 6045
Registered No. _____

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

Edward J. Swartz

If death occurred in a hospital, institution or camp give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX Male 4. COLOR OR RACE White 5. ~~SINGLE, MARRIED, WIDOWED OR DIVORCED.~~ Widower
(Write the word.)

6. DATE OF BIRTH May 10 1875
(Month) (Day) (Year)

7. AGE 38 yrs. 5 mos. _____ ds. IF LESS than 1 day how many _____ hrs. or _____ min.?

8. OCCUPATION
(a) Trade, profession, or particular kind of work Farmer
(b) General nature of industry business, or establishment in which employed (or employer) U.S. Employee

9. BIRTHPLACE (State or Country) Ind

10. NAME OF FATHER Isaac Swartz

11. BIRTHPLACE OF FATHER (State or Country) Penn

12. MAIDEN NAME OF MOTHER Kathryn Studebaker

13. BIRTHPLACE OF MOTHER (State or Country) Ind.

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Isaac Swartz
(Address) Delphi Ind.

15. Filed 10/11 1913 P.D. Calonge
Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH 10/10 1913
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from Sept 12 1913 to Oct 10 1913
that I last saw him alive on 10/10 1913

and that death occurred on the date stated above, at 10:30 AM

The CAUSE OF DEATH* was as follows:

Typhoid fever followed by lobar pneumonia

(Duration) yrs. mos. 29 ds.
Contributory (Secondary) Typhoid fever

(Duration) yrs. mos. 29 ds.
(Signed) P.D. Calonge M. D.
10/11 1913 (Address) McCalla Ida

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place In the
of death _____ yrs. _____ mos. _____ ds. State _____ yrs. _____ mos. _____ ds.
Where was Disease contracted,
If not at place of death?
Former or usual residence _____

19. PLACE OF BURIAL OR REMOVAL Delphi Ind. DATE OF BURIAL 10/16 1913

20. UNDERTAKER F.H. Robinson ADDRESS McCalla Ida

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Form V. S. No. 5. 10M. 6-20-11.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

6045

1. PLACE OF DEATH.

Registration District No.

County of

Primary Registration District No.

City of

(No., St.)

Registered No.

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

Minnie Van Elsberg

If death occurred in a hospital, institution or camp give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX

4. COLOR OR RACE 5. SINGLE, MARRIED, WIDOWED OR DIVORCED.

Female White

(Write the word.) Married

6. DATE OF BIRTH

October 6

(Month)

(Day)

1870 (Year)

7. AGE

42 yrs. - mos. 25 ds.

IF LESS than 1 day
how many hrs. or
min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work

Housewife

(b) General nature of industry business or establishment in which employed (or employer)

9. BIRTHPLACE

(State or Country)

Canada

10. NAME OF FATHER

Robert Russell

11. BIRTHPLACE OF FATHER

(State or Country)

Canada

12. MAIDEN NAME OF MOTHER

Margaret Benson

13. BIRTHPLACE OF MOTHER

(State or Country)

Canada

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

Miss Jesse Heilner

(Address)

Nampa Idaho

15.

Filed

Nov 2 1913

D. D. Calange

Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

Nov 2

(Month)

(Day)

1913 (Year)

17. I HEREBY CERTIFY, That I attended deceased from

Nov 15 1909, to Nov 2 1913

that I last saw him alive on Nov 2 1913,

and that death occurred on the date stated above, at 5 AM

The CAUSE OF DEATH* was as follows:

Heart Perforation due to perforation from duodenal ulcer

(Duration)

14 yrs. mos. 14 ds.

Contributory

(Secondary)

Recurrent duodenal and gastric ulcers

(Duration)

15 yrs. my knowledge

(Signed)

D. D. Calange

M. D.

Nov 2 1913

(Address)

Nampa Idaho

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place

of death

yrs.

mos.

In the

da. State

yrs.

mos.

ds.

Where was disease contracted.

If not at place of death?

Former or

usual residence.

19. PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

Tahler Lawn

Nov 4 1913

20. UNDERTAKER

ADDRESS

D. D. Shellabarger

Nampa Idaho

D. D. Shellabarger

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Form V. S. No. 5 20M.1-16-12

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH.

Registration District No.

County of Cassia

Primary Registration District No.

City of Hamlet

(No. 116, 9th ave St.)

File No. 6054

Registered No.

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

A. C. Fralich

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX

Male

4. COLOR OR RACE

White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED.

Single
(Write the word.)

6. DATE OF BIRTH

Nov. 6 1865
(Month) (Day) (Year)

7. AGE

48 yrs. 2 mos. 2 ds.

IF LESS than 1 day
how many hrs. or
..... mins.?

8. OCCUPATION

(a) Trade, profession or particular kind of work
(b) General nature of industry business, or establishment in which employed (or employer)

Mining Assays

9. BIRTHPLACE

(State or Country)

Cassia

10. NAME OF FATHER

David Fralich

11. BIRTHPLACE OF FATHER

(State or Country)

Pa.

12. MAIDEN NAME OF MOTHER

Sarah Mc Coy

13. BIRTHPLACE OF MOTHER

(State or Country)

Ireland

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

Wm. L. Carl

(Address)

B. Carl

15.

Filed

Nov 9th 1913 B. D. Calonge

Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH

Nov. 8 1913
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from

June 1913, to adip death 1913,

that I last saw him alive on Oct 1 1913,

and that death occurred on the date stated above, at 10 AM.

The CAUSE OF DEATH* was as follows:

Pernicious Anemia

(Duration) 4 yrs. — mos. — ds.

Contributory
(Secondary)

(Duration) — yrs. — mos. — ds.

(Signed) Wm. L. Carl M. D.

19. (Address)

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death yrs. mos. days. In the State yrs. mos. days.

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL DATE OF BURIAL

Boise Idaho Nov 9 1913

20. UNDERTAKER

ADDRESS

Schreib & Sidenforn Boise

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Form V. S. No. 5. 12½ M. 7-24-11

CERTIFICATE OF DEATH

1. PLACE OF DEATH.
County of Bingham
City of Aberdeen

Registration District No. 116
Primary Registration District No. 2195
(No. _____, _____ St.)

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics
File No. 1605
Registered No. 6

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME John Schmidt

If death occurred in a hospital, institution or camp give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX Male 4. COLOR OR RACE white 5. SINGLE, MARRIED, WIDOWED OR DIVORCED. Single
(Write the word.)

6. DATE OF BIRTH Nov 18 1913
(Month) (Day) (Year)

7. AGE _____ yrs. _____ mos. 9 ds. IF LESS than 1 day
how many _____ hrs. or _____ min?

8. OCCUPATION
(a) Trade, profession or particular kind of work. _____
(b) General nature of industry business or establishment in which employed (or employer) _____

9. BIRTHPLACE Aberdeen Ida
(State or Country)

10. NAME OF FATHER Henry P. Schmidt

11. BIRTHPLACE OF FATHER Russia
(State or Country)

12. MAIDEN NAME OF MOTHER Amie Hebert

13. BIRTHPLACE OF MOTHER Kansas
(State or Country)

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) J. B. Wedel
(Address) Aberdeen

15. Filed Nov 28 1913 McMurtre
Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH Nov 27 1913
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from birth 191____, to Nov 27 1913 that I last saw him alive on Nov 27 1913 and that death occurred on the date stated above, at 5 P. M.

The CAUSE OF DEATH* was as follows:

Conjugal Debility

(Duration) _____ yrs. _____ mos. 9 ds.
Contributory Constipation
(Secondary)

(Duration) _____ yrs. _____ mos. 7 ds.
(Signed) McMurtre M. D.
Nov 28 1913 (Address) Aberdeen Ida

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place _____ In the _____
of death _____ yrs. _____ mos. _____ ds. State _____ yrs. _____ mos. _____ ds.
Where was disease contracted, _____
If not at place of death? _____
Former or _____
usual residence _____

19. PLACE OF BURIAL OR REMOVAL McMurtre Cemetery DATE OF BURIAL Nov 30 1913

20. UNDERTAKER Henry Schmidt ADDRESS Aberdeen

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Form V. S. No. 5. 12½ M. 7-24-11

CERTIFICATE OF DEATH

State of Idaho

BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH. Registration District No. 109
County of Custer Primary Registration District No. 2187
City of Pauch on Lake East (No. _____, _____ St.)

File No. 6052

Registered No. 4

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

Martin Houston

If death occurred in a hospital, institution or camp give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX M 4. COLOR OR RACE Wh 5. SINGLE, MARRIED, WIDOWED OR DIVORCED. Married
(Write the word.)

6. DATE OF BIRTH July 26 1844
(Month) (Day) (Year)

7. AGE 69 yrs. 3 mos. 8 ds. IF LESS than 1 day how many _____ hrs. or _____ min?

8. OCCUPATION

(a) Trade, profession or particular kind of work. Farmer.
(b) General nature of industry business or establishment in which employed (or employer)

9. BIRTHPLACE

(State or Country) Ohio

10. NAME OF FATHER

Mart Houston

11. BIRTHPLACE OF FATHER

(State or Country) N.Y.

12. MAIDEN NAME OF MOTHER

Susan Stewart

13. BIRTHPLACE OF MOTHER

(State or Country) N.Y.

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) J. H. Barts

(Address) Macray, Idaho

15.

Filed Nov 6 1913

J. P. Richards

Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH

November 4 1913
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from 191, to 191

that I last saw h. _____ alive on _____ 191

and that death occurred on the date stated above, at A M.

The CAUSE OF DEATH* was as follows:

Probable - Chronic Nephritis.
Senility.

_____ (Duration) _____ yrs. _____ mos. _____ ds.

Contributory (Secondary) Had no attending physician.

_____ (Duration) _____ yrs. _____ mos. _____ ds.

(Signed) Francis P. Richards M. D.

11/6 1913 (Address) Macray, Idaho

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place _____ In the _____
of death _____ yrs. _____ mos. _____ ds. State _____ yrs. _____ mos. _____ ds.

Where was disease contracted, _____

If not at place of death? _____

Former or

usual residence _____

19. PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

Houston Idaho

November 6, 1913

20. UNDERTAKER

ADDRESS

J. H. Barts

Macray.

MARGIN RESERVED FOR BINDING
WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY.
CLANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified.
ment of OCCUPATION is very important. See instructions on back of certificate.

S. No. 5. 12½ M. 7-24-11

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics
File No. 6053
Registered No. 6

PLACE OF DEATH.

Registration District No. 50
Primary Registration District No. 2129
(No. _____, _____ St.)

County of Lewis
City of Wallmer

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Mrs Mary M. Coy

If death occurred in a hospital, institution or camp give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX Female 4. COLOR OR RACE White 5. SINGLE, MARRIED, WIDOWED OR DIVORCED. married.
(Write the word.)
6. DATE OF BIRTH June 20 1860
(Month) (Day) (Year)

7. AGE 53 yrs. 4 mos. 12 ds. IF LESS than 1 day
how many _____ hrs. or _____ min?

8. OCCUPATION
(a) Trade, profession or particular kind of work. Housewife.
(b) General nature of industry business or establishment in which employed (or employer)

9. BIRTHPLACE
(State or Country) St. Johns N.B.

10. NAME OF FATHER John M. Donough

11. BIRTHPLACE OF FATHER
(State or Country) Ireland

12. MAIDEN NAME OF MOTHER Catharine Burke
Mary M. Donough

13. BIRTHPLACE OF MOTHER
(State or Country) Ireland

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) E. L. Burke
(Address) Wallmer, Ida.

15. Filed Nov 4 1913 H. C. Parrish
Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH Nov 2 1913
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from Oct 1 1913, to Nov 2 1913
that I last saw h. alive on Oct 31 1913
and that death occurred on the date stated above, at 1 A.M.
The CAUSE OF DEATH* was as follows:
Diabetes

(Duration) _____ yrs. _____ mos. _____ ds.
Contributory Heart Disarrangement
(Secondary) swiftness
(Duration) _____ yrs. _____ mos. _____ ds.
(Signed) E. L. Burke M. D.
Nov 4 1913 (Address) Wallmer, Ida.

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death _____ yrs. _____ mos. _____ ds. State _____ yrs. _____ mos. _____ ds.
Where was disease contracted, If not at place of death? _____
Former or usual residence. _____

19. PLACE OF BURIAL OR REMOVAL Lewiston, Ida DATE OF BURIAL Nov 6 1914

20. UNDERTAKER P. J. Felt ADDRESS Myer, Ida

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PLAINLY state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exactment of OCCUPATION is very important. See instructions on back of certificate.

County of Washington
City of Cambridge

Registration District No. 8-8Primary Registration District No. 216

(No. _____ St.)

BOARD OF HEALTH
Bureau of Vital Statistics

File No. 6054

Registered No. _____

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

Stillborn

If death occurred in a hospital, institution or camp give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX

Female

4. COLOR OR RACE

White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED.

(Write the word.) Single

6. DATE OF BIRTH

Dec41913

(Month)

(Day)

(Year)

7. AGE

_____ yrs. _____ mos. _____ ds.

IF LESS than 1 day
how many _____ hrs. or
_____ min?

8. OCCUPATION

- (a) Trade, profession or particular kind of work.....
(b) General nature of industry business or establishment in which employed (or employer).....

9. BIRTHPLACE

(State or Country)

Cambridge Idn

10. NAME OF FATHER

James K. K. K.

11. BIRTHPLACE OF FATHER

(State or Country)

Ireland

12. MAIDEN NAME OF MOTHER

Bessie Goss

13. BIRTHPLACE OF MOTHER

(State or Country)

Ireland

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

F. H. Hager

(Address)

Cambridge

15.

Filed Dec 4 1913C. E. Schmidt

Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH

Dec51913

(Month)

(Day)

(Year)

17. I HEREBY CERTIFY, That I attended deceased from

Dec 51913to Dec 51913that I last saw her alive on _____ 1913

and that death occurred on the date stated above, at _____ M.

The CAUSE OF DEATH* was as follows:

Immature

(Duration) _____ yrs. _____ mos. _____ ds.

Contributory (Secondary) Falling over chair

(Duration) _____ yrs. _____ mos. _____ ds.

(Signed) C. E. Schmidt M. D.Dec 5 1913 (Address) Cambridge

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place _____ In the _____
of death _____ yrs. _____ mos. _____ ds. State _____ yrs. _____ mos. _____ ds.

Where was disease contracted,
If not at place of death? _____

Former or
usual residence _____

19. PLACE OF BURIAL OR REMOVAL DATE OF BURIAL

CambridgeDec 4 1913

20. UNDERTAKER

ADDRESS

Jas KudelsanCambridge

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Form V, S. No. 5. 12½ M. 7-24-11

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics
File No. 6052
Registered No.

1. PLACE OF DEATH. Registration District No. 58
County of Washington Primary Registration District No. 2164
City of Cambridge (No. St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Ida M Over

If death occurred in a hospital, institution or camp give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX Female 4. COLOR OR RACE white 5. SINGLE, MARRIED, WIDOWED OR DIVORCED. Married
(Write the word.)
6. DATE OF BIRTH Nov 22 1896
(Month) (Day) (Year)

7. AGE 37 yrs. 11 mos. 3 ds. IF LESS than 1 day how many hrs. or min?

8. OCCUPATION
(a) Trade, profession or particular kind of work. Housewife
(b) General nature of industry business or establishment in which employed (or employer)

9. BIRTHPLACE Idaho
(State or Country)

10. NAME OF FATHER Geo Moser

11. BIRTHPLACE OF FATHER Tennessee
(State or Country)

12. MAIDEN NAME OF MOTHER Elizabeth Smith

13. BIRTHPLACE OF MOTHER Tennessee
(State or Country)

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) C E Schmitt
(Address) Cambridge

15. Filed Nov 1 1913 C E Schmitt Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH Oct 23 1913
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from Oct 1 1913, to Oct 22 1913
that I last saw her alive on Oct 22 1913
and that death occurred on the date stated above, at 1 A.M.

The CAUSE OF DEATH* was as follows:
Sign of Brain or Lunging chin

(Duration) yrs. mos. 22 ds.
Contributory Cause of Death (Secondary) Leg

(Duration) yrs. mos. ds.
(Signed) C E Schmitt M. D.
19 (Address) Cambridge Idaho

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place In the
of death yrs. mos. ds. State yrs. mos. ds.
Where was disease contracted,
If not at place of death?
Former or usual residence.

19. PLACE OF BURIAL OR REMOVAL DATE OF BURIAL
Medvale, Idn. Oct 24 1913

20. UNDERTAKER ADDRESS
L G Kay Medvale Idn

CERTIFICATE OF DEATH

State of Idaho

BOARD OF HEALTH
Bureau of Vital Statistics

File No. 6057

Registered No.

If death occurred in a hospital, institution or camp give its NAME instead of street and number.

1. PLACE OF DEATH Registration District No. 52
County of Bear Lake Primary Registration District No. 2136
City of Montpelier (No. , St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Baby Robinson

PERSONAL AND STATISTICAL PARTICULARS

3. SEX 4. COLOR OR RACE 5. SINGLE, MARRIED, WIDOWED OR DIVORCED.

Girl White Single (Write the word.)

6. DATE OF BIRTH Dec 2 1913
(Month) (Day) (Year)

7. AGE 19 mos. IF LESS than 1 day how many hrs. or min?

8. OCCUPATION

- (a) Trade, profession or particular kind of work.
(b) General nature of industry business or establishment in which employed (or employer)

None

9. BIRTHPLACE

(State or Country)

Montpelier
Bear Lake Co

10. NAME OF FATHER

Charles Robinson

11. BIRTHPLACE OF FATHER

(State or Country)

Plum Creek Idaho

12. MAIDEN NAME OF MOTHER

C. Passy

13. BIRTHPLACE OF MOTHER

(State or Country)

Paris Idaho

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Budd Weaver

(Address) Montpelier

15. Filed 12/31 1913 Noting.

Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH

Dec 2 1913
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from Dec 2 1913, to Dec 2 1913

that I last saw him alive on Dec 3 1913

and that death occurred on the date stated above, at 7 9 M.

The CAUSE OF DEATH* was as follows:

Premature Birth

(Duration) yrs. mos. ds.

Contributory (Secondary)

(Duration) yrs. mos. ds.

(Signed) Geo F Ashley M.D.

19 (Address)

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place 19 mos. In the 19 mos. of death yrs. mos. ds. State yrs. mos. ds.

Where was disease contracted,

If not at place of death?

Former or

usual residence.

19. PLACE OF BURIAL OR REMOVAL DATE OF BURIAL

Montpelier

12/4/ 1913

20. UNDERTAKER ADDRESS

None

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Form V. S. No. 5. 12½ M. 7-24-11

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics
File No. **6058**
Registered No. **6058**

1. PLACE OF DEATH. Registration District No. **2136**
County of **Blaine Lake** Primary Registration District No. **2136**
City of **Montpelier** (No. _____ St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME **Mrs Chas. Robinson**

If death occurred in a hospital, institution or camp give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX **Female** 4. COLOR OR RACE **White** 5. SINGLE, MARRIED, WIDOWED OR DIVORCED. **Married**
(Write the word.)

6. DATE OF BIRTH **January 26 1873**
(Month) (Day) (Year)

7. AGE **40 yrs. 7 mos. 14 ds.** IF LESS THAN 1 day how many _____ hrs. or _____ min?

8. OCCUPATION
(a) Trade, profession or particular kind of work.
(b) General nature of industry business or establishment in which employed (or employer) **Wife**

9. BIRTHPLACE **Idaho**
(State or Country)

10. NAME OF FATHER **Thomas Parson**

11. BIRTHPLACE OF FATHER **England**
(State or Country)

12. MAIDEN NAME OF MOTHER **Lucretia Theobald**

13. BIRTHPLACE OF MOTHER **England**
(State or Country)

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) **Budd Weaver**
(Address) **Montpelier Ida**

15. Filed **12/31** 191**3** **W. H. King**
Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH **Dec 2 1913**
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from **Dec 2 1913**, to **Dec 2 1913**
that I last saw him alive on **Dec 2 1913**
and that death occurred on the date stated above, at **340 M.**

The CAUSE OF DEATH* was as follows:

Embolism of the heart.

(Duration) _____ yrs. _____ mos. _____ ds.
Contributory (Secondary) **Cholera**

(Duration) _____ yrs. _____ mos. _____ ds.
(Signed) **A. F. Ashley** M. D.
19 _____ (Address)

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death **7** yrs. _____ mos. _____ ds. State **Id**
Where was disease contracted,
If not at place of death?
Former or usual residence.

19. PLACE OF BURIAL OR REMOVAL **Montpelier** DATE OF BURIAL **12/4/1913**

20. UNDERTAKER **None** ADDRESS

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Form V. S. No. 5 20M.1-16-12

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH. Registration District No. 52
County of Bearlake Primary Registration District No. 2136
City of Bernington N.P. 12. St.

File No. 6059

Registered No. _____

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Sarah E. Weaver

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX Female 4. COLOR OR RACE White 5. SINGLE, MARRIED, WIDOWED OR DIVORCED Widowed
(Write the word.)

6. DATE OF BIRTH June 30 1894
(Month) (Day) (Year)

7. AGE 79 yrs. 4 mos. 6 ds. IF LESS than 1 day how many hrs. or mins.?

8. OCCUPATION
(a) Trade, profession or particular kind of work Retired
(b) General nature of industry business, or establishment in which employed (or employer)

9. BIRTHPLACE (State or Country) Illinois

10. NAME OF FATHER Peter W. Conover

11. BIRTHPLACE OF FATHER (State or Country) unknown

12. MAIDEN NAME OF MOTHER Catharine Golden

13. BIRTHPLACE OF MOTHER (State or Country) unknown

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Peter W. Weaver

(Address) Bernington Ida.

15. 11/6/1913 St. Anthony

Filed 11/6/1913 Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH Nov 6 1913
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from Orbit 1913, to Nov 6 1913, that I last saw her alive on Nov 2 1913, and that death occurred on the date stated above, at 10 A.M.

The CAUSE OF DEATH* was as follows:
Senile Congest (Left Heart)

(Duration) yrs. 1 mos. ds.

Contributory (Secondary)

(Duration) yrs. mos. ds.

(Signed) St. Anthony M. D.

11-7-1913 (Address) St. Anthony

*State the DISEASE CAUSING DEATH; or in death from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death.....yrs.....mos.....days. In the State.....yrs.....mos.....days.

Where was disease contracted if not at place of death?.....

Former or usual residence.....

19. PLACE OF BURIAL OR REMOVAL DATE OF BURIAL

Whitney Ida Nov 9 1913

20. UNDERTAKER ADDRESS

St. Anthony St. Anthony

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Form V. S. No. 5 20M.1-16-12

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital StatisticsFile No. **6061**Registered No. **14**

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

1. PLACE OF DEATH.

Registration District No. **42**County of **Lemhi**Primary Registration District No. **216**City of **May**

(No. , St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

Joseph I. Wagner

PERSONAL AND STATISTICAL PARTICULARS

3. SEX

Male

4. COLOR OR RACE

White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED.

single
(Write the word.)

6. DATE OF BIRTH

April 8 1902
(Month) (Day) (Year)

7. AGE

11 yrs. 5 mos. 24 ds.IF LESS than 1 day
how many hrs. or
..... mins.?

8. OCCUPATION

(a) Trade, profession or particular kind of work

(b) General nature of industry business, or establishment in which employed (or employer)

Son of Rancher

9. BIRTHPLACE

(State or Country)

Lemhi Co. Idaho

10. NAME OF FATHER

Joseph Wagner

11. BIRTHPLACE OF FATHER

(State or Country)

Byer, or Bier, Germany

12. MAIDEN NAME OF MOTHER

Francis Meybrunn

13. BIRTHPLACE OF MOTHER

(State or Country)

Marshall Co. Kansas

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

Sam T. Coary

(Address)

Patterson, Idaho

15.

Filed

Oct 22 1913**Kelen L. Smith**
Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH

September 27th 1913
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from

Aug 31 1913, to Sept 13 1913,that I last saw him alive on **Sept 13 1913,**and that death occurred on the date stated above, at **M.**

The CAUSE OF DEATH* was as follows:

Mitral Insufficiency(Duration) **2** yrs. **2** mos. **—** ds.

Contributory

(Secondary)

(Duration) **—** yrs. **—** mos. **—** ds.

(Signed)

L. F. Hume M. D.**Oct 21 1913** (Address) **623, Benton, Blk. 1, Salt Lake, Utah**

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place

of death yrs. mos. days. In the

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL

May Idaho

DATE OF BURIAL

Sep 30th 1913

20. UNDERTAKER

No undertaker

ADDRESS

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Form V. S. No. 5 20M.1-16-12

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics
File No. 1 6062
Registered No. 13

1. PLACE OF DEATH
County of Lemhi
City of Salmon
Registration District No. 42
Primary Registration District No. 2116
(No. _____ St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Joseph J. Black

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX male 4. COLOR OR RACE white 5. SINGLE, MARRIED, WIDOWED OR DIVORCED. Married

6. DATE OF BIRTH Feb. 27th. 1828
(Month) (Day) (Year)

7. AGE 85 yrs. 7 mos. ds.
IF LESS than 1 day how many _____ hrs. or _____ mins.?

8. OCCUPATION
(a) Trade, profession or particular kind of work Rancher
(b) General nature of industry, business, or establishment in which employed (or employer) Retired 8 yrs.

9. BIRTHPLACE
(State or Country) New Hampshire

10. NAME OF FATHER Hazen Black

11. BIRTHPLACE OF FATHER
(State or Country) New Hampshire

12. MAIDEN NAME OF MOTHER don't know

13. BIRTHPLACE OF MOTHER
(State or Country) New Hampshire

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Mrs. Josephine Steele
(Address) Salmon Idaho

15. Filed October 21-1913 Klen L. Smith
Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH Oct 20 1913
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from Oct 12 1913, to Oct 20 1913, that I last saw him alive on Oct 20 1913, and that death occurred on the date stated above, at 11:30 P.

The CAUSE OF DEATH* was as follows:

Heart failure due to old age

(Duration) _____ yrs. _____ mos. _____ ds.
Contributory (Secondary) _____

(Duration) _____ yrs. _____ mos. _____ ds.
(Signed) W. B. Whitwell M. D.
10/21-1913 (Address) Salmon, Idaho

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death _____ yrs. _____ mos. _____ days. In the State _____ yrs. _____ mos. _____ days.

Where was disease contracted if not at place of death? _____

Former or usual residence _____

19. PLACE OF BURIAL OR REMOVAL Salmon Cemetery DATE OF BURIAL Oct. 22nd 1913

20. UNDERTAKER Ann. E. Roebler ADDRESS Salmon Idaho

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Form V. S. No. 5 20M.1-16-12

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH.

Registration District No. 42

County of Lemhi

Primary Registration District No. 2116

City of Salmon

(No. St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

John R. Pyleatt

File No. 6063

Registered No. 12

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX

4. COLOR OR RACE

5. SINGLE, MARRIED, WIDOWED OR DIVORCED.

male

white

Married

6. DATE OF BIRTH

Feb

10

1953

(Month)

(Day)

(Year)

7. AGE

60

yrs.

8

mos.

6

ds.

If LESS than 1 day
how many hrs. or
mins.?

8. OCCUPATION

(a) Trade, profession or
particular kind of work

(b) General nature of industry
business, or establishment in
which employed (or employer)

Rancher

9. BIRTHPLACE

(State or Country)

Illinois

10. NAME OF FATHER

Gordon Pyleatt

11. BIRTHPLACE OF FATHER

(State or Country)

Ohio

12. MAIDEN NAME OF MOTHER

Mary McGlothlin

13. BIRTHPLACE OF MOTHER

(State or Country)

Illinois

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

Clarence Pyleatt

(Address)

Leadore Idaho

15.

Filed

October 17 1913

Klein Smith

Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH

Oct.

16th

1913

(Month)

(Day)

(Year)

17. I HEREBY CERTIFY, That I attended deceased from

Oct. 1

1913

to Oct. 16

1913

that I last saw him alive on Oct. 16 1913

and that death occurred on the date stated above, at 11:45 M.

The CAUSE OF DEATH was as follows:

Respiratory
Paralysis preceded by spinal
cord lesion in cervical region
traumatic, accidental

(Duration)

yrs.

mos.

ds.

Contributory
(Secondary)

Cystitis

(Duration)

yrs.

mos.

ds.

(Signed)

V. Stratton

M. D.

10/17/13

(Address)

Salmon, Ida

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place

of death

yrs.

In the

State

yrs.

mos.

days.

Where was disease contracted
if not at place of death?

Former or
usual residence

19. PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

Leadore Idaho

Oct. 18th 1913

20. UNDERTAKER

ADDRESS

Hm. C. Woebler

Salmon

Ida.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
 N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Form V. S. No. 5 20M.1-16-12

CERTIFICATE OF DEATH

1. PLACE OF DEATH

Registration District No. 42County of LemhiPrimary Registration District No. 2116City of Salmon

(No. _____) (St. _____)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

Thomas P. Snook
 State of Idaho
 BOARD OF HEALTH
 Bureau of Vital Statistics
 File No. 6064
Registered No. 11

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX

4. COLOR OR RACE

5. SINGLE, MARRIED, WIDOWED OR DIVORCED

male white Married

6. DATE OF BIRTH

1847
 (Month) (Day) (Year)

7. AGE

66 yrs. 0 mos. 0 ds.

 IF LESS than 1 day
 how many _____ hrs. or
 _____ mins.

8. OCCUPATION

(a) Trade, profession or particular kind of work

(b) General nature of industry, business, or establishment in which employed (or employer)

Carpenter

9. BIRTHPLACE

(State or Country)

Oregon

10. NAME OF FATHER

don't know

11. BIRTHPLACE OF FATHER

(State or Country)

don't know

12. MAIDEN NAME OF MOTHER

don't know

13. BIRTHPLACE OF MOTHER

(State or Country)

don't know

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

Charles Cockrell

(Address)

Salmon Idaho

15.

Filed October 12 1913Helen L. Smith

Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

Oct. 12th 1913
 (Month) (Day) (Year)

 17. I HEREBY CERTIFY, That I attended deceased from
Sept. 1 1913, to Oct. 10 1913
 that I last saw him alive on Oct. 10 1913
and that death occurred on the date stated above, at 2 A.M.

The CAUSE OF DEATH* was as follows:

Chronic myocarditis,
mitral regurgitation

 (Duration) Several yrs. 0 mos. 0 ds.

Contributory

(Secondary)

(Duration) _____ yrs. _____ mos. _____ ds.

(Signed)

10/13/13 1913 (Address) Salmon, Ida. M. D.

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death

_____ yrs. _____ mos. _____ days.

In the

State _____ yrs. _____ mos. _____ days.

Where was disease contracted if not at place of death? _____

Former or

usual residence _____

19. PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

Salmon Cemetery Oct. 13th 1913

20. UNDERTAKER

ADDRESS

Wm. C. Woebler Salmon
Idaho

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Form V. S. No. 5 20M.1-16-12

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics
File No. **6065**
Registered No. **16**

1. PLACE OF DEATH. Registration District No. _____
County of Lemhi Primary Registration District No. _____
City of Rortley Creek (No. _____ St.) _____

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Lyda Chaffin

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX female 4. COLOR OR RACE white 5. SINGLE, MARRIED, WIDOWED OR DIVORCED. Single (word.)
6. DATE OF BIRTH May 23 1912
(Month) (Day) (Year)

7. AGE 1 yrs. 6 mos. 8 ds. IF LESS than 1 day how many _____ hrs. or _____ mins.?

8. OCCUPATION
(a) Trade, profession or particular kind of work X
(b) General nature of industry business, or establishment in which employed (or employer) _____

9. BIRTHPLACE (State or Country) Lemhi Co. Idaho

10. NAME OF FATHER John L. Chaffin

11. BIRTHPLACE OF FATHER (State or Country) Montana

12. MAIDEN NAME OF MOTHER Nora M. Cheney

13. BIRTHPLACE OF MOTHER (State or Country) Idaho

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) John Cheney
(Address) Baker Idaho

15. Filed 11-4-1913 Helena Smith
Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH Oct 31st 1913
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from Oct 30 3am 1913, to Oct 31, 4am 1913, that I last saw him alive on Oct 31 1913, and that death occurred on the date stated above, at 10 A.M.
The CAUSE OF DEATH* was as follows:

Acute anterior poliomyelitis
(Duration) About mos. 2 ds.

Contributory (Secondary) _____

(Duration) _____ yrs. _____ mos. _____ ds.
(Signed) Chas. F. Hammer M. D.
11-4-1913 (Address) Salmon

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death _____ yrs. _____ mos. _____ days. In the State _____ yrs. _____ mos. _____ days.

Where was disease contracted if not at place of death? _____

Former or usual residence _____

19. PLACE OF BURIAL OR REMOVAL Salmon Cemetery DATE OF BURIAL Nov. 1st 1913
20. UNDERTAKER Wm. C. Koebler ADDRESS Salmon

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Form V. S. No. 5 20M.1-16-12

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics
File No. **6066**

1. PLACE OF DEATH

Registration District No. 42County of BlainePrimary Registration District No. 2116City of Salmon

(No. _____)

St. _____

Registered No. 16

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

Wm. H. Nicol

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX

Female

4. COLOR OR RACE

White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED.

Infant
(Write the word.)

6. DATE OF BIRTH

10 31 1913
(Month) (Day) (Year)

7. AGE

24 hours
hrs. mos. ds.

IF LESS than 1 day
how many 24 hrs. or
..... mins.?

8. OCCUPATION

(a) Trade, profession or

particular kind of work

(b) General nature of industry

business, or establishment in

which employed (or employer)

9. BIRTHPLACE

(State or Country)

Ida

10. NAME OF FATHER

Murdoch W. H. Nicol

11. BIRTHPLACE OF FATHER

(State or Country)

Ida

12. MAIDEN NAME OF MOTHER

Clair Sharkey

13. BIRTHPLACE OF MOTHER

(State or Country)

Ida

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

C. Stratton

(Address)

Salmon, Ida.

15.

Filed

November 1 1913Helen L. Smith
Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH

10 31 1913
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from

birth 1913, to death 1913that I last saw her alive on Oct. 31 1913and that death occurred on the date stated above, at 11:00 M.

The CAUSE OF DEATH was as follows:

Premature birth

(Duration) yrs. mos. ds.

Contributory

(Secondary)

(Duration) yrs. mos. ds.

(Signed)

11/1 1913

(Address)

C. Stratton M. D.
Salmon, Ida

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place

of death yrs. mos. days.

In the

State yrs. mos. days.

Where was disease contracted
if not at place of death?

Former or

usual residence

19. PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

Salmon CemeteryNov. 1st 1913

20. UNDERTAKER

ADDRESS

Wm. C. HoebleySalmon

Form V. S. No. 5 20M.1-16-12

CERTIFICATE OF DEATH

 State of Idaho
 BOARD OF HEALTH
 Bureau of Vital Statistics

1. PLACE OF DEATH.

Registration District No. 52County of BlainePrimary Registration District No. 2136File No. 6067City of Bennington

(No. _____ St.)

Registered No. _____

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Edward Melman

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX

Male

4. COLOR OR RACE

White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED.

Widower
(Write the word.)

6. DATE OF BIRTH

Nov.5th1836

(Month)

(Day)

(Year)

7. AGE

77 yrs. 0 mos. 3 ds.
 IF LESS than 1 day
 how many hrs. or
 mins.?

8. OCCUPATION

(a) Trade, profession or particular kind of work

Farmer

(b) General nature of industry business, or establishment in which employed (or employer)

9. BIRTHPLACE

(State or Country)

Canada

10. NAME OF FATHER

Don't know

11. BIRTHPLACE OF FATHER

(State or Country)

England

12. MAIDEN NAME OF MOTHER

Don't know

13. BIRTHPLACE OF MOTHER

(State or Country)

England

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

Glen Mowatt

(Address)

Bennington Ida

15.

Filed

11/11/1913W. H. Smith
Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH

Nov.8th1913

(Month)

(Day)

(Year)

17. I HEREBY CERTIFY, That I attended deceased from

1913, to1913that I last saw him alive on Nov. 8 1913and that death occurred on the date stated above, at 4:30 M.

The CAUSE OF DEATH* was as follows:

Cerebral Hemorrhage
(apoplexy)

(Duration)

yrs.

mos.

2 ds.

Contributory

no doctor in attendance

(Secondary)

(See attached affidavit)

(Duration)

yrs.

mos.

ds.

(Signed)

Glen Mowatt
(Home health)

19.

(Address)

Bennington Ida

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place

4

yrs.

mos.

days.

In the

4

yrs.

mos.

days.

Where was disease contracted if not at place of death?

Former or usual residence

Utah

19. PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

Bennington Ida11/11/1913

20. UNDERTAKER

none

ADDRESS

State of Idaho,)
County of Bear Lake)

Glenn Mouritsen, of Bennington, Idaho, being first
duly sworn deposes and says: That he was well acquainted with Edward
Wildman, aged 77 years, who died on the 8th day of November, 1913, at
said Bennington, Idaho, That said affiant was present at ~~his~~ the death of
the said Edward Wildman, and that he died from a stroke of apoplexy, or
paralysis, which caused his death, according to his best knowledge and be-
lief. No physician was in attendance.

Glenn Mouritsen

Subscribed and sworn to before me this 11th day of November, 1913.

Chas E. Harris
Notary Public.

Form V. S. No. 5. 10M. 6-20-11.

CERTIFICATE OF DEATH

State of Idaho

BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH.

Registration District No.

County of Lincoln

Primary Registration District No.

City of Jerome

(No., St.)

File No. 6068

Registered No.

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

Anna Mayne Agan

If death occurred in a hospital, institution or camp give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX

4. COLOR OR RACE 5. SINGLE, MARRIED, WID-
OWED OR DIVORCED.Female White Single

6. DATE OF BIRTH

May 20 1910
(Month) (Day) (Year)

7. AGE

3 yrs. 4 mos. 20 ds.
IF LESS than 1 day
how many hrs. or
..... min.?

8. OCCUPATION

(a) Trade, profession or
particular kind of work
(b) General nature of industry
business or establishment in
which employed (or employer)Infant.

9. BIRTHPLACE

(State or Country)

Iowa10. NAME OF
FATHERClarence Agan11. BIRTHPLACE
OF FATHER

(State or Country)

Iowa12. MAIDEN NAME
OF MOTHERElla E. Hulan13. BIRTHPLACE
OF MOTHER

(State or Country)

Indiana

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Clarence Agan(Address) Jerome

15.

Filed Oct 12 1913 C. P. Piper
Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

Oct 10 1913
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from

Oct 3 1913, to Oct 10 1913that I last saw her alive on Oct 10 1913and that death occurred on the date stated above, at 11.30 M.

The CAUSE OF DEATH* was as follows:

Pneumonia
lobar (F)(Duration) yrs. mos. 8 ds.Contributory Convulsions, Intestinal disturbance
(Secondary) gastroenteritis (F)

(Duration) yrs. mos. ds.

(Signed) C. D. Piper M. D.Oct 12 1913 (Address) Jerome, Ida

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place yrs. mos. ds. State yrs. mos. ds.

Where was disease contracted,

If not at place of death?

Former or

usual residence

19. PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

IowaOct 12 1913

20. UNDERTAKER

ADDRESS

D. G. HarrisonJerome

-SUPPLEMENTARY DEATH CERTIFICATE-

(Please reply on this sheet to
the registrar of Vital Statistics)

Death Certificate No. _____

Name ~~Wm. H. Agan~~ *Agan*

Date of Death *Oct 10 1913*

Cause of Death *Lobar Pneumonia*

Contributory Cause of death *Gastro Enteritis*

(Sign here) *E. D. Piper*

M.D.

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Form V. S. No. 5 20M.1-16-12

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH. Registration District No. 2
County of Ada Primary Registration District No. 1004
City of Boise (No. 402 S. 11th St.)
If death occurs away from usual residence, give facts called for under special information.

File No. 6069
Registered No. 247
If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Merrill Card

PERSONAL AND STATISTICAL PARTICULARS

3. SEX M 4. COLOR OR RACE W 5. SINGLE, MARRIED, WID-
OWED OR DIVORCED Single
(Write the word.)
6. DATE OF BIRTH July 21 1913
(Month) (Day) (Year)
7. AGE 3 yrs. 1 mos. 1 ds. IF LESS than 1 day
how many hrs. or mins.?

8. OCCUPATION none
(a) Trade, profession or particular kind of work
(b) General nature of industry, business, or establishment in which employed (or employer)

9. BIRTHPLACE Boise Ida
(State or Country)

10. NAME OF FATHER E. S. Card

11. BIRTHPLACE OF FATHER Michigan
(State or Country)

12. MAIDEN NAME OF MOTHER Maudie Mason

13. BIRTHPLACE OF MOTHER Ill
(State or Country)

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) E. S. Card
(Address) Boise

15. Filed 10 - 23 1913 W. S. Parker
Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH Oct 22 1913
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from Oct 21 1913 to Oct 22 1913
that I last saw him alive on Oct 22 1913
and that death occurred on the date stated above, at 9 A M.

The CAUSE OF DEATH* was as follows:
Acute Enteric Colitis

(Duration) yrs. mos. 5 ds.

Contributory (Secondary)

(Duration) yrs. mos. ds.
(Signed) W. S. Parker M. D.

10-23-1913 (Address) Boise

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death yrs. mos. days. In the State yrs. mos. days.

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL Winnick Hill Cem DATE OF BURIAL Oct 23 1913

20. UNDERTAKER Gay Summers & Co ADDRESS Boise

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Form V. S. No. 5 20M.1-16-12

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics
File No. 86070
Registered No. 247

1. PLACE OF DEATH. Registration District No. 1004
County of Ada Primary Registration District No. 1004
City of Boise (No. _____ St.)
If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Viola Charity Wardell

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX Female 4. COLOR OR RACE White 5. SINGLE, MARRIED, WID-
OWED OR DIVORCED. Married
(Write the word.)

6. DATE OF BIRTH June 6 1892
(Month) (Day) (Year)

7. AGE 21 yrs. 4 mos. 15 ds.
IF LESS than 1 day
how many _____ hrs. or
_____ mins.?

8. OCCUPATION
(a) Trade, profession or particular kind of work Housework
(b) General nature of industry business, or establishment in which employed (or employer)

9. BIRTHPLACE Idaho
(State or Country)

10. NAME OF FATHER Johnston Maw.

11. BIRTHPLACE OF FATHER Idaho
(State or Country)

12. MAIDEN NAME OF MOTHER Mary Maw.

13. BIRTHPLACE OF MOTHER Idaho
(State or Country)

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Mrs Maw
(Address) 13 N. 10th St.

15. Filed 10/22 1913 M. S. Parker
Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH Oct 21 1913
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from Oct 21 1913, to Oct 21 1913,
that I last saw him alive on Oct 21 1913,
and that death occurred on the date stated above, at 1020 N.

The CAUSE OF DEATH* was as follows:
Gunshot wound in large vessels of neck - also through abdomen
(Duration) _____ yrs. _____ mos. _____ ds.
Contributory _____
(Secondary) _____
(Duration) _____ yrs. _____ mos. _____ ds.
(Signed) R. L. Glaze M. D.
19 _____ (Address) Boise

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death _____ yrs. _____ mos. _____ days. In the State _____ yrs. _____ mos. _____ days.
Where was disease contracted if not at place of death? _____
Former or usual residence _____

19. PLACE OF BURIAL OR REMOVAL Morris Hill Cemetery DATE OF BURIAL Oct 23 1913
20. UNDERTAKER J. W. Summers ADDRESS Boise

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Form V. S. No. 5 20M.1-16-12

CERTIFICATE OF DEATH

6071

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics
File No. 246
Registered No. 246

1. PLACE OF DEATH.

Registration District No. 2County of AdaPrimary Registration District No. 1004City of Boise

(No. _____ St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

Glenn E. Wardell

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX

4. COLOR OR RACE

5. SINGLE, MARRIED, WID-
OWED OR DIVORCED.Male WhiteMarried
(Write the word.)

6. DATE OF BIRTH

Nov. 10 1889
(Month) (Day) (Year)

7. AGE

23 yrs. 11 mos. 21 ds.IF LESS than 1 day
how many hrs. or
..... mins.?

8. OCCUPATION

(a) Trade, profession or
particular kind of work(b) General nature of industry
business, or establishment in
which employed (or employer)Farmer

9. BIRTHPLACE

(State or Country)

Iowa10. NAME OF
FATHERE. L. & E. Wardell11. BIRTHPLACE
OF FATHER

(State or Country)

Iowa12. MAIDEN NAME
OF MOTHERLillian Brooks13. BIRTHPLACE
OF MOTHER

(State or Country)

Iowa

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

G. E. Wardell

(Address)

Boise

15.

Filed

11/221913M. J. Parker
Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH

Dec 21 1913
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from

1913, to 1913,that I last saw him alive on 1913,and that death occurred on the date stated above, at 10 A.M.

The CAUSE OF DEATH* was as follows:

Gunshot wound in
heart - suicidal

(Duration) yrs. mos. ds.

Contributory
(Secondary)

(Duration) yrs. mos. ds.

(Signed)

R. L. Glass M. D.19. (Address) Boise

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death yrs. mos. days. In the State yrs. mos. days.

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL DATE OF BURIAL

Morris Hill Cemetery, Oct 23 1913

20. UNDERTAKER

ADDRESS

Try & Summers Boise

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Form V. S. No. 5 20M.1-16-12

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH.

Registration District No. 2

County of Ada

Primary Registration District No. 1004

City of Boise

(No. 918, Grave St.)

File No. 6072

Registered No. 245

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

Morris Meyers

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX

Male

4. COLOR OR RACE

White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED.

Divorced
(Write the word.)

6. DATE OF BIRTH

Not obtainable
(Month) (Day) (Year)

7. AGE

About 50 years
yrs. mos. ds.

IF LESS than 1 day
how many hrs. or mins?

8. OCCUPATION

(a) Trade, profession or particular kind of work

Veteran

(b) General nature of industry business, or establishment in which employed (or employer)

9. BIRTHPLACE

(State or Country)

Germany

10. NAME OF FATHER

Not obtainable

11. BIRTHPLACE OF FATHER

(State or Country)

"

"

12. MAIDEN NAME OF MOTHER

"

"

13. BIRTHPLACE OF MOTHER

(State or Country)

"

"

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

A. Schreiber

(Address)

Boise

15.

Filed 10-22 1913

M. S. Parker
Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH

Oct. 18 1913
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I ~~attended~~ deceased ~~from~~

sur
~~101 to 101~~
that I last saw alive or dead Oct. 18 1913

and that death occurred on the date stated above, at 12³⁰ M.

The CAUSE OF DEATH* was as follows:

Green woman according to statement of Prop. of Rooming house on Street (Duration) yrs. mos. ds.

Contributory (Secondary)

(Duration) yrs. mos. ds.

(Signed) Adolph Schreiber

19 (Address) Boise

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death yrs. mos. days. In the State yrs. mos. days.

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

Boys. Beth Israel Cemetery Oct. 22 1913

20. UNDERTAKER

ADDRESS

Schreiber & Hidenfaden Boise

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Form V. S. No. 5 20M.1-16-12

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH.

Registration District No. 2County of AdaPrimary Registration District No. 1004City of Boise(No. 210)

St.)

File No. 60.13Registered No. 244

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

Suella Caldwell

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX

4. COLOR OR RACE

5. SINGLE, MARRIED, WIDOWED OR DIVORCED.

Female WhiteMarried
(Write the word.)

6. DATE OF BIRTH

June 21 1881
(Month) (Day) (Year)

7. AGE

32 yrs. 4 mos. - ds.IF LESS than 1 day
how many hrs. or
..... mins.?

8. OCCUPATION

(a) Trade, profession or particular kind of work

(b) General nature of industry, business, or establishment in which employed (or employer)

Housekeeper

9. BIRTHPLACE

(State or Country)

Oklahoma

10. NAME OF FATHER

Tora Ferrell

11. BIRTHPLACE OF FATHER

(State or Country)

Mo.

12. MAIDEN NAME OF MOTHER

Susan Paterson

13. BIRTHPLACE OF MOTHER

(State or Country)

Kas.

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

(Address)

J. Caldwell
Boise

15.

Filed 10-20

1913

Ms. Parker

Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

Oct 21 1913
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from

Jan 1912, to Oct 21 1913
that I last saw her alive on Oct 20 1913and that death occurred on the date stated above, at 4 AM

The CAUSE OF DEATH* was as follows:

Pneumonia - pulmonary.(Duration) short yrs. mos. ds.Contributory
(Secondary)

(Duration) yrs. mos. ds.

(Signed) Maurice J. Talbot M. D.4-21-1913 (Address) Boise

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death yrs. mos. days. In the State yrs. mos. days.

Where was disease contracted if not at place of death?

Former or usual residence.

19. PLACE OF BURIAL OR REMOVAL DATE OF BURIAL

St. Joseph's Cemetery Oct 21 1913

20. UNDERTAKER

ADDRESS

Schreiber & Sons Boise

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Form V. S. No. 5 20M.1-16-12

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH.

Registration District No. 2

County

Ada

Primary Registration District No. 1004

City of

Boise

(No. 110 East Broadway St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

Tom Clark

File No.

6074

Registered No. 243

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX

Male

4. COLOR OR RACE

White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED.

Widower
(Write the word.)

6. DATE OF BIRTH

Not obtainable

(Month)

(Day)

(Year)

7. AGE

About 65 years

yrs.

mos.

ds.

IF LESS than 1 day
how many hrs. or mins.

8. OCCUPATION

(a) Trade, profession or particular kind of work

House Painter

(b) General nature of industry business, or establishment in which employed (or employer)

9. BIRTHPLACE

(State or Country)

Not obtainable

10. NAME OF FATHER

"

"

11. BIRTHPLACE OF FATHER

(State or Country)

"

"

12. MAIDEN NAME OF MOTHER

"

"

13. BIRTHPLACE OF MOTHER

(State or Country)

"

"

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

Jas. H. Whitman

(Address)

Boise, Idaho

15.

Filed October 19th, 1913

Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH

Oct

18

1913

(Month)

(Day)

(Year)

17. I HEREBY CERTIFY, That I attended deceased from

Oct 18

1913, to

Oct 18

1913,

that I last saw him alive on Oct 17 1913,

and that death occurred on the date stated above, at M.

The CAUSE OF DEATH* was as follows:

Chronic Endocarditis
Chronic Intestinal nephritis

(Duration) 10 yrs. mos. ds.

Contributory
(Secondary)

(Duration) yrs. mos. ds.

(Signed) James H. Whitman M. D.

1913 (Address) Boise

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL OR HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death yrs. mos. days. In the State yrs. mos. days.

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

Morris Hill Cemetery

Oct. 19th 1913

20. UNDERTAKER

ADDRESS

Schreiber & Sons
Boise, Idaho

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Form V. S. No. 5 20M.1-16-12

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH

Registration District No. 2

County

Primary Registration District No. 1004

City of

(No. 110, East Bannock St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

Class H. Palmer

File No. 6075

Registered No. 242

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX

4. COLOR OR RACE

5. SINGLE, MARRIED, WID-
OWED OR DIVORCED.

Female White

Married
(Write the word.)

6. DATE OF BIRTH

March 22, 1858
(Month) (Day) (Year)

7. AGE

55 yrs. 6 mos. 26 ds.

IF LESS than 1 day
how many hrs. or
..... mins.?

8. OCCUPATION

(a) Trade, profession or
particular kind of work

Housekeeper

(b) General nature of industry
business, or establishment in
which employed (or employer)

9. BIRTHPLACE

(State or Country)

N. York

10. NAME OF
FATHER

Chas Wilbur

11. BIRTHPLACE
OF FATHER

(State or Country)

Conn.

12. MAIDEN NAME
OF MOTHER

Julia Pemberton

13. BIRTHPLACE
OF MOTHER

(State or Country)

Conn.

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

Charlie X Palmer

(Address)

Star Idaho

15.

Filed October 19th 1913

Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

Oct. 18, 1913
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from

Sept 25, 1913, to Oct 18, 1913

that I last saw him alive on Oct 18, 1913

and that death occurred on the date stated above, at 4/10

The CAUSE OF DEATH* was as follows:

Carcinoma of Stomach

(Duration) yrs. mos. ds.

Contributory

(Secondary)

(Duration) yrs. mos. ds.

(Signed)

J. S. Springer M. D.
Oct 19/13 (Address) Boise

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death yrs. mos. days. In the State yrs. mos. days. 23

Where was disease contracted if not at place of death?

St Luke Hosp

Former or usual residence

Star 2da

19. PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

Morris Hill Cemetery Oct 19, 1913

20. UNDERTAKER

ADDRESS

Schubert & Hiden Idaho Boise

MARGIN RESERVED FOR BINDING
WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Form V. S. No. 5 20M.1-16-12

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH

Registration District No. 2

County of Ada

Primary Registration District No. 1004

City of Boise

(No. 21st & Dewey St.)

File No. 6076

Registered No. 228

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Arnold Edward Nixon
If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX M

4. COLOR OR RACE W

5. SINGLE, MARRIED, WIDOWED OR DIVORCED.

Single
(Write the word.)

6. DATE OF BIRTH

Jan 5 1913
(Month) (Day) (Year)

7. AGE

— yrs. 9 mos. 11 ds.

IF LESS than 1 day
how many hrs. or
..... mins.?

8. OCCUPATION

(a) Trade, profession or particular kind of work

none

(b) General nature of industry business, or establishment in which employed (or employer)

9. BIRTHPLACE

(State or Country)

Boise, Idaho

10. NAME OF FATHER

Fred B. Nixon

11. BIRTHPLACE OF FATHER

(State or Country)

Ohio

12. MAIDEN NAME OF MOTHER

Essie L. Dixon

13. BIRTHPLACE OF MOTHER

(State or Country)

Vibr

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

Eerie Nixon

(Address)

Boise, Ida.

15.

Filed 10 - 17 1913

W. Parker
Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH

Oct 16 1913
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from

Oct 12 1913 to Oct 16 1913

that I last saw him alive on Oct 16 1913

and that death occurred on the date stated above, at 1 P.M.

The CAUSE OF DEATH* was as follows:

Bronchopneumonia

(Duration) yrs. 16 ds.

Contributory
(Secondary)

(Duration) yrs. mos. ds.

(Signed)

Maure Henry Tallman, M.D.

10/16 1913 (Address) 1015 Boise, Idaho

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death yrs. mos. days. In the State yrs. mos. days.

Where was disease contracted if not at place of death?

Former or usual residence 21st & Dewey ave

19. PLACE OF BURIAL OR REMOVAL

Morris Hill cemetery

DATE OF BURIAL

10/17 1913

20. UNDERTAKER

Schneider & Sidergaden

ADDRESS

Boise, Ida

Tallman

Exact state-
ment of OCCUPATION is very important. See instructions on back of certificate.

Form V. S. No. 5 20M.1-16-12

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics
File No. 237007
Registered No. 237

1. PLACE OF DEATH.

Registration District No. 2

County of Ada

Primary Registration District No. 1004

City of Boise

(No. 525 St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

George X. Curf

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX

Male

4. COLOR OR RACE

White

5. SINGLE, MARRIED, WID-
OWED OR DIVORCED.

Married
(Write the word.)

6. DATE OF BIRTH

— — 1843
(Month) (Day) (Year)

7. AGE

68 yrs. — mos. — ds.

IF LESS than 1 day
how many hrs. or
mins.?

8. OCCUPATION

(a) Trade, profession or
particular kind of work

(b) General nature of industry
business, or establishment in
which employed (or employer)

Veteran Civil War

9. BIRTHPLACE

(State or Country)

Not obtainable

10. NAME OF
FATHER

Not obtainable

11. BIRTHPLACE
OF FATHER

(State or Country)

Not obtainable

12. MAIDEN NAME
OF MOTHER

Not obtainable

13. BIRTHPLACE
OF MOTHER

(State or Country)

Not obtainable

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

E. G. Burnett

(Address)

Soldiers' Home

15.

Filed 10-15 1913

M. C. Parker

Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH

October 14 1913
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from

Jan 1912 to Oct 14 1913,

that I last saw him alive on Oct 13 1913

and that death occurred on the date stated above, at 6:30 A.M.

The CAUSE OF DEATH* was as follows:

Mitral insufficiency

(Duration) 3 yrs. — mos. — ds.

Contributory
(Secondary)

Arterial fibrillation

(Duration) 2 yrs. — mos. — ds.

(Signed)

Maurice J. Sullivan, M. D.

1414 1913 (Address) Boise Idaho

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death — yrs. — mos. — days. In the State — yrs. — mos. — days.

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

Morris Hill Cemetery Oct 15 1913

20. UNDERTAKER

ADDRESS

Wm. J. Summers Boise Idaho

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Form V. S. No. 5 20M.1-16-12

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics
File No. 235-6078

1. PLACE OF DEATH.

Registration District No. 2

County of Ada

Primary Registration District No. 1004

City of Boise

(No. 1362 W 13 St.)

Registered No. 6078

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

Mathurine E. Mallison

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX

4. COLOR OR RACE

5. SINGLE, MARRIED, WIDOWED OR DIVORCED.

Female White Married

6. DATE OF BIRTH

Oct 29 1867
(Month) (Day) (Year)

7. AGE

45 yrs. 11 mos. 17 ds.

IF LESS than 1 day
how many hrs. or mins.

8. OCCUPATION

(a) Trade, profession or particular kind of work

(b) General nature of industry business, or establishment in which employed (or employer)

Housekeeper

9. BIRTHPLACE

(State or Country)

Marionna Minn

10. NAME OF FATHER

John S. White

11. BIRTHPLACE OF FATHER

(State or Country)

N. Y.

12. MAIDEN NAME OF MOTHER

Etta Wheeler

13. BIRTHPLACE OF MOTHER

(State or Country)

N. Y.

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

S. N. Mallison

(Address)

Boise

15.

Filed 10-13 1913

W. B. Parker

Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH

October 12 1913
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from four years to Oct 11 1913

that I last saw her alive on Oct 11 1913

and that death occurred on the date stated above, at 7 AM.

The CAUSE OF DEATH* was as follows:

Chronic Nephritis

(Duration) Several years ds.

Contributory (Secondary)

(Duration) Several years ds.

(Signed)

Oct 29 1913

(Address)

Boise, Idaho

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death. yrs. mos. days. In the State. yrs. mos. days.

Where was disease contracted if not at place of death?

Former or usual residence.

19. PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

Morris Hill Cemetery Oct 13 1913

20. UNDERTAKER

ADDRESS

Shirley & Hiden Jan Bon

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Form V. S. No. 5 20M.1-16-12

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH.

Registration District No. 2

County of Ada

Primary Registration District No. 1004

City of Boise

(No. 410, State St.)

File No. 234

Registered No. 6519

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Charlie W. Heesler

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX

Male

4. COLOR OR RACE

White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED.

Single
(Write the word.)

6. DATE OF BIRTH

March 18th 1 887
(Month) (Day) (Year)

7. AGE

26 yrs. 6 mos. 24 ds.

IF LESS than 1 day
how many hrs. or mins.?

8. OCCUPATION

(a) Trade, profession or particular kind of work
(b) General nature of industry business, or establishment in which employed (or employer)

Butcher Prop.

9. BIRTHPLACE

(State or Country) Nebraska City Nebraska

10. NAME OF FATHER

Not obtainable

11. BIRTHPLACE OF FATHER

(State or Country)

12. MAIDEN NAME OF MOTHER

" "

13. BIRTHPLACE OF MOTHER

(State or Country)

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) W. H. Kuehler

(Address) Boise

15.

Filed Oct. 13 1913 M. L. Parker
Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH

Oct. 11 1913
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from

Oct 2 1913, to Oct 1913,

that I last saw him alive on Oct 12 1913,

and that death occurred on the date stated above, at M.

The CAUSE OF DEATH* was as follows:

Zyphoid fever

(Duration) yrs. mos. ds.

Contributory
(Secondary)

(Duration) yrs. mos. ds.

(Signed) E. O. Cameron M. D.

19 (Address)

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death St. Alphonsus Hos. yrs. mos. days. State yrs. mos. days.

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

Nebraska City Neb. Oct. 13 1913

20. UNDERTAKER

ADDRESS

Schreiber & Kidenfaden Boise

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Form V. S. No. 5 20M.1-16-12

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH.

Registration District No. 2County of AdaPrimary Registration District No. 1004City of Boise(No. 142 & Grove St.)File No. 6080Registered No. 233

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

George G. Ek

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX

Male

4. COLOR OR RACE

White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED.

Single
(Write the word.)

6. DATE OF BIRTH

Not obtainable

(Month)

(Day)

(Year)

7. AGE

about 26

yrs.

mos.

ds.

IF LESS than 1 day
how many hrs. or
mins?

8. OCCUPATION

(a) Trade, profession or particular kind of work

Water Man

(b) General nature of industry business, or establishment in which employed (or employer)

Electric

9. BIRTHPLACE

(State or Country)

Min.

10. NAME OF FATHER

Not obtainable

11. BIRTHPLACE OF FATHER

(State or Country)

" "

12. MAIDEN NAME OF MOTHER

(State or Country)

" "

13. BIRTHPLACE OF MOTHER

(State or Country)

" "

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

A. Schreiber

(Address)

Boise

15.

Filed 10-151913M. S. Parker

Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH

Oct141913

(Month)

(Day)

(Year)

17. I HEREBY CERTIFY, That I attended deceased ~~from~~ fromthat I last saw him alive on deadand that death occurred on the date stated above, at 1:30 P. M.

The CAUSE OF DEATH* was as follows:

Electric Shock at
Sub station Idaho Power
Light & Power Co.
(Duration) yrs. mos. ds.

Contributory

(Secondary)

(Duration)

yrs.

mos.

ds.

(Signed) A. Schreiber

(Address)

Boise

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL OR HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place

of death

yrs.

mos.

days.

In the

State

yrs.

mos.

days.

Where was disease contracted
if not at place of death?Former or
usual residenceIdaho

19. PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

Idaho, Min.Oct 15 1913

20. UNDERTAKER

ADDRESS

Schreiber & Sons, Boise

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Form V. S. No. 5 20M.1-16-12

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH.

Registration District No. 2County of IdahoPrimary Registration District No. 1004City of Boise(No. St. Luke's Hospital)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME James M. ElliottFile No. 6051Registered No. 232

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX

Male

4. COLOR OR RACE

White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED.

married
(Write the word.)

6. DATE OF BIRTH

Sept 10 1871
(Month) (Day) (Year)

7. AGE

42 yrs. — 28 mos. 28 ds.IF LESS than 1 day
how many hrs. or
..... mins.?

8. OCCUPATION

(a) Trade, profession or particular kind of work

Farmer

(b) General nature of industry, business, or establishment in which employed (or employer)

9. BIRTHPLACE

(State or Country)

Illinois

10. NAME OF FATHER

John Elliott

11. BIRTHPLACE OF FATHER

(State or Country)

Missouri

12. MAIDEN NAME OF MOTHER

Elizabeth Gough

13. BIRTHPLACE OF MOTHER

(State or Country)

Illinois

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Walter Evans(Address) Meridian

15.

Filed 10-91913W. Parker

Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH

Oct 8 1913
(Month) (Day) (Year)17. I HEREBY CERTIFY, That I attended deceased from Sept 28 1913, to Oct 8 1913, that I last saw him alive on Oct 8 1913, and that death occurred on the date stated above, at 10 A.M.

The CAUSE OF DEATH* was as follows:

General Peritonitis
from Perforation of Stomach

(Duration) yrs. mos. ds.

Contributory
(Secondary)

(Duration) yrs. mos. ds.

(Signed) James L. Stewart M. D.198 19 (Address) Boise

State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death yrs. mos. days. In the State yrs. mos. days.

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

Meridian Cemetery Oct 10 1913

20. UNDERTAKER

ADDRESS

Joyce Summers Co Boise Id

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Form V. S. No. 5 20M.1-16-12

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics
File No. 6082
Registered No. 231

1. PLACE OF DEATH.

Registration District No. 2

County of Ada

Primary Registration District No. 1004

City of Boise

(No. 508, N. 6th St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Clara E. W. Wright

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX

F.

4. COLOR OR RACE

W.

5. SINGLE, MARRIED, WIDOWED OR DIVORCED.

Married
(Write the word.)

6. DATE OF BIRTH

Mar 14th 1877
(Month) (Day) (Year)

7. AGE

36 yrs. 6 mos. 22 ds.

IF LESS than 1 day
how many hrs. or
..... mins.?

8. OCCUPATION

(a) Trade, profession or particular kind of work

housekeeper

(b) General nature of industry, business, or establishment in which employed (or employer)

9. BIRTHPLACE

(State or Country)

Canada

10. NAME OF FATHER

Wm Wigglesworth

11. BIRTHPLACE OF FATHER

(State or Country)

Canada

12. MAIDEN NAME OF MOTHER

Emma Boomer

13. BIRTHPLACE OF MOTHER

(State or Country)

Canada

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

C. B. Wright

(Address)

Caldwell Idaho

15.

Filed 10-9 1913

W. L. Porter
Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH

Oct 6th 1913
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from

1913 to now 1913,
that I last saw him alive on dead Oct 5 1913,
and that death occurred on the date stated above, at 7:45 A.M.

The CAUSE OF DEATH* was as follows:

Carbolic Acid Poisoning
by her own hands administered
suicide

(Duration) yrs. mos. ds.

Contributory (Secondary)

Malancholia

(Duration) yrs. mos. ds.

(Signed)

Adolph Schreiber

19.

(Address) Boise Idaho

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death yrs. mos. 10 days. In the State yrs. mos. days.

Where was disease contracted if not at place of death?

Former or usual residence near Caldwell Ida.

19. PLACE OF BURIAL OR REMOVAL

Caldwell Ida.

DATE OF BURIAL

Oct 5 1913

20. UNDERTAKER

Schreiber & Hidenfiden Boise

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Form V. S. No. 5 20M, 1-16-12

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH

Registration District No. 2County of AdaPrimary Registration District No. 1004File No. 6083City of Boise(No. 1304 W. Jefferson St.)Registered No. 230

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

Christine Robertson

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX

F

4. COLOR OR RACE

W.5. SINGLE, MARRIED, WID-
OWED OR DIVORCED.Married
(Give the word.)

6. DATE OF BIRTH

Sept 15th 1890
(Month) (Day) (Year)

7. AGE

73 yrs. — 20 ds.IF LESS than 1 day
how many hrs. or
..... mins.?

8. OCCUPATION

- (a) Trade, profession or particular kind of work
(b) General nature of industry, business, or establishment in which employed (or employer)

Housewife

9. BIRTHPLACE

(State or Country)

Allbrough, Canada

10. NAME OF FATHER

Dugald McFarlane

11. BIRTHPLACE OF FATHER

(State or Country)

Scotland

12. MAIDEN NAME OF MOTHER

Nancy McMillan

13. BIRTHPLACE OF MOTHER

(State or Country)

Scotland

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

A. E. Robertson

(Address)

1304 Jeff St

15.

Filed

10-71913M. S. Parker

Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH

Oct 5 1913
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from

Aug. 25 1913, to Oct 5 1913
that I last saw her alive on Oct 5 1913and that death occurred on the date stated above, at 8:30 PM

The CAUSE OF DEATH* was as follows:

Chronic Nephritis(Duration) 3 yrs. — mos. — ds.Contributory
(Secondary)Myocarditis(Duration) 1 yr. — mos. — ds.

(Signed)

Joe R. Numbers, M. D.
Oct 6 1913 (Address) Boise, Idaho

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death yrs. mos. days. In the State yrs. mos. days.

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

Morris Hill10/8 1913

20. UNDERTAKER

ADDRESS

Schreiber & Sidenfaden, Boise, Idaho

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Form V. S. No. 5 20M.1-16-12

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics
File No. 6085
Registered No. 18

1. PLACE OF DEATH.

Registration District No. 8

County of Ada

Primary Registration District No. 2004

City of Boise

(No. Soldiers Home St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

Robert Ketchum

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX

male

4. COLOR OR RACE

white
Caucasian

5. SINGLE, MARRIED, WIDOWED OR DIVORCED.

(Write the word.)

6. DATE OF BIRTH

not obtainable

(Month)

(Day)

(Year)

7. AGE

81 yrs. — mos. — ds.

IF LESS than 1 day
how many hrs. or mins.?

8. OCCUPATION

(a) Trade, profession or particular kind of work

Civil War veteran

(b) General nature of industry business, or establishment in which employed (or employer)

9. BIRTHPLACE

(State or Country)

not obtainable

10. NAME OF FATHER

11. BIRTHPLACE OF FATHER

(State or Country)

12. MAIDEN NAME OF MOTHER

13. BIRTHPLACE OF MOTHER

(State or Country)

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

E. G. Burnett

(Address)

Soldiers Home

15.

Filed 10 - 31 1913

M. J. Parker
Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH

10 30 1913
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from July 1913, to Oct 30 1913
that I last saw him alive on Oct 30 1913

and that death occurred on the date stated above, at 10 P.M.

The CAUSE OF DEATH* was as follows:

Chronic Morphine

(Duration) yrs. mos. ds.

Contributory
(Secondary)

(Duration) yrs. mos. ds.

(Signed) J. A. Pittenger M. D.

10/31 1913 (Address) Soldiers Home

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death yrs. mos. days. In the State yrs. mos. days.

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

Monis Hill Cem Oct 1 1913

20. UNDERTAKER

ADDRESS

Fry & Summers Co Boise Ida

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Form V. S. No. 5 20M.1-16-12

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH.

Registration District No. 8

County of Ada
City of Near Boise

Primary Registration District No. 2004
(No. Soldiers Home St.)

File No. 6086

Registered No. 16

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

George Hopkins

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX

4. COLOR OR RACE

5. SINGLE, MARRIED, WIDOWED OR DIVORCED.

Male White

Single widower
(Write the word.)

6. DATE OF BIRTH

Not Obtainable 1942
(Month) (Day) (Year)

7. AGE

11 yrs. — mos. — ds.

IF LESS than 1 day
how many hrs. or
..... mins.

8. OCCUPATION

(a) Trade, profession or particular kind of work

(b) General nature of industry business, or establishment in which employed (or employer)

Veteran Civil War

9. BIRTHPLACE

(State or Country)

New York

10. NAME OF FATHER

Not Obtainable

11. BIRTHPLACE OF FATHER

(State or Country)

Not Obtainable

12. MAIDEN NAME OF MOTHER

Not Obtainable

13. BIRTHPLACE OF MOTHER

(State or Country)

Not Obtainable

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

E. G. Burnett

(Address)

Soldiers Home

15.

Filed

Oct. 13 1913

M. S. Parker
Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH

Oct. 12 1913
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from

July 25 1913, to Oct. 11 1913
that I last saw him alive on Oct. 10 1913

and that death occurred on the date stated above, at 7 A. M.

The CAUSE OF DEATH* was as follows:

Apoplexy

(Duration) yrs. mos. ds.

Contributory
(Secondary)

(Duration) yrs. mos. ds.

(Signed)

Ind. Attorney M. D.

19. (Address)

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death yrs. mos. days. In the State yrs. mos. days.

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

Morris Hill Cemetery Oct. 13 1913

20. UNDERTAKER

ADDRESS

Try & Summers Boise 2d

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Form V. S. No. 5 20M.1-16-12

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH.

Registration District No. 8

County of Ada
Swan Falls

Primary Registration District No. 2004
(No. _____ St.)

File No. 6087
Registered No. 15

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Chas. Martin

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX Male 4. COLOR OR RACE White 5. SINGLE, MARRIED, WIDOWED OR DIVORCED. Not obtainable
(Write the word.)

6. DATE OF BIRTH Not obtainable
(Month) (Day) (Year)

7. AGE About 30 years IF LESS than 1 day how many hrs. or mins.?

8. OCCUPATION
(a) Trade, profession or particular kind of work Laborer
(b) General nature of industry business, or establishment in which employed (or employer)

9. BIRTHPLACE Ill.
(State or Country)

10. NAME OF FATHER Not obtainable

11. BIRTHPLACE OF FATHER "
(State or Country)

12. MAIDEN NAME OF MOTHER "

13. BIRTHPLACE OF MOTHER "
(State or Country)

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Adolph Schreiber
(Address) Boise

15. Filed 10-11 1913 M. S. Parker
Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH About March 23/24 1913
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I ~~attended~~ deceased from
about 1911 Oct. 6 1913
that I last saw him alive on 191

and that death occurred on the date stated above, at M.

The CAUSE OF DEATH* was as follows:

Exposure. Body found
Oct 5th 1913 - Body eaten
up nothing but skeleton.
Exposure yrs. mos. ds.

Contributory (Secondary) Alcohol
(Duration) yrs. mos. ds.

(Signed) Adolph Schreiber M.D.
19 (Address) Boise Garnes

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death yrs. mos. days. In the State yrs. mos. days.

Where was disease contracted if not at place of death?

Former or usual residence.

19. PLACE OF BURIAL OR REMOVAL Union Hill Cemetery Ada, Ill. DATE OF BURIAL Oct 13, 1913

20. UNDERTAKER Schreiber & Deufaden ADDRESS Boise

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Form V. S. No. 5. 12½ M. 7-24-11

CERTIFICATE OF DEATH

1. PLACE OF DEATH.

Registration District No. 64

County of Latah

Primary Registration District No. 2144

City of Troy

(No. _____, _____ St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

Paul William Calen

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics
File No. 6088
Registered No. _____

If death occurred in a hospital, institution or camp give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX

4. COLOR OR RACE

5. SINGLE, MARRIED, WIDOWED OR DIVORCED.

Male

White

Single
(Write the word.)

6. DATE OF BIRTH

July

29

1893
(Month) (Day) (Year)

7. AGE

20 yrs. 3 mos. 17 ds.

IF LESS than 1 day
how many.....hrs. or
.....min?

8. OCCUPATION

(a) Trade, profession or particular kind of work.

Farmer.

(b) General nature of industry business or establishment in which employed (or employer)

Farming

9. BIRTHPLACE

(State or Country)

Troy Idaho

10. NAME OF FATHER

John Calen

11. BIRTHPLACE OF FATHER

(State or Country)

Sweden

12. MAIDEN NAME OF MOTHER

Luga Pearson

13. BIRTHPLACE OF MOTHER

(State or Country)

Sweden

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

John Calen

(Address)

Troy Idaho

15.

Filed Nov. 17 1913

B. F. Johnson

Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH

Nov

16

1913
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from

Oct 1

1913

to Nov 16

1913

that I last saw him alive on Nov 8 1913

and that death occurred on the date stated above, at 9 P. M.

The CAUSE OF DEATH* was as follows:

Pulmonary Tuberculosis

(Duration) 2 yrs. mos. ds.

Contributory Tubercular Entailments
(Secondary)

(Duration) 1 1/2 yrs. mos. ds.

(Signed) J. W. Johnson M. D.

Nov 17 1913 (Address) Troy Idaho

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place

In the

of death.....yrs.....mos.....ds. State.....yrs.....mos.....ds.

Where was disease contracted,

If not at place of death?

Former or

usual residence.

19. PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

Dry Creek Cemetery

Nov 19 1913

20. UNDERTAKER

ADDRESS

Ang Pearson

Troy Idaho

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
 N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Form V. S. No. 5 20M 1-16-12

CERTIFICATE OF DEATH

 State of Idaho
 BOARD OF HEALTH
 Bureau of Vital Statistics

1. PLACE OF DEATH.

Registration District No. 1085County of Shoshone

Primary Registration District No. _____

City of " "

(No. _____ St.)

Registered No. _____

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

Benj. F. M. Mullin

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX

4. COLOR OR RACE

5. SINGLE, MARRIED, WIDOWED OR DIVORCED.

Male White Single

6. DATE OF BIRTH

(Month) _____ (Day) _____ (Year) _____

7. AGE

55 yrs. _____ mos. _____ ds.IF LESS than 1 day
how many _____ hrs. or
_____ mins.?

8. OCCUPATION

(a) Trade, profession or particular kind of work

(b) General nature of industry business, or establishment in which employed (or employer)

Farmer

9. BIRTHPLACE

(State or Country)

Missouri

10. NAME OF FATHER

11. BIRTHPLACE OF FATHER

(State or Country)

12. MAIDEN NAME OF MOTHER

13. BIRTHPLACE OF MOTHER

(State or Country)

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

B. J. Kersey
Shoshone Falls

(Address)

15.

Filed 10-29 1913John H. Engler
Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH

Oct 27 1913
(Month) (Day) (Year)17. I HEREBY CERTIFY, That I attended deceased from Oct 22 1913, to Oct 27 1913, that I last saw him alive on Oct 27 1913and that death occurred on the date stated above, at 12 M.

The CAUSE OF DEATH* was as follows:

Peritonitis & paresis of bowels(Duration) _____ yrs. _____ mos. 5 ds.Contributory Appendicitis
(Secondary)

(Duration) _____ yrs. _____ mos. _____ ds.

(Signed) G. O. Boyd M. D.10-29-1913 (Address) Shoshone Falls, Ida.

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death _____ yrs. _____ mos. _____ days. In the State _____ yrs. _____ mos. _____ days.

Where was disease contracted if not at place of death? _____

Former or usual residence _____

19. PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

Shoshone Falls10-29 1913

20. UNDERTAKER

ADDRESS

B. J. KerseyShoshone Falls

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Form V. S. No. 5 20M.1-16-12

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH

Registration District No. 1085County of Thom Falls

Primary Registration District No. _____

City of _____

(No. _____ St.)

Registered No. _____

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

No Name

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX

4. COLOR OR RACE

5. SINGLE, MARRIED, WIDOWED OR DIVORCED.

(Write the word.)

6. DATE OF BIRTH

(Month) (Day) (Year)

7. AGE

yrs. mos. ds.

IF LESS than 1 day
how many hrs. or
mins.?

8. OCCUPATION

(a) Trade, profession or particular kind of work

(b) General nature of industry business, or establishment in which employed (or employer)

9. BIRTHPLACE

(State or Country)

10. NAME OF FATHER

11. BIRTHPLACE OF FATHER

(State or Country)

12. MAIDEN NAME OF MOTHER

13. BIRTHPLACE OF MOTHER

(State or Country)

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

(Address)

15.

Filed 10-20 1913

Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from found unknown foetus probably half developed no clue to identity 191 to 191 that I last saw him alive on 191and that death occurred on the date stated above, at M.

The CAUSE OF DEATH* was as follows:

Premature Birth

(Duration) yrs. mos. ds.

Contributory
(Secondary)

(Duration) yrs. mos. ds.

(Signed) Charles J. Crosby M. D.10 (Address) Coroner

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death.....yrs.....mos.....days. In the State.....yrs.....mos.....days.

Where was disease contracted if not at place of death?

Former or usual residence.

19. PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

Thom Falls10-24 1913

20. UNDERTAKER

ADDRESS

C. CrosbyThom Falls

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Form V. S. No. 5 20M.1-16-12

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH Registration District No. 1085
County of Twin Falls Primary Registration District No. _____
City of _____ (No. _____ St.)

File No. 6091
Registered No. _____

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME No Name

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX _____ 4. COLOR OR RACE _____ 5. SINGLE, MARRIED, WIDOWED OR DIVORCED. _____
(Write the word.)

6. DATE OF BIRTH _____
(Month) (Day) (Year)

7. AGE _____
IF LESS than 1 day
how many _____ hrs. or
_____ mins.?

8. OCCUPATION _____
(a) Trade, profession or particular kind of work
(b) General nature of industry business, or establishment in which employed (or employer)

9. BIRTHPLACE _____
(State or Country)

10. NAME OF FATHER _____

11. BIRTHPLACE OF FATHER _____
(State or Country)

12. MAIDEN NAME OF MOTHER _____

13. BIRTHPLACE OF MOTHER _____
(State or Country)

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) B. J. Gray
(Address) Twin Falls

15. Filed 10-24 1913 John B. Hughes
Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH Oct 22nd 1913
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended _____ from _____
found a _____ foetus probably half developed _____ 191 _____ to _____ 191 _____
that I last saw h. _____ alive on _____ 191 _____
and that death occurred on the date stated above, at _____ M.

The CAUSE OF DEATH* was as follows:
Premature Birth

(Duration) _____ yrs. _____ mos. _____ ds.

Contributory _____
(Secondary)

(Duration) _____ yrs. _____ mos. _____ ds.

(Signed) Charles J. Crosby M. D.
19 _____ (Address) Corvallis

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death _____ yrs. _____ mos. _____ days. In the State _____ yrs. _____ mos. _____ days.

Where was disease contracted if not at place of death? _____

Former or usual residence _____

19. PLACE OF BURIAL OR REMOVAL Twin Falls DATE OF BURIAL 10-24 1913

20. UNDERTAKER C. Crosby ADDRESS Twin Falls

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Form V. S. No. 5 20M.1-16-12

1. PLACE OF DEATH.

County of Twins FallsCity of "

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

Registration District No. 1005Primary Registration District No. "(No. " St.)of Idaho
DEPARTMENT OF HEALTH
Bureau of Vital StatisticsFile No. 6092Registered No. "

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX

4. COLOR OR RACE

5. SINGLE, MARRIED, WID-
OWED OR DIVORCED.Female WhiteSingle (Married)

6. DATE OF BIRTH

Sept. 8 1900
(Month) (Day) (Year)

7. AGE

13 yrs. 1 mos. 1 ds.IF LESS than 1 day
how many hrs. or
mins.?

8. OCCUPATION

(a) Trade, profession or
particular kind of work(b) General nature of industry
business, or establishment in
which employed (or employer)School girl.

9. BIRTHPLACE

(State or Country)

Nebr.10. NAME OF
FATHERGeorge Smith11. BIRTHPLACE
OF FATHER

(State or Country)

Iowa12. MAIDEN NAME
OF MOTHERCherry Drury13. BIRTHPLACE
OF MOTHER

(State or Country)

Missouri

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

George Smith

(Address)

Twins Falls, Ida.

15.

Filed

10-201913John H. Engleman
Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH

Oct. 19 1913
(Month) (Day) (Year)17. I HEREBY CERTIFY, That I attended deceased from
Oct 12 1913, to Oct 19 1913,that I last saw him alive on Oct 19 1913and that death occurred on the date stated above, at 11 A.M.

The CAUSE OF DEATH* was as follows:

Typhoid fever.(Duration) yrs. mos. 19 ds.Contributory
(Secondary)

(Duration) yrs. mos. ds.

(Signed)

H. W. Wilson M. D.Oct 20 1913 (Address) Twins Falls, Ida.

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL OR HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions,
Transients or Recent Residents.)

At place of death yrs. mos. days. In the State yrs. mos. days.

Where was disease contracted
if not at place of death?Former or
usual residence

19. PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

Twins FallsOct 21 1913

20. UNDERTAKER

ADDRESS

J. J. Groenman Twins Falls,

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Form V. S. No. 5 20M.1-16-12

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH
County of Twin Falls
City of " "

Registration District No. 1085
Primary Registration District No. _____
(No. Cecil Christian Jensen St.)

File No. 6093
Registered No. _____

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

Cecil Christian Jensen

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX Male 4. COLOR OR RACE White 5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.)

6. DATE OF BIRTH May 19 1908
(Month) (Day) (Year)

7. AGE 5 yrs. 4 mos. 1 ds.
IF LESS than 1 day how many hrs. or mins.?

8. OCCUPATION

(a) Trade, profession or particular kind of work
(b) General nature of industry, business, or establishment in which employed (or employer)

9. BIRTHPLACE

(State or Country)

Idaho

10. NAME OF FATHER

Joseph Jensen

11. BIRTHPLACE OF FATHER

(State or Country)

Utah

12. MAIDEN NAME OF MOTHER

Amelia Mortensen

13. BIRTHPLACE OF MOTHER

(State or Country)

Utah

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

(Address)

Twin Falls

15.

Filed 10-21 1913

John C. Buehler
Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH

Oct 20 1913
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from Oct 20 1913, to Oct 20 1913, that I last saw him alive on Oct 20 1913, and that death occurred on the date stated above, at 119 M.

The CAUSE OF DEATH* was as follows:

Acute Pericarditis

(Duration) yrs. mos. 3 ds.
Contributory Acute Dilatation Heart
(Secondary)

(Duration) yrs. mos. 1 ds.
(Signed) Bureau L. Hendon M. D.

10/20/13 (Address) Twin Falls, Id.

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death yrs. mos. days. In the State yrs. mos. days.

Where was disease contracted if not at place of death?

Former or usual residence.

19. PLACE OF BURIAL OR REMOVAL

Twin Falls

DATE OF BURIAL

10-22 1913

20. UNDERTAKER

Sprouby

ADDRESS

Twin Falls

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Form V. S. No. 5 20M.1-16-12

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH Registration District No. 1085
County of Twins Falls Primary Registration District No. _____
City of " (No. _____ St.)

File No. 6094

Registered No. _____

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Kathleen E. Atkinson

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX ♀ 4. COLOR OR RACE W. 5. SINGLE, MARRIED, WIDOWED OR DIVORCED. Married

6. DATE OF BIRTH Nov. 26 1865
(Month) (Day) (Year)

7. AGE 47 yrs. 10 mos. 9 ds.
IF LESS than 1 day how many hrs. or mins.?

8. OCCUPATION
(a) Trade, profession or particular kind of work House wife
(b) General nature of industry business, or establishment in which employed (or employer)

9. BIRTHPLACE (State or Country) Missouri

10. NAME OF FATHER John Price

11. BIRTHPLACE OF FATHER (State or Country) North Carolina

12. MAIDEN NAME OF MOTHER Loena Duke

13. BIRTHPLACE OF MOTHER (State or Country) North Carolina

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Marion S. Atkinson

(Address) Twins Falls

15. _____

Filed 10-7 1913 John H. Boyden
Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH Oct. 5 1913
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from Sept 29 1913 to Oct 5 1913, that I last saw her alive on Oct 5 1913 and that death occurred on the date stated above, at 3:20 P.M.
The CAUSE OF DEATH* was as follows:

Embolus into Brain

(Duration) yrs. mos. 3 ds.

Contributory Paralysis of Bowels
(Secondary)

(Duration) yrs. mos. 3 ds.

(Signed) Drs. Alexander & Wright M. D.

Oct 7 1913 (Address) Twins Falls

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death. yrs. mos. days. In the State. yrs. mos. days.

Where was disease contracted if not at place of death?

Former or usual residence.

19. PLACE OF BURIAL OR REMOVAL DATE OF BURIAL

Twins Falls Oct. 7 1913

20. UNDERTAKER ADDRESS

J. J. Crossman Twins Falls

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Form V. S. No. 5. 12½ M. 7-24-11

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH. Registration District No. 23
County of Power Primary Registration District No. 2072
City of American Falls No. _____ St.)

File No. 6095

Registered No. _____

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

Frances M. Lyons

If death occurred in a hospital, institution or camp give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX Female 4. COLOR OR RACE White 5. SINGLE, MARRIED, WIDOWED OR DIVORCED. Single
(Write the word.)

6. DATE OF BIRTH June 23 1853
(Month) (Day) (Year)

7. AGE 60 yrs. 7 mos. 13 ds. IF LESS than 1 day
how many _____ hrs. or _____ min?

8. OCCUPATION

(a) Trade, profession or particular kind of work.

School teacher

(b) General nature of industry business or establishment in which employed (or employer)

9. BIRTHPLACE

(State or Country)

Michigan

10. NAME OF FATHER

Robert Lyons

11. BIRTHPLACE OF FATHER

(State or Country)

Ireland

12. MAIDEN NAME OF MOTHER

Arminda Van Warden

13. BIRTHPLACE OF MOTHER

(State or Country)

New York

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

Mary E. Lyons

(Address)

American Falls

15.

Filed

Sept 11 1913 R. F. Voth
Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH

Sept 9th 1913
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from Sept 9th 1913, to Sept 9th 1913

that I last saw her alive on Sept 9th 1913 and that death occurred on the date stated above, at 12 M.

The CAUSE OF DEATH* was as follows:

Voluntarily

(Duration) _____ yrs. _____ mos. 3 ds.

Contributory (Secondary)

(Duration) _____ yrs. _____ mos. _____ ds.

(Signed)

Richard T. Voth, M. D.
Sept 11 1913 (Address) American Falls

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place _____ yrs. _____ mos. _____ ds. In the _____ yrs. _____ mos. _____ ds.

Where was disease contracted,

If not at place of death?

Former or

usual residence.

19. PLACE OF BURIAL OR REMOVAL DATE OF BURIAL

American Falls Sept 11 1913

20. UNDERTAKER

ADDRESS

Harry R. Hager American Falls

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Form V. S. No. 5 20M.1-16-12

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics
File No. **6096**

1. PLACE OF DEATH.

Registration District No. **75**

County of **Shoshone**

Primary Registration District No. **2104**

City of

(No. **near, Pritchard Dist.**)

Registered No.

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME **H. H. Hendrickson**

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX

4. COLOR OR RACE

5. SINGLE, MARRIED, WIDOWED OR DIVORCED.

male

white

single
(Write the word.)

6. DATE OF BIRTH

(Month)

(Day)

(Year)

7. AGE

60 yrs. mos. ds.

IF LESS than 1 day
how many hrs. or mins.?

8. OCCUPATION

(a) Trade, profession or particular kind of work

(b) General nature of industry business, or establishment in which employed (or employer)

woodman

9. BIRTHPLACE

(State or Country)

Finland

10. NAME OF FATHER

11. BIRTHPLACE OF FATHER

(State or Country)

12. MAIDEN NAME OF MOTHER

13. BIRTHPLACE OF MOTHER

(State or Country)

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

(Address)

R. P. Bacon
Pritchard Id

15.

Filed

Sept 2

191**3**

Dr. H. H. Hendrickson
Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH

8
(Month)

30
(Day)

1913
(Year)

17. I HEREBY CERTIFY, That I attended deceased from

191**3**, to

191**3**,

that I last saw h. alive on

191**3**,

and that death occurred on the date stated above, at **104** M.

The CAUSE OF DEATH* was as follows:

Apoplexy, Cerebral

(Duration) yrs. mos. ds.

Contributory
(Secondary)

(Duration) yrs. mos. ds.

(Signed)

Dr. Henry

M. D.

6/30/13

(Address) **Wallace Id**

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death. yrs. mos. days. In the State. yrs. mos. days.

Where was disease contracted if not at place of death?

Former or usual residence.

19. PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

Wallace Id

6/5 191**3**

20. UNDERTAKER

ADDRESS

Dr. H. H. Hendrickson

Wallace

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Form V. S. No. 5 20M.1-16-12

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH.

Registration District No. 75

County of Shoshone

Primary Registration District No. 2104

City of Waite

(No. St.)

File No. 6097

Registered No.

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Mrs. Anna Garrett

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX

F

4. COLOR OR RACE

White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED.

Married

6. DATE OF BIRTH

Aug. 3 1913
(Month) (Day) (Year)

7. AGE

29 yrs. 2 mos. 2 ds.

IF LESS than 1 day
how many hrs. or
mins.?

8. OCCUPATION

(a) Trade, profession or particular kind of work

House Wife

(b) General nature of industry business, or establishment in which employed (or employer)

9. BIRTHPLACE

(State or Country)

Norway

10. NAME OF FATHER

John Granlie

11. BIRTHPLACE OF FATHER

(State or Country)

Norway

12. MAIDEN NAME OF MOTHER

Do not know

13. BIRTHPLACE OF MOTHER

(State or Country)

Norway

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

Lafayette Garrett

(Address)

Waite

15.

Filed

Aug 5

1913

Dr. C. G. Dutton
Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH

Aug. 3 1913
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from

Aug 3 1913, to Aug 3 1913,
that I saw the deceased alive on Aug 3 1913
and that death occurred on the date stated above, at 5 P.M.

The CAUSE OF DEATH* was as follows:

presumably from Periperal
Convulsions

(Duration)

3 hours

Contributory
(Secondary)

Child birth

(Duration)

yrs. mos. ds.

(Signed)

Geo. S. Lesher M. D.

19

(Address)

Kellogg, Ida.

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place
of death

yrs. 3 mos. 10 days

In the
State

yrs. 1 mos. 2 days

Where was disease contracted
if not at place of death?Former or
usual residence

Waite

19. PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

Murray

Aug 5 1913

20. UNDERTAKER

No undertaker

ADDRESS

Waite

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Form V. S. No. 5 20M.1-16-12

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH.

Registration District No. 25

County of ShoshonePrimary Registration District No. 2108File No. 6098City of Kellogg

(No. _____ St.)

Registered No. _____

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

Mary Carnivalli

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX ♀ 4. COLOR OR RACE W 5. SINGLE, MARRIED, WIDOWED OR DIVORCED. Single

6. DATE OF BIRTH

Aug 2 1913
(Month) (Day) (Year)

7. AGE

2 yrs. 7 mos. 7 ds.

IF LESS than 1 day
how many _____ hrs. or
_____ mins.?

8. OCCUPATION

(a) Trade, profession or particular kind of work

(b) General nature of industry business, or establishment in which employed (or employer)

Infant

9. BIRTHPLACE

(State or Country)

California

10. NAME OF FATHER

Thom. Carnivalli

11. BIRTHPLACE OF FATHER

(State or Country)

Italy

12. MAIDEN NAME OF MOTHER

Madeira Antonio's

13. BIRTHPLACE OF MOTHER

(State or Country)

Italy

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

Mrs. Orlan...

(Address)

Kellogg

15.

Filed

Aug 111913

Arthur G. Britton
Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH

Aug 9 1913
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from

Aug 7 1913 to Aug 7 1913

that I last saw her alive on Aug 7 1913

and that death occurred on the date stated above, at 10 AM

The CAUSE OF DEATH* was as follows:

Gastro-enteritis

(Duration) 2 yrs. 7 mos. 7 ds.

Contributory (Secondary)

(Duration) _____ yrs. _____ mos. _____ ds.

(Signed)

Geo. J. Leshar M. D.

Aug 10 1913 (Address) Kellogg

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death _____ yrs. _____ mos. _____ days. In the State _____ yrs. _____ mos. _____ days.

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

KelloggAug 10 1913

20. UNDERTAKER

ADDRESS

FatherKellogg

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Form V. S. No. 5 20M.1-16-12

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH

Registration District No. 25

County of Shoshone

Primary Registration District No. 2105

City of Kellogg

(No. St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

C. O. Martin

File No. 6099

Registered No.

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX

m

4. COLOR OR RACE

W

5. SINGLE, MARRIED, WIDOWED OR DIVORCED.

(Write the word.)

6. DATE OF BIRTH

2-1-1886
(Month) (Day) (Year)

7. AGE

27 yrs. - mos. - ds.

IF LESS than 1 day
how many hrs. or mins.

8. OCCUPATION

(a) Trade, profession or particular kind of work

miner - lead mine

(b) General nature of industry, business, or establishment in which employed (or employer)

9. BIRTHPLACE

(State or Country)

Norway

10. NAME OF FATHER

11. BIRTHPLACE OF FATHER

(State or Country)

12. MAIDEN NAME OF MOTHER

13. BIRTHPLACE OF MOTHER

(State or Country)

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

(Address)

15.

Filed Aug 6 1913 In Charge Withers
Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH

Aug 3 1913
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from

1913 to 1913

that I last saw him alive on 1913

and that death occurred on the date stated above, at M.

The CAUSE OF DEATH* was as follows:

Accident - killed in mine explosion

(Duration) yrs. mos. ds.

Contributory (Secondary)

(Duration) yrs. mos. ds.

(Signed) H. C. Ruffey Acty. Coroner

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death. yrs. mos. days. In the State. yrs. mos. days.

Where was disease contracted if not at place of death?

Former or usual residence.

19. PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

Greenwood Aug 5 1913

20. UNDERTAKER

ADDRESS

C. B. Shankle Kellogg Ave

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Form V. S. No. 5 20M.1-16-12

1. PLACE OF DEATH

County of *Shoshone*Primary Registration District No. *2105*City of *Idaho Kellogg* (No. _____ St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

*America Romeo Albinoia*State of Idaho
BOARD OF HEALTH
Bureau of Vital StatisticsFile No. *6109*

Registered No. _____

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX

M

4. COLOR OR RACE

White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED.

Single
(Write the word.)

6. DATE OF BIRTH

Jan 17 1892
(Month) (Day) (Year)

7. AGE

*24 yrs. 5 mos. 17 ds.*IF LESS than 1 day
how many _____ hrs. or
_____ mins.

8. OCCUPATION

(a) Trade, profession or particular kind of work

miner

(b) General nature of industry, business, or establishment in which employed (or employer)

9. BIRTHPLACE

(State or Country)

Idaho

10. NAME OF FATHER

Peter Albinoia

11. BIRTHPLACE OF FATHER

(State or Country)

Italy

12. MAIDEN NAME OF MOTHER

Lucy Gandola

13. BIRTHPLACE OF MOTHER

(State or Country)

Italy

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

Peter Albinoia

(Address)

Kellogg, Idaho

15.

Filed *Aug 6 1913**Dr. Chas. G. Tilton*

Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH

Aug 3 1913
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from

1913 to *1913*that I last saw him alive on *1913*and that death occurred on the date stated above, at *M.*

The CAUSE OF DEATH* was as follows:

Accident - killed by explosion in mine.
(Duration) _____ yrs. _____ mos. _____ ds.Contributory
(Secondary)

(Duration) _____ yrs. _____ mos. _____ ds.

(Signed) *W. B. Rodley, M.D.*

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death _____ yrs. _____ mos. _____ days. In the State _____ yrs. _____ mos. _____ days.

Where was disease contracted if not at place of death? _____

Former or usual residence _____

19. PLACE OF BURIAL OR REMOVAL

Greenwood - Kellogg

DATE OF BURIAL

Aug 6 1913

20. UNDERTAKER

E. B. Thornhill

ADDRESS

Kellogg, Idaho

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Form V. S. No. 5 20M.1-16-12

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics
File No. **6191**

1. PLACE OF DEATH

Registration District No. **28**

County of **Shoshone**

Primary Registration District No. **2106**

City of **Andover**

(No. _____ St. _____)

Registered No. _____

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME **Lott Richard Duville Whiting**

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX

4. COLOR OR RACE

5. SINGLE, MARRIED, WIDOWED OR DIVORCED

male

white

married
(Write the word.)

6. DATE OF BIRTH

November 9, 1877
(Month) (Day) (Year)

7. AGE

35 yrs. 9 mos. 13 ds.

IF LESS than 1 day
how many _____ hrs. or
_____ mins?

8. OCCUPATION

(a) Trade, profession or particular kind of work

Miner

(b) General nature of industry business, or establishment in which employed (or employer)

9. BIRTHPLACE

(State or Country)

Northfleet, Kent Co England

10. NAME OF FATHER

Frank Whiting

11. BIRTHPLACE OF FATHER

(State or Country)

England

12. MAIDEN NAME OF MOTHER

Miss Cracknell

13. BIRTHPLACE OF MOTHER

(State or Country)

England

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

Frederick Fudge

(Address)

Andover, Idaho

15.

Filed

July 24

191**3**

Dr. Chas. C. Wetmore

Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

July 22 191**3**
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from

191**3**, to 191**3**,

that I last saw h. alive on 191**3**,

and that death occurred on the date stated above, at **6 A.M.**

The CAUSE OF DEATH* was as follows:

**Acute obstruction of the bowels
died before medical assistance
arrived**
(Duration) _____ yrs. _____ mos. _____ ds.

Contributory
(Secondary)

(Duration) _____ yrs. _____ mos. _____ ds.

(Signed)

**W. C. Bradley, M.D., Coroner
Justice of the Peace Kellogg No. 2**

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place

of death _____ yrs. _____ mos. _____ days.

In the

State _____ yrs. _____ mos. _____ days.

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

Kellogg, Ida

July 23, 1913

20. UNDERTAKER

ADDRESS

Worrell Thorpe

Kellogg, Ida

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Form V. S. No. 5. 12½ M. 7-24-11

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics
File No. 6102
Registered No. _____

1. PLACE OF DEATH.
County of Shoshone
City of Mullan

Registration District No. 35
Primary Registration District No. 2108
(No. _____, _____ St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

Mary Devine

If death occurred in a hospital, institution or camp give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX girl 4. COLOR OR RACE W 5. SINGLE, MARRIED, WIDOWED OR DIVORCED. Single
(Write the word.)

6. DATE OF BIRTH June 17 1911
(Month) (Day) (Year)

7. AGE 2 yrs. 1 mos. 16 ds. IF LESS than 1 day how many _____ hrs. or _____ min?

8. OCCUPATION

- (a) Trade, profession or particular kind of work.
(b) General nature of industry business or establishment in which employed (or employer)

9. BIRTHPLACE Washington
(State or Country)

10. NAME OF FATHER John Devine

11. BIRTHPLACE OF FATHER Missouri
(State or Country)

12. MAIDEN NAME OF MOTHER Hellie Bithurst

13. BIRTHPLACE OF MOTHER Missouri
(State or Country)

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Mr. John Devine
(Address) Mullan

15. Filed Aug 2 1913 FW Rolfe
Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH Aug 2 1913
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from 8 day June 1913, to Aug 2 1913 that I last saw her alive on Aug 2 1913 and that death occurred on the date stated above, at 3:30 P.M.

The CAUSE OF DEATH* was as follows:

Whooping Cough

(Duration) _____ yrs. _____ mos. 25 ds.
Contributory (Secondary) _____

(Duration) _____ yrs. _____ mos. _____ ds.
(Signed) FW Rolfe M. D.
Aug 2 1913 (Address) Mullan

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place _____ In the _____
of death _____ yrs. _____ mos. _____ ds. State _____ yrs. _____ mos. _____ ds.
Where was disease contracted, _____
If not at place of death? _____
Former or _____
usual residence _____

19. PLACE OF BURIAL OR REMOVAL Mullan Ida. DATE OF BURIAL Aug 3 1913

20. UNDERTAKER H. P. Ward ADDRESS Wallace

Dr. Chas. W. Britman

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Form V. S. No. 5 20M.1-16-12

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH.

Registration District No. 70

County of Shoshone

Primary Registration District No. 1011

File No. 8103

City of Wallace

(No. St.)

Registered No. 75

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

Harry Jervis

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX

male

4. COLOR OR RACE

white

5. SINGLE, MARRIED, WIDOWED OR DIVORCED.

married
(Write the word.)

6. DATE OF BIRTH

(Month) 1 (Day) (Year)

7. AGE

35 yrs. — mos. — ds.

IF LESS than 1 day
how many hrs. or
mins.?

8. OCCUPATION

(a) Trade, profession or particular kind of work

miner

(b) General nature of industry, business, or establishment in which employed (or employer)

9. BIRTHPLACE

(State or Country)

unknown

10. NAME OF FATHER

11. BIRTHPLACE OF FATHER

(State or Country)

12. MAIDEN NAME OF MOTHER

13. BIRTHPLACE OF MOTHER

(State or Country)

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

(Address)

15.

Filed

1913

Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH

Oct

6

1913

(Month)

(Day)

(Year)

17. I HEREBY CERTIFY, That I attended deceased from

1913, to 1913,

that I last saw him alive on 1913,

and that death occurred on the date stated above, at M.

The CAUSE OF DEATH* was as follows:

Struck by slab + fracture
of left clavicle + 3 superimposed
fractures with compression on
heart
(Duration) yrs. mos. ds.

Contributory
(Secondary)

(Duration) yrs. mos. ds.

(Signed)

Chas. R. Mourry M. D.
1913/3 (Address) Wallace Ida

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death yrs. mos. days. In the State yrs. mos. days.

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

Wallace Idaho Oct 9 1913

20. UNDERTAKER

ADDRESS

Hard Undertaking Co Wallace Ida

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Form V. S. No. 5 20M.1-16-12

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH.

Registration District No. 70

County of Shoshone

Primary Registration District No. 1011

City of Wallace

(No. _____, St.)

File No. 810+

Registered No. 76

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Albert H. King
If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX

4. COLOR OR RACE

5. SINGLE, MARRIED, WIDOWED OR DIVORCED.
married
(Write the word.)malewhite

6. DATE OF BIRTH

(Month)

(Day)

(Year)

7. AGE

40 yrs. — mos. — ds.IF LESS than 1 day
how many hrs. or
..... mins.?

8. OCCUPATION

(a) Trade, profession or particular kind of work
(b) General nature of industry business, or establishment in which employed (or employer)Bar tender

9. BIRTHPLACE

(State or Country)

New York

10. NAME OF FATHER

John King

11. BIRTHPLACE OF FATHER

(State or Country)

New York

12. MAIDEN NAME OF MOTHER

Blanca Evans

13. BIRTHPLACE OF MOTHER

(State or Country)

New York

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) A C McDonald(Address) Wallace Idaho

15.

Filed 10/8 1913F. Leslie
Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH

Oct

(Month)

6

(Day)

1913

(Year)

17. I HEREBY CERTIFY, That I attended deceased from

Sept 11 1913 to Oct 6 1913that I last saw him alive on Oct 6 1913and that death occurred on the date stated above, at 6 P. M.

The CAUSE OF DEATH* was as follows:

Chronic Parenchymatous Nephritis
Myocarditis(Duration) 1 yrs. — mos. — ds.Contributory
(Secondary)(Duration) — yrs. — mos. — ds.(Signed) Wm. J. Smith M. D.10-8-1913 (Address) Wallace Idaho

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death yrs. mos. days. In the State yrs. mos. days.

Where was disease contracted if not at place of death?

Former or usual residence.

19. PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

WallaceOct 9 1913

20. UNDERTAKER

ADDRESS

Hard Undertaking CoWallace Idaho

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Form V. S. No. 5 20M.1-16-12

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH

Registration District No. 70

County of

Primary Registration District No. 1011

City of

(No. Providence Hospital

File No. 6190

Registered No. 78

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

Edward Jones

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX

4. COLOR OR RACE

5. SINGLE, MARRIED, WIDOWED OR DIVORCED.

male

white

single
(Write the word.)

6. DATE OF BIRTH

1827
(Month) (Day) (Year)

7. AGE

86 yrs. mos. ds.

IF LESS than 1 day
how many hrs. or mins.?

8. OCCUPATION

(a) Trade, profession or particular kind of work

merchant

(b) General nature of industry business, or establishment in which employed (or employer)

9. BIRTHPLACE

(State or Country)

Ireland

10. NAME OF FATHER

not given

11. BIRTHPLACE OF FATHER

(State or Country)

"

12. MAIDEN NAME OF MOTHER

"

13. BIRTHPLACE OF MOTHER

(State or Country)

"

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

L. L. Smith

(Address)

Wallace Id

15.

Filed

Oct 17

1913

F. Leo Lindsey
Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH

10 11 1913
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from

Sept 11 1913, to Oct 11 1913
that I last saw him alive on Oct 11 1913

and that death occurred on the date stated above, at 9:30 A.M.

The CAUSE OF DEATH* was as follows:

Hypertrophy Prostate
gland

(Duration) 10 yrs. mos. ds.

Contributory
(Secondary)

Anemia

(Duration) 2 yrs. mos. ds.

(Signed)

Oct 11 1913 Dr. Mowery
(Address) Wallace Id.

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

Providence Hospital

At place of death 2 yrs. 1 mos. 7 days. In the State yrs. mos. days.

Where was disease contracted if not at place of death? not given

Former or usual residence Wallace Idaho

19. PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

Wallace Id

10/11 1913

20. UNDERTAKER

ADDRESS

Bruce E. Woodstock

Wallace

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Form V. S. No. 5 20M.1-16-12

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH.

Registration District No. 70County of ShoshonePrimary Registration District No. 1011City of Wallace

(No. _____, St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

unknownFile No. 6105Registered No. 79

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX

male

4. COLOR OR RACE

white

5. SINGLE, MARRIED, WIDOWED OR DIVORCED.

single
(Write the word.)

6. DATE OF BIRTH

(Month) (Day) (Year)

7. AGE

yrs. mos. ds.IF LESS than 1 day
how many _____ hrs. or
_____ mins.

8. OCCUPATION

(a) Trade, profession or particular kind of work
(b) General nature of industry, business, or establishment in which employed (or employer)none

9. BIRTHPLACE

(State or Country)

unknown

10. NAME OF FATHER

11. BIRTHPLACE OF FATHER

(State or Country)

12. MAIDEN NAME OF MOTHER

13. BIRTHPLACE OF MOTHER

(State or Country)

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

(Address)

Coroner Mowery
Wallace, Ida.

15.

Filed

Oct 14

191

3 F. P. Linn

Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH

(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from

191____, to _____ 191____,

that I last saw h. _____ alive on _____ 191____,

and that death occurred on the date stated above, at _____ M.

The CAUSE OF DEATH* was as follows:

Found in creek
a premature perhaps
10 months old baby
(Duration) _____ yrs. _____ mos. _____ ds.Contributory
(Secondary)

(Duration) _____ yrs. _____ mos. _____ ds.

(Signed)

Chas. R. Mowery, M.D.
Oct 13 (Address) Wallace, Ida.

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death _____ yrs. _____ mos. _____ days. In the State _____ yrs. _____ mos. _____ days.

Where was disease contracted if not at place of death?

Former or usual residence _____

19. PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

Wallace Ida Oct 14 1913

20. UNDERTAKER

ADDRESS

Hard Undertaking Co. Wallace Ida

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Form V. S. No. 5 20M.1-16-12

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH Registration District No. 70
County of Shoshone Primary Registration District No. 1011
City of Burke (No. _____, _____ St.)

File No. 6107Registered No. 80

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Anna Norman

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX Female 4. COLOR OR RACE white 5. SINGLE, MARRIED, WIDOWED OR DIVORCED. married
(Write the word.)

6. DATE OF BIRTH

(Month) (Day) (Year)

7. AGE

45 yrs. 3 mos. 19 ds.

IF LESS than 1 day
how many hrs. or
mins.?

8. OCCUPATION

(a) Trade, profession or particular kind of work
(b) General nature of industry, business, or establishment in which employed (or employer)

housewife

9. BIRTHPLACE

(State or Country)

Iowa

10. NAME OF FATHER

John Johnson

11. BIRTHPLACE OF FATHER

(State or Country)

Harrison

12. MAIDEN NAME OF MOTHER

Anna Carter

13. BIRTHPLACE OF MOTHER

(State or Country)

Norway

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Mrs. A. Bittner

(Address)

Terra

15. A

Filed Oct. 23, 1913

Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH

Oct 19th 1913
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from

Feb 5th 1912, to Jan 27th 1913that I last saw her alive on Jan 27th 1913and that death occurred on the date stated above, at 5:30 PM

The CAUSE OF DEATH* was as follows:

Recurring carcinoma of cervix uteri(Duration) 2 yrs. mos. ds.

Contributory

(Secondary)

(Duration) yrs. mos. ds.

(Signed)

Wm. J. Dwyer M. D.Oct 2, 1913 (Address) Wallace 2da

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL OR HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death, yrs. mos. days. In the State, yrs. mos. days.

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL DATE OF BURIAL

Shoshone Hall Oct 22 1913

20. UNDERTAKER

ADDRESS

Edmund Spokan

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Form V. S. No. 5 20M.1-16-12

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH.

Registration District No. 70

County of *Spokane*

Primary Registration District No. 1011

City of *Wallace*

(No. _____ St.)

File No. *6403*Registered No. *81*

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

Infant Clifford

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX

male

4. COLOR OR RACE

white

5. SINGLE, MARRIED, WIDOWED OR DIVORCED.

single
(Write the word.)

6. DATE OF BIRTH

(Month) _____ (Day) _____ (Year) _____

7. AGE

_____ yrs. _____ mos. *2* ds.

IF LESS than 1 day
how many _____ hrs. or
_____ mins.?

8. OCCUPATION

(a) Trade, profession or particular kind of work

none

(b) General nature of industry business, or establishment in which employed (or employer)

9. BIRTHPLACE

(State or Country)

Wallace

10. NAME OF FATHER

C. L. Clifford

11. BIRTHPLACE OF FATHER

(State or Country)

Iowa

12. MAIDEN NAME OF MOTHER

Madna Grant

13. BIRTHPLACE OF MOTHER

(State or Country)

Texas

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

R. N. Clifford

(Address)

Wallace, Idaho

15.

Filed *Oct 24* 191*3*

Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH

Oct 24 191*3*
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from

Oct 24 191*3*, to *Oct 24* 191*3*

that I last saw him alive on *Oct 24* 191*3*

and that death occurred on the date stated above, at *2 P.* M.

The CAUSE OF DEATH* was as follows:

Lobar Pneumonia

(Duration) _____ yrs. _____ mos. *1* ds.

Contributory
(Secondary)

(Duration) _____ yrs. _____ mos. _____ ds.

(Signed)

Dr. J. Mowery

Oct 24 191*3* (Address) *Wallace, Idaho*

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death _____ yrs. _____ mos. _____ days. In the State _____ yrs. _____ mos. _____ days.

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL

Wallace

DATE OF BURIAL

Oct 25 191*3*

20. UNDERTAKER

ADDRESS

*Ward Undertaking Co. Wallace**Ida*

Form V. S. No. 5 20M.1-16-12

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH.

Registration District No. 70

County of

Primary Registration District No. 144

City of

(No. 3, Smets Hotel St.)

File No. 6409

Registered No. 77

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

Alfred Johnson

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX

male

4. COLOR OR RACE

white

5. SINGLE, MARRIED, WIDOWED OR DIVORCED.

single
(Write the word.)

6. DATE OF BIRTH

(Month) 1 (Day) (Year)

7. AGE

45

yrs. — mos. — ds.

IF LESS than 1 day
how many hrs. or
mins.?

8. OCCUPATION

(a) Trade, profession or particular kind of work

miner

(b) General nature of industry business, or establishment in which employed (or employer)

9. BIRTHPLACE

(State or Country)

Sweden

10. NAME OF FATHER

not given

11. BIRTHPLACE OF FATHER

(State or Country)

"

12. MAIDEN NAME OF MOTHER

"

13. BIRTHPLACE OF MOTHER

(State or Country)

"

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

J. J. Philis

(Address)

Wallace Idaho

15.

Filed

Oct. 9, 1913

1913

F. Leo Dunphy
Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH

(Month) 10 (Day) 8 (Year) 1913

17. I HEREBY CERTIFY, That I attended deceased from

Oct 8, 1913, to Oct 8, 1913

that I last saw him alive on Oct 8, 1913

and that death occurred on the date stated above, at 8 P. M.

The CAUSE OF DEATH* was as follows

Acute Dilatation of heart

(Duration) yrs. mos. ds.

Contributory (Secondary) Alcoholism

(Duration) yrs. mos. ds.

(Signed) J. S. Mowery M. D.

10/8/13 (Address) Wallace Idaho

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death. yrs. mos. days. In the State. yrs. mos. days.

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

Wallace Idaho 10/10 1913

20. UNDERTAKER

ADDRESS

B. S. Norstall Wallace

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Form V. S. No. 5. 10M. 6-20-11.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH.

Registration District No.

County of CanyonPrimary Registration District No. 7City of Nampa

(No. St.)

Registered No.

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

Walter Howard Lore

If death occurred in a hospital, institution or camp give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX

4. COLOR OR RACE 5. SINGLE, MARRIED, WIDOWED OR DIVORCED.

(Write the word.)

6. DATE OF BIRTH

Aug 28 1895
(Month) (Day) (Year)

7. AGE

18 yrs. 17 mos. 17 ds.
IF LESS than 1 day how many hrs. or min.

8. OCCUPATION

(a) Trade, profession or particular kind of work

(b) General nature of industry business or establishment in which employed (or employer)

going to school

9. BIRTHPLACE

(State or Country)

Wis.

10. NAME OF FATHER

Chas. E. Lore

11. BIRTHPLACE OF FATHER

(State or Country)

Wis.

12. MAIDEN NAME OF MOTHER

Elizabeth Miller

13. BIRTHPLACE OF MOTHER

(State or Country)

New York

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

(Address)

Chas. E. Lore
Nampa

15.

Filed 9/14 1913

B. D. Calange
Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

Aug 9/14 1913
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from

Sept — 1912, to Sept 14 1913
that I last saw him alive on " " 1913

and that death occurred on the date stated above, at 11:30 AM

The CAUSE OF DEATH* was as follows:

acute cardiac dilatation due to endocarditis(Duration) 1 yrs. — mos. — ds.

Contributory (Secondary)

Articular Rheumatism(Duration) 3 yrs. — mos. — ds.(Signed) B. D. Calange M. D.9/14 1913 (Address) Nampa, Ida.

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death — yrs. — mos. — ds. State — yrs. — mos. — ds.

Where was disease contracted,

If not at place of death?

Former or usual residence.

19. PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

Kohler-Lawson 9/16 1913

20. UNDERTAKER

ADDRESS

B. B. Shellabarger Nampa, Ida.

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Form V. S. No. 5. 10M. 6-20-11.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics
File No. 6112

1. PLACE OF DEATH. Registration District No. _____
County of Canyon Primary Registration District No. 7
City of Naupho (No. _____, St.)

If death occurs away from usual residence, give facts called for under special information. 2. FULL NAME Ida Walbur

Registered No. _____
If death occurred in a hospital, institution or camp give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX Female 4. COLOR OR RACE White 5. SINGLE, MARRIED, WIDOWED OR DIVORCED. Married
(Write the word.)

6. DATE OF BIRTH Sept 9 1878
(Month) (Day) (Year)

7. AGE 37 yrs 7 mos 13 ds IF LESS than 1 day how many hrs. or min.?

8. OCCUPATION
(a) Trade, profession, or particular kind of work House keeping
(b) General nature of industry, business, or establishment in which employed (or employer)

9. BIRTHPLACE (State or Country) Ill

10. NAME OF FATHER Don't know

11. BIRTHPLACE OF FATHER (State or Country) Penn

12. MAIDEN NAME OF MOTHER Don't know

13. BIRTHPLACE OF MOTHER (State or Country) Don't know

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) J. K. Wilbur
(Address) Naupho Idaho

15. Filed Sept 23 1913 J. D. Calange
Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH Sept 22 1913
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from Sept 1st 1913 to Sept 22 1913
that I last saw her alive on 7/22 1913,
and that death occurred on the date stated above, at 11 A.M.

The CAUSE OF DEATH* was as follows:
Typhoid fever followed by pneumonia

(Duration) yrs. mos. 21 ds.
Contributory (Secondary) See above

(Duration) yrs. mos. ✓ ds.
(Signed) J. D. Calange M. D.
9/23/13 (Address) Naupho, Ida.

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place _____ In the _____
of death _____ yrs. _____ mos. _____ ds. State _____ yrs. _____ mos. _____ ds.
Where was Disease contracted, _____
If not at place of death? _____
Former or _____
usual residence _____

19. PLACE OF BURIAL OR REMOVAL Kokharlawn Cem DATE OF BURIAL 9/23 1913

20. UNDERTAKER H. Robinson ADDRESS Naupho Ida

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. N. B.—Every item of information should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Form V. S. No. 5. 10M. 6-20-11.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH. Registration District No. _____
County of Canyon Primary Registration District No. 7
City of Nampa (No. _____, St.)

File No. 6113
Registered No. _____

If death occurs away from usual residence, give facts called for under special information.

If death occurred in a hospital, institution or camp give its NAME instead of street and number.

2. FULL NAME

Candall Sears Stiles

PERSONAL AND STATISTICAL PARTICULARS

3. SEX male 4. COLOR OR RACE American 5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.)

6. DATE OF BIRTH Sept 11 1912
(Month) (Day) (Year)

7. AGE 1 yrs. 3 mos. 0 ds. IF LESS than 1 day how many... 2 hrs. or min.?

8. OCCUPATION

- (a) Trade, profession, or particular kind of work
(b) General nature of industry, business, or establishment in which employed (or employer)

9. BIRTHPLACE (State or Country) Nampa Canyon, Idaho

10. NAME OF FATHER Ernest Leane Stiles

11. BIRTHPLACE OF FATHER (State or Country) New Hampshire

12. MAIDEN NAME OF MOTHER Myra Harrell

13. BIRTHPLACE OF MOTHER (State or Country) Louisville Kentucky

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Myra Harrell Stiles
(Address) Nampa R.R. No. 4

15. Filed Oct 11 1913 P.D. Calange md
Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH 10/11 1913
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from 12 PM. 10/11 1913, to 4 AM 10/12 1913, that I last saw him alive on 10/10 1913, and that death occurred on the date stated above, at 4 AM, The CAUSE OF DEATH* was as follows:

Bronchial pneumonia
Don't know history of case
Saw patient only just before death
(Duration) _____ yrs. _____ mos. _____ ds.

Contributory (Secondary) Don't know. saw patient just before death
(Duration) _____ mos. _____ ds.
(Signed) P.D. Calange D.
10/11 1913 (Address) Nampa Ida.

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place _____ In the _____
of death _____ yrs. _____ mos. _____ ds. State _____ yrs. _____ mos. _____ ds.
Where was Disease contracted,
If not at place of death?
Former or
usual residence _____

19. PLACE OF BURIAL OR REMOVAL Fahler Lawn DATE OF BURIAL 10/12 1913

20. UNDERTAKER F.R. Robinson ADDRESS Nampa Ida.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Form V. S. No. 5. 10M. 6-20-11.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH. Registration District No. _____
County of Canyon Co Primary Registration District No. 7
City of Hammond, Ida (No. _____ St.)

File No. 6114

Registered No. _____

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

Infant

If death occurred in a hospital, institution or camp give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX male 4. COLOR OR RACE white 5. SINGLE, MARRIED, WIDOWED OR DIVORCED. single
(Write the word.)

6. DATE OF BIRTH

Oct. 24th 1913.
(Month) (Day) (Year)

7. AGE

7 hours. IF LESS than 1 day
how many 7 hrs. or
_____ yrs. _____ mos. _____ ds. _____ min.

8. OCCUPATION

(a) Trade, profession, or particular kind of work _____
(b) General nature of industry, business, or establishment in which employed (or employer) _____

9. BIRTHPLACE

(State or Country) Idaho.

10. NAME OF FATHER

J. W. Kesner.

11. BIRTHPLACE OF FATHER

(State or Country) Illinois

12. MAIDEN NAME OF MOTHER

Laura Houston

13. BIRTHPLACE OF MOTHER

(State or Country) Minnesota

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) J. W. Kesner
(Address) _____

15.

Filed 10/25 1913 P. D. Calaugher
Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

Oct. 24th 1913.
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from

11 AM 10/24/1913. to 6 P.M. 10/24 1913.

that I last saw him alive on 10/24/1913.

and that death occurred on the date stated above, at 6 P. M.

The CAUSE OF DEATH* was as follows:

Premature birth.

(Duration) _____ yrs. _____ mos. _____ ds.

Contributory (Secondary)

(Duration) _____ yrs. _____ mos. _____ ds.

(Signed) Geo. O. C. Kellogg, M. D.

10/24/1913. (Address) Hammond, Idaho

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place _____ In the _____
of death _____ yrs. _____ mos. _____ ds. State _____ yrs. _____ mos. _____ ds.

Where was Disease contracted, If not at place of death?

Former or usual residence.

19. PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

Kahler Lawn 10/25 1913.

20. UNDERTAKER

ADDRESS

No Undertaker 7 c

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Form V. S. No. 5. 10M. 6-20-11.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics
File No. 6415
Registered No. _____

1. PLACE OF DEATH. Registration District No. _____
County of Canyon Primary Registration District No. 7
City of Nampa (No. _____, St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Anna Lichtner

If death occurred in a hospital, institution or camp give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX Female 4. COLOR OR RACE White 5. SINGLE, MARRIED, WIDOWED OR DIVORCED. Married
(Write the word.)

6. DATE OF BIRTH Aug 5 1877
(Month) (Day) (Year)

7. AGE 35 yrs. 1 mos. 19 ds. IF LESS than 1 day how many hrs. or min.?

8. OCCUPATION
(a) Trade, profession, or particular kind of work Housewife
(b) General nature of industry, business, or establishment in which employed (or employer) _____

9. BIRTHPLACE (State or Country) Ill

10. NAME OF FATHER Henry Frithking

11. BIRTHPLACE OF FATHER (State or Country) Germany

12. MAIDEN NAME OF MOTHER Doris Knorr

13. BIRTHPLACE OF MOTHER (State or Country) Germany

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Aug. Lichtner
(Address) Nampa, Ida

15. 9/24 1913 D. D. Calange
Filed Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH Sept 24 1913
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from Sept 10 1913, to Sept 24 1913, that I last saw her alive on Sept 24 1913, and that death occurred on the date stated above, at 300 W.

The CAUSE OF DEATH* was as follows:
Rupture of Hepatic
abscess through
diaphragm into pulmonary
cavity (Duration) 36 hrs.
Contributory Suppurative Hepatitis
(Secondary) Do not know (Address) Nampa, Ida
(Signed) D. D. Calange M. D.
9/24 1913

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place _____ In the _____
of death yrs. mos. ds. State yrs. mos. ds.
Where was Disease contracted, _____
If not at place of death? _____
Former or _____
usual residence _____

19. PLACE OF BURIAL OR REMOVAL Kohlerlawn Cem DATE OF BURIAL 9 1913

20. UNDERTAKER J. K. Robinson ADDRESS Nampa, Ida

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Form V. S. No. 5. 10M. 6-20-11.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital StatisticsFile No. 6116

Registered No. _____

1. PLACE OF DEATH.

Registration District No. _____

County of CanyonPrimary Registration District No. 7City of Nampa

(No. _____ St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

Fred W Fox

If death occurred in a hospital, institution or camp give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX

Male

4. COLOR OR RACE

White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED.

Single
(Write the word.)

6. DATE OF BIRTH

July291885

(Month)

(Day)

(Year)

7. AGE

28

yrs.

3

mos.

3

ds.

IF LESS than 1 day
how many _____ hrs. or
_____ min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work

Ditch Rider

(b) General nature of industry business or establishment in which employed (or employer)

Farmer

9. BIRTHPLACE

(State or Country)

New York

10. NAME OF FATHER

Frank A Fox

11. BIRTHPLACE OF FATHER

(State or Country)

New York

12. MAIDEN NAME OF MOTHER

Orgood

13. BIRTHPLACE OF MOTHER

(State or Country)

New York

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

D. B. Shellabarger

(Address)

Nampa Idaho

15.

Filed

7/26

1913

S. D. Calonge

Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

September25th1913
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from

8/14/1913

to

9/25/1913that I last saw him alive on 9/25/ 1913,and that death occurred on the date stated above, at 3 P. M.

The CAUSE OF DEATH* was as follows:

Pneumonia with secondary abscesses in lungs & liver.(Duration) _____ yrs. 1 mos. 10 ds.

Contributory (Secondary)

Purpura on S. buttock(Duration) _____ yrs. _____ mos. 8 ds.(Signed) Geo. D. A. Kellogg M. D.9/27/1913 (Address) Nampa, Ida.

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death _____ yrs. _____ mos. _____ ds. State _____ yrs. _____ mos. _____ ds.

Where was disease contracted,

If not at place of death?

Former or

usual residence _____

19. PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

Nahles Lawn9/27 1913

20. UNDERTAKER

ADDRESS

D. B. ShellabargerNampa, Ida.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Form V. S. No. 5 20M.1-16-12

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH.

Registration District No. 117

County of Cassia

Primary Registration District No. 2196

City of Burley

(No. , St.)

File No. 6117

Registered No. 16

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME *Amelia Gilbert*

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX

4. COLOR OR RACE

5. SINGLE, MARRIED, WIDOWED OR DIVORCED.

female white married

6. DATE OF BIRTH

Unknown 1881
(Month) (Day) (Year)

7. AGE

*32 yrs. mos. ds.*IF LESS than 1 day
how many hrs. or mins.?

8. OCCUPATION

(a) Trade, profession or particular kind of work

(b) General nature of industry business, or establishment in which employed (or employer)

Housewife

9. BIRTHPLACE

(State or Country)

England

10. NAME OF FATHER

George Loughton

11. BIRTHPLACE OF FATHER

(State or Country)

England

12. MAIDEN NAME OF MOTHER

May Mace

13. BIRTHPLACE OF MOTHER

(State or Country)

England

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

W. L. Gilbert

(Address)

Burley Idaho

15.

Filed *Oct 15* 1913 *Dr. J. C. Patterson*
Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH

Oct 14 1913
(Month) (Day) (Year)17. I HEREBY CERTIFY, That I attended deceased from *Oct 13 - 1913* to *Oct 14 1913*that I last saw her alive on *Oct 14 1913*and that death occurred on the date stated above, at *10:30 P.M.*

The CAUSE OF DEATH* was as follows:

Neurovascular(Duration) yrs. mos. *6* ds.Contributory
(Secondary)

(Duration) yrs. mos. ds.

(Signed)

Oct 13 1913 J. M. Minter M. D.
(Address) *Burley*

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death yrs. mos. days. In the State yrs. mos. days.

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

Brigham City Utah Oct 16 1913

20. UNDERTAKER

ADDRESS

L. B. Gallogly Burley Ida

-SUPPLEMENTARY DEATH CERTIFICATE-

(Please reply on this sheet to
the registrar of Vital Statistics)

Death Certificate No. _____

Name

Amelia Gilbert

Date of Death

Oct 14. 1913

Cause of Death

Labor Pneumonia

Contributory Cause of death

none

(Sign here)

John M. Minter

M.D.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exactment of OCCUPATION is very important. See instructions on back of certificate.

Form V. S. No. 5 20M.1-16-12

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics
File No. **6118**

1. PLACE OF DEATH. Registration District No. **3**
County of **Canyon** Primary Registration District No. **2005**
City of **Near Caldwell** (No. , St.)

Registered No. **101**
If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME **George Perkins**

PERSONAL AND STATISTICAL PARTICULARS

3. SEX **M** 4. COLOR OR RACE **W** 5. SINGLE, MARRIED, WIDOWED OR DIVORCED. **Widower**
(Write the word.)

6. DATE OF BIRTH **About 1825**
(Month) (Day) (Year)

7. AGE **88** yrs. mos. ds. IF LESS than 1 day how many hrs. or mins.?

8. OCCUPATION (a) Trade, profession or particular kind of work **Farmer**
(b) General nature of industry business, or establishment in which employed (or employer)

9. BIRTHPLACE **Illinois**
(State or Country)

10. NAME OF FATHER **Do not know**

11. BIRTHPLACE OF FATHER **- - -**
(State or Country)

12. MAIDEN NAME OF MOTHER **- - -**

13. BIRTHPLACE OF MOTHER **- - -**
(State or Country)

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) **T. G. Pearson**
(Address) **Caldwell**

15. Filed **Oct. 21 - 1913** **John S. Meyer**
Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH **Oct 20 1913**
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from **Oct 15 1913** to **Oct 20 1913**
that I last saw him alive on **Oct 20 1913**
and that death occurred on the date stated above, at **2 PM**.

The CAUSE OF DEATH* was as follows:

Neurorrhoea
(Duration) yrs. mos. **6** ds.

Contributory (Secondary)
(Duration) yrs. mos. ds.
(Signed) **John S. Meyer** M. D.
Oct. 20 1913 (Address) **Caldwell, Ida.**

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death yrs. mos. days. In the State yrs. mos. days.
Where was disease contracted if not at place of death?
Former or usual residence

19. PLACE OF BURIAL OR REMOVAL **Cemetery Idaho** DATE OF BURIAL **Oct 21 1913**

20. UNDERTAKER **W. B. Dyer** ADDRESS **Caldwell**

-SUPPLEMENTARY DEATH CERTIFICATE-

(Please reply on this sheet to
the registrar of Vital Statistics)

Death Certificate No.

Name Geo Perkins

Date of Death Oct 20th 1913

Cause of Death Lobar pneumonia

Contributory Cause of death Atherosclerosis

(Sign here) J. M. Cole M.D.

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Form V. S. No. 5. 12½M.7-24-11

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics
File No. 6119
Registered No. 104

1. PLACE OF DEATH. Registration District No. 3
County of Canyon Primary Registration District No. 2005
City of Caldwell (No. , St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

Doris Gleason

If death occurred in a hospital, institution or camp give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX female 4. COLOR OR RACE white 5. SINGLE, MARRIED, WIDOWED OR DIVORCED. Single (Write the word.)

6. DATE OF BIRTH June 7 1898
(Month) (Day) (Year)

7. AGE 15 yrs. 4 mos. 27 ds. IF LESS than 1 day how many hrs. or min?

8. OCCUPATION

(a) Trade, profession or particular kind of work.
(b) General nature of industry business or establishment in which employed (or employer)

9. BIRTHPLACE (State or Country)

Illinois

10. NAME OF FATHER

W. E. Gleason

11. BIRTHPLACE OF FATHER (State or Country)

N. Y.

12. MAIDEN NAME OF MOTHER

Etta Butterfield

13. BIRTHPLACE OF MOTHER (State or Country)

Illinois

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) W. E. Gleason
(Address) Caldwell Ida

15.

Filed Nov. 6 1913 John D. Meyer Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH 11 5 1913
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from 10/26/13 191, to 11/4/13 1913
that I last saw her alive on 11/4/13 1913
and that death occurred on the date stated above, at 8:15 P.M.

The CAUSE OF DEATH* was as follows:

Pneumonia
(Please address information furnished by D. W. V. Johnson 11/2/13
Raggs, W. D. 500 Registration ds.)

Contributory (Secondary)

(Duration) yrs. mos. ds.
(Signed) W. E. Johnson M. D.
11/5/13 19 (Address) Caldwell

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place In the
of death yrs. mos. ds. State yrs. mos. ds.
Where was disease contracted,
If not at place of death?
Former or usual residence

19. PLACE OF BURIAL OR REMOVAL DATE OF BURIAL

Canyon Hill Cemetery Nov 6 1913

20. UNDERTAKER ADDRESS

Blatt & Pughman Caldwell

-SUPPLEMENTARY DEATH CERTIFICATE-

(Please reply on this sheet to
the registrar of Vital Statistics)

Death Certificate No.

Name

Doris Gleason

Date of Death

11/5, 13

Cause of Death

Pneumonia

Contributory Cause of death

Preceded Septic Puerperal Septic

(Sign here)

Wm. B. Johnson

M.D.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
N. B.—Every item of information should be carefully supplied. AGE should be state EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Form V. S. No. 5. 10M. 6-20-11.

CERTIFICATE OF DEATH

1. PLACE OF DEATH,
County of Sweadine
City of Mendell

Registration District No. 22
Primary Registration District No. 2018
(No. _____ St. _____)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

Elizabeth Staples

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics
File No. 6120
Registered No. _____

If death occurred in a hospital, institution or camp give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX Female 4. COLOR OR RACE White 5. SINGLE, MARRIED, WIDOWED OR DIVORCED. Single
(Write the word.)

6. DATE OF BIRTH 12 5 1910
(Month) (Day) (Year)

7. AGE 3 yrs. 6 mos. 20 ds. IF LESS than 1 day how many 3 hrs. or — min.

8. OCCUPATION

(a) Trade, profession or particular kind of work —
(b) General nature of industry business or establishment in which employed (or employer) —

9. BIRTHPLACE (State or Country) Gooding, Idaho

10. NAME OF FATHER John Staples

11. BIRTHPLACE OF FATHER (State or Country) Canada

12. MAIDEN NAME OF MOTHER Edith Anna Burright

13. BIRTHPLACE OF MOTHER (State or Country) Idaho

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) John Staples
(Address) Mendell, Idaho

15. Filed July 2 1913 H. E. Lamb
Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH 6 25 1913
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from June 25 1913, to June 25 1913, that I last saw her alive on June 25 1913, and that death occurred on the date stated above, at 1:20 PM.

The CAUSE OF DEATH* was as follows:

Concussion of brain due to fall from horse

(Duration) _____ yrs. _____ mos. 3 1/2 ds.

Contributory (Secondary) none

(Duration) _____ yrs. _____ mos. _____ ds.

(Signed) _____ M. D.

_____ 19 _____ (Address)

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death _____ yrs. _____ mos. _____ ds. In the State _____ yrs. _____ mos. _____ ds.

Where was disease contracted, If not at place of death? _____ Former or usual residence _____

19. PLACE OF BURIAL OR REMOVAL Mendell, Idaho DATE OF BURIAL June 26 1913

20. UNDERTAKER — ADDRESS —

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Form V. S. No. 5 20M.1-16-12

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics
File No. 6121
Registered No. 82

1. PLACE OF DEATH. Registration District No. 70
County of Shoshone Primary Registration District No. 1011
City of Wallace (No. _____ St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME William Crumey

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX male 4. COLOR OR RACE white 5. SINGLE, MARRIED, WIDOWED OR DIVORCED. single
(Write the word.)

6. DATE OF BIRTH _____
(Month) (Day) (Year)

7. AGE 47 yrs. _____ mos. _____ ds. IF LESS than 1 day how many _____ hrs. or _____ mins.?

8. OCCUPATION
(a) Trade, profession or particular kind of work miner
(b) General nature of industry, business, or establishment in which employed (or employer)

9. BIRTHPLACE
(State or Country) Massachusetts

10. NAME OF FATHER Spencer Crumey

11. BIRTHPLACE OF FATHER Georgia
(State or Country)

12. MAIDEN NAME OF MOTHER Lottie Rumbogh

13. BIRTHPLACE OF MOTHER Penn.
(State or Country)

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) _____
(Address) Mrs. J. H. Terman
Wallace Ida

15. Filed Oct 29 1913 3 H. L. Lingle
Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH Oct 27 1913
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from Oct. 25 1913, to Oct 27 1913
that I last saw him alive on Oct 27 1913
and that death occurred on the date stated above, at 7 AM.

The CAUSE OF DEATH* was as follows:

Pneumonia
lobar
(Duration) _____ yrs. _____ mos. 2 ds.
Contributory (Secondary) Emphysema
(Duration) _____ yrs. _____ mos. _____ ds.
(Signed) E. H. Jean M. D.
Oct 27 1913. (Address) Wallace Ida

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death _____ yrs. _____ mos. 2 days. In the Stk. State. Id. yrs. 19 mos. 2 days.
Where was disease contracted if not at place of death? Idaho - Idaho
Former or usual residence _____

19. PLACE OF BURIAL OR REMOVAL Pollack 2da DATE OF BURIAL Oct 29 1913

20. UNDERTAKER E. C. Smith ADDRESS Spokane Wash

-SUPPLEMENTARY DEATH CERTIFICATE-

(Please reply on this sheet to
the registrar of Vital Statistics)

Death Certificate No.

Name..... William Crinnery

Date of Death..... Oct. 27, 1913

Cause of Death..... *Lobar Pneumonia*

Contributory Cause of death..... *Exposure*

(Sign here)..... *J. H. Jean*..... M.D.

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Form V. S. No. 5. 12½ M. 7-24-11

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics
File No. 6122
Registered No. 74

1. PLACE OF DEATH. Registration District No. 70
County of Shoshone Primary Registration District No. 1011
City of Wallace (No. , St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

Jacob Jekel

If death occurred in a hospital, institution or camp give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX male 4. COLOR OR RACE white 5. SINGLE, MARRIED, WIDOWED OR DIVORCED. married (Write the word.)

6. DATE OF BIRTH 1 (Month) (Day) (Year)

7. AGE 45 yrs. mos. ds. IF LESS than 1 day how many hrs. or min?

8. OCCUPATION (a) Trade, profession or particular kind of work miner (b) General nature of industry business or establishment in which employed (or employer)

9. BIRTHPLACE (State or Country) New York

10. NAME OF FATHER unknown

11. BIRTHPLACE OF FATHER (State or Country)

12. MAIDEN NAME OF MOTHER

13. BIRTHPLACE OF MOTHER (State or Country)

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Sam Jekel (Address) Mullan Idaho

15.

Filed Oct. 1, 1913

H. Leo Zupke Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH Oct 1 1913 (Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from Sept 29 1913; to Oct 1 1913 that I last saw him alive on Oct 1 1913 and that death occurred on the date stated above, at 12 M. The CAUSE OF DEATH* was as follows:

Pneumonia (Lobar)

(Duration) yrs. mos. 4 ds. Contributory Cause Exposure (Secondary)

(Signed) J. H. Gray M. D. Oct 1 1913 (Address) Mullan Idaho

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents)

At place Mullan Idaho in the State of Idaho of death yrs. mos. ds. 2 ds. Where was disease contracted, If not at place of death? Mullan Idaho Former or usual residence.

19. PLACE OF BURIAL OR REMOVAL DATE OF BURIAL

Mullan Oct 1 1913

20. UNDERTAKER ADDRESS

Wards Undertaking Co. Wallace Idaho

-SUPPLEMENTARY DEATH CERTIFICATE-

(Please reply on this sheet to
the registrar of Vital Statistics)

Death Certificate No.

Name..... Jacob Jekel

Date of Death..... Oct. 1st 1913

Cause of Death..... *Lobar Pneumonia*

Contributory Cause of death..... *Exposure*

(Sign here)

J. E. Jean

M.D.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Form V. S. No. 5 20M.1-16-12

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH.

Registration District No. 10 14County of GoodingPrimary Registration District No. 2014City of Gooding

(No. _____, St.)

Registered No. _____

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Mary Agnes Swenson

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX

Female

4. COLOR OR RACE

White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED.

(Write the word.)

6. DATE OF BIRTH

December, 12th, 1909
(Month) (Day) (Year)

7. AGE

Three yrs. 8 mos. 14 ds.IF LESS than 1 day
how many _____ hrs. or
_____ mins.?

8. OCCUPATION

(a) Trade, profession or particular kind of work
(b) General nature of industry business, or establishment in which employed (or employer)at Home

9. BIRTHPLACE

(State or Country)

Portland, Oregon

10. NAME OF FATHER

Joseph A. Swenson

11. BIRTHPLACE OF FATHER

(State or Country)

Ogden, Utah

12. MAIDEN NAME OF MOTHER

Mary Agnes Fish

13. BIRTHPLACE OF MOTHER

(State or Country)

Salt Lake City Utah

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

A. J. Jureman
Gooding, Idaho

(Address)

15.

Filed 10-23 1913 J. P. Perry, M.D.
(Local Registrar)

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH

August, 26th, 1913
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from

Aug 23rd, 1913, to Aug 26th, 1913,
that I last saw her alive on Aug 26th, 1913,
and that death occurred on the date stated above, at 10:30 AM.

The CAUSE OF DEATH* was as follows:

Cerebral Meningitis
complicated with
Progressive Diarrhoea
(Duration) _____ yrs. _____ mos. 9 ds.Contributory Persistent Diarrhoea
(Secondary)(Duration) _____ yrs. _____ mos. 9 ds.
(Signed) J. C. Johnson, M. D.Aug. 27, 1913, (Address) Gooding, Idaho

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death _____ yrs. 4 mos. _____ days. In the State _____ yrs. 4 mos. _____ days.Where was disease contracted if not at place of death? at ResidenceFormer or usual residence Salt Lake City, Ut.

19. PLACE OF BURIAL OR REMOVAL DATE OF BURIAL

Gooding, Idaho Aug. 28, 1913,

20. UNDERTAKER

ADDRESS

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Form V. S. No. 5 20M.1-16-12

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital StatisticsFile No. **6124**

Registered No. _____

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

1. PLACE OF DEATH.

Registration District No. 10 14County of GoodingPrimary Registration District No. 20 14City of Gooding

(No. _____ St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

John Gilbert Patterson

PERSONAL AND STATISTICAL PARTICULARS

3. SEX

Male

4. COLOR OR RACE

White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED.

Married
(Write the word.)

6. DATE OF BIRTH

Nov. 12th, 1886

(Month)

(Day)

(Year)

7. AGE

26 yrs. 10 mos. 1 d.IF LESS than 1 day
how many _____ hrs. or
_____ mins.?

8. OCCUPATION

(a) Trade, profession or particular kind of work

Barber

(b) General nature of industry business, or establishment in which employed (or employer)

9. BIRTHPLACE

(State or Country)

Porter, Arkansas

10. NAME OF FATHER

Ben. Patterson

11. BIRTHPLACE OF FATHER

(State or Country)

New York City

12. MAIDEN NAME OF MOTHER

Irene Thompson

13. BIRTHPLACE OF MOTHER

(State or Country)

Missouri

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

C. L. Patterson

(Address)

Gooding, Idaho

15.

Filed Dec - 6 - 1913F. P. Carr M. D.
Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH

September 13th, 1913

(Month)

(Day)

(Year)

17. I HEREBY CERTIFY, That I attended deceased from Sept. 12th, 1913, to Sept. 13th, 1913,that I last saw him alive on Sept. 13th, 1913,and that death occurred on the date stated above, at 8 A.M.

The CAUSE OF DEATH* was as follows

Chronic Bright's Disease(Duration) _____ yrs. 1 mos. 26 ds.Contributory
(Secondary)

(Duration) _____ yrs. _____ mos. _____ ds.

(Signed) W. R. Johanson M. D.Sept. 14, 1913. (Address) Gooding, Idaho

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death.....yrs. 5 mos. 15 days. In the State.....yrs. 3 mos. 15 days.Where was disease contracted if not at place of death? Not knownFormer or usual residence.....Montana

19. PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

Gooding, Idaho, Sept. 14, 1913

20. UNDERTAKER

ADDRESS

G. E. Thompson, Gooding

MARGIN RESERVED FOR INDEXING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Form V. S. No. 5 20M.1-16-12

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH.

Registration District No. 1014

County of Gooding

Primary Registration District No. 2014

City of _____

(No. _____, _____ St.)

File No. 6125

Registered No. _____

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Andrew Hess

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX

4. COLOR OR RACE

5. SINGLE, MARRIED, WIDOWED OR DIVORCED.

male white

married
(Write the word.)

6. DATE OF BIRTH

March 1 1830
(Month) (Day) (Year)

7. AGE

63 yrs. 1 mos. 14 ds.

IF LESS than 1 day
how many _____ hrs. or
_____ mins.?

8. OCCUPATION

(a) Trade, profession or particular kind of work

Farmer

(b) General nature of industry business, or dtablissement in which employed (or employer)

9. BIRTHPLACE

(State or Country)

Pennsylvania

10. NAME OF FATHER

George Hess

11. BIRTHPLACE OF FATHER

(State or Country)

12. MAIDEN NAME OF MOTHER

Cole

13. BIRTHPLACE OF MOTHER

(State or Country)

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Mrs. Belle Hess

(Address) Blanche Idaho

15.

Filed 6-17 1913 F. T. Cary
Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH

April 15 1913
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from

Apr. 12 1913, to Apr 15 1913
that I last saw him alive on Apr 15 1913

and that death occurred on the date stated above, at about 3:30 P M.

The CAUSE OF DEATH* was as follows:

Pneumonia

(Duration) _____ yrs. _____ mos. 7 ds.

Contributory
(Secondary)

(Duration) _____ yrs. _____ mos. _____ ds.

(Signed) J. H. Cronin M. D.

5/30/13 (Address) Gooding, Ida

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OR INJURY; and (2) whether ACCIDENTAL, SUICIDAL OR HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death 1 yrs. 6 mos. 4 days. In the State 30 yrs. _____ mos. _____ days.

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

Bliss Idaho

Apr. 16 1913

20. UNDERTAKER

ADDRESS

None

Form V. S. No. 5. 10M. 6-20-11.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH.

County of Gordug
City of GordugRegistration District No. 1014Primary Registration District No. 2014

(No. _____ St.)

File No. 6126

Registered No. _____

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

Lizzie Borneman

If death occurred in a hospital, institution or camp give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX

Female

4. COLOR OR RACE

White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED.

Married
(Write the word.)

6. DATE OF BIRTH

Nov 16th 1865
(Month) (Day) (Year)

7. AGE

47 yrs. 5 mos. 27 ds.IF LESS than 1 day
how many _____ hrs. or
_____ min.?

8. OCCUPATION

(a) Trade, profession, or particular kind of work

Housewife

(b) General nature of industry business, or establishment in which employed (or employer)

9. BIRTHPLACE

(State or Country)

Germany

10. NAME OF FATHER

Hartman Kruegel

11. BIRTHPLACE OF FATHER

(State or Country)

Germany

12. MAIDEN NAME OF MOTHER

Linker

13. BIRTHPLACE OF MOTHER

(State or Country)

Germany

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

H. J. Borneman

(Address)

Gordug Ida

15.

Filed 6-17 1913F. T. Cary, M. D.
Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

May 13th 1913
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from

May 5 1911, to May 13 1911that I last saw her alive on 11th of May 1913and that death occurred on the date stated above, at 6 P. M.

The CAUSE OF DEATH* was as follows:

Chronic Brights Disease(Duration) 7 yrs. _____ mos. _____ ds.Contributory
(Secondary)

(Duration) _____ yrs. _____ mos. _____ ds.

(Signed) J. H. Cromwell M. D.5/31- 1913 (Address) Gordug

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place _____ In the _____
of death _____ yrs. _____ mos. _____ ds. State _____ yrs. _____ mos. _____ ds.

Where was Disease contracted,

If not at place of death?

Former or

usual residence.

19. PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

La Salle Illinois May 19 1913

20. UNDERTAKER

ADDRESS

A. E. Thompson Gordug

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
N. B.—Every item of information should be carefully supplied. AGE should be state EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Form V. S. No. 5. 10M. 6-20-11.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH.

Registration District No. 1014

County of Gooding

Primary Registration District No. 2014

City of Gooding

(No. _____ St.)

File No. 6127

Registered No. _____

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

John C. Smith

If death occurred in a hospital, institution or camp give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX

Male

4. COLOR OR RACE

White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED.

Married
(Write the word.)

6. DATE OF BIRTH

(Month) (Day) (Year)

7. AGE

yrs. mos. ds. IF LESS than 1 day how many hrs. or min.?

8. OCCUPATION

(a) Trade, profession, or particular kind of work Farming
(b) General nature of industry business, or establishment in which employed (or employer) _____

9. BIRTHPLACE

(State or Country) England

10. NAME OF FATHER

Smith

11. BIRTHPLACE OF FATHER

(State or Country) England

12. MAIDEN NAME OF MOTHER

Unknown

13. BIRTHPLACE OF MOTHER

(State or Country) England

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) L. Griffith

(Address) Ketchikan, Idaho

15.

Filed 10/23 1913 H. T. Carey, M.D.
Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

June 1 1913
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from

May 28 1913, to May June 1 1913

that I last saw him alive on May 30 1913,

and that death occurred on the date stated above, at 6 PM.

The CAUSE OF DEATH* was as follows:

Pneumonia

(Duration) _____ yrs. _____ mos. 7 ds.

Contributory (Secondary)

(Duration) _____ yrs. _____ mos. _____ ds.

(Signed) J. H. Cronwell M. D.

6-1 1913 (Address) Gooding

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL,

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place _____ In the _____

of death _____ yrs. _____ mos. _____ ds. State _____ yrs. _____ mos. _____ ds.

Where was Disease contracted,

If not at place of death? _____

Former or usual residence _____

19. PLACE OF BURIAL OR REMOVAL

Bius Idaho

DATE OF BURIAL

June 1913

20. UNDERTAKER

None

ADDRESS

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

CERTIFICATE OF DEATH

1. PLACE OF DEATH.

Registration District No. 1014

County of Gooding

Primary Registration District No. 2014

City of Gooding

(No. , St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Cyrus Nicodemus

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics
File No. 3 612

Registered No. _____
If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX

Male

4. COLOR OR RACE

White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED.

Married

6. DATE OF BIRTH

Oct 12 1848

(Month)

(Day)

(Year)

7. AGE

64 yrs 8 mos 16 ds.

IF LESS than 1 day
how many hrs. or mins.?

8. OCCUPATION

(a) Trade, profession or particular kind of work

None

(b) General nature of industry business, or establishment in which employed (or employer)

9. BIRTHPLACE

(State or Country)

Unknown

10. NAME OF FATHER

Unknown

11. BIRTHPLACE OF FATHER

(State or Country)

Unknown

12. MAIDEN NAME OF MOTHER

Unknown

13. BIRTHPLACE OF MOTHER

(State or Country)

Unknown

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

Joe Maurais

(Address)

Gooding, Id.

15.

Filed 10 / 23 1913

J. T. Cary M.D.
Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH

June

28

1913

(Month)

(Day)

(Year)

17. I HEREBY CERTIFY, That I attended deceased from

June 28 1913 to June 28 1913

that I last saw him alive on June 28 1913

and that death occurred on the date stated above, at 9 P.M.

The CAUSE OF DEATH* was as follows:

Acute Cystitis

(Duration) yrs. mos. 7 ds.

Contributory (Secondary)

By perlephial phosphate

(Duration) 3 yrs. mos. ds.

(Signed)

J. H. Cronwell M. D.

6/28 1913 (Address) Gooding, Ida

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death yrs. mos. days. In the State yrs. mos. days.

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

Polo, Ogilvie Co. Ill.

1913

20. UNDERTAKER

ADDRESS

A. C. Thompson Gooding, Id.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

FORM V. S. No. 5-25 M. 1-16-13

CERTIFICATE OF DEATH.

1. PLACE OF DEATH.

County of Gooding
City of Bliss

Registration District No. 10 14
Primary Registration District No. 20 14
(No. _____ St.)

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

File No. 6129

Registered No. _____

If death occurs away from
usual residence, give facts
called for under special
information.

2. FULL NAME

Betty Wilkins

If death occurred in a hos-
pital, institution or care,
give its NAME instead of
street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX

Female

4. COLOR OR RACE

White

5. SINGLE, MARRIED, WID-
OWED OR DIVORCED.

Single
(Write the word.)

6. DATE OF BIRTH.

Oct 4 1913
(Month) (Day) (Year)

7. AGE

..... Yrs. Mos. 3 ds.

IF LESS than 1 day
how many hrs. or
..... min.?

8. OCCUPATION

(a) Trade, profession or
particular kind of work.....
(b) General nature of in-
dustry, business, or estab-
lishment in which employ-
ed (or employer).....

9. BIRTHPLACE

(State or Country) Bliss Idaho

10. NAME OF
FATHER

A. B. Wilkins

11. BIRTHPLACE
OF FATHER

(State or Country) Alabama

12. MAIDEN NAME
OF MOTHER

Sarah feeding Wilkins

13. BIRTHPLACE
OF MOTHER

(State or Country) Utah

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) J. L. Wilkins
(Address) Bliss Idaho

15.

Filed 10-23 1913

H. T. Cary, M.D.
Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

Oct 7 1913
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from
191 to 191

that I last saw h..... alive on 191

and that death occurred on the date stated above, at M.

The CAUSE OF DEATH* was as follows:

No Physician

(Duration) Yrs. mos. ds.

Contributory
(Secondary)

(Duration) yrs. mos. ds.

(Signed) M. D.

10 (Address)

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1)
MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions,
Transients or Recent Residents.)

At place of death.....yrs.....mos.....3 days In the State.....yrs.....mos.....3 days

Where was disease contracted
if not at place of death?.....

Former or
usual residence

19. PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

Bliss Idaho Oct-8-1913

20. UNDERTAKER

ADDRESS

None

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

FORM V. S. No. 5-25 M. 1-16-13

CERTIFICATE OF DEATH.

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH.

County of Gooding
City of GoodingRegistration District No. 1014
Primary Registration District No. 2014
(No. _____ St.)File No. 6130
Registered No. _____

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Mrs. Prewitt

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX

Female

4. COLOR OR RACE 5. SINGLE, MARRIED, WID-OWED OR DIVORCED.

whiteMarried
(Write the word.)

6. DATE OF BIRTH.

April
(Month)4
(Day)1865
(Year)

7. AGE

67 Yrs. 6 Mos. 20 ds.IF LESS than 1 day
how many _____ hrs. or
_____ min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work...
(b) General nature of industry, business, or establishment in which employed (or employer).....Housewife

9. BIRTHPLACE

(State or Country)

Missouri

10. NAME OF FATHER

J. P. Willis

11. BIRTHPLACE OF FATHER

(State or Country)

Missouri

12. MARRIED NAME OF MOTHER

Angeline Willis

13. BIRTHPLACE OF MOTHER

(State or Country)

Missouri

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant)

(Address)

Dr. F. T. Carey
Gooding Ida.

15.

Filed Dec 6 1913F. T. Carey M.D.
Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

Oct
(Month)24
(Day)1913
(Year)17. I HEREBY CERTIFY, That I attended deceased from Oct - 21 - 1913 to Oct 24 1913, that I last saw her alive on Oct 24 1913 and that death occurred on the date stated above, at 8 A. M.

The CAUSE OF DEATH* was as follows:

Mucositis Complicated by Hypostatic Congestion of Lungs.(Duration) _____ Yrs. _____ mos. 8 ds.

Contributory (Secondary)

(Duration) _____ Yrs. _____ mos. _____ ds.

(Signed) Dr. F. T. Carey M. D.Oct 21 1913 (Address) Gooding Ida.

*State the DISEASE CAUSING DEATH; or in deaths from PRESENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death 3 yrs. _____ mos. _____ days In the State _____ yrs. _____ mos. _____ days

Where was disease contracted if not at place of death?

Former or usual residence

Oklahoma

19. PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

Gooding26 1913

20. UNDERTAKER

ADDRESS

A. E. ThompsonGooding Ida.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Form V. S. No. 5. 12½ M. 7-24-11

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics
File No. 6132
Registered No. 2

1. PLACE OF DEATH. Registration District No. 43
County of Owyhee Primary Registration District No. 2120
City of Silver (No. St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

Mrs Mary Grete

If death occurred in a hospital, institution or camp give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX Female 4. COLOR OR RACE White 5. SINGLE, MARRIED, WIDOWED OR DIVORCED. Widowed (Write the word.)

6. DATE OF BIRTH Feb 14 1841
(Month) (Day) (Year)

7. AGE 72 yrs. 7 mos. 19 ds. IF LESS than 1 day how many hrs. or min?

8. OCCUPATION (a) Trade, profession or particular kind of work. House work. (b) General nature of industry business or establishment in which employed (or employer)

9. BIRTHPLACE (State or Country) New York

10. NAME OF FATHER Jacob. Hornum

11. BIRTHPLACE OF FATHER Germany (State or Country)

12. MAIDEN NAME OF MOTHER Antonina Wood.

13. BIRTHPLACE OF MOTHER Germany (State or Country)

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE (Informant) Fred Grete (Address) Caldwell, Ida

15. Filed October 7 1913 H. H. Schuyler, M.D. Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH October 3 1913
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from October 3 1913, to October 3 1913 that I last saw her alive on October 3 1913 and that death occurred on the date stated above, at 10 P. M.

The CAUSE OF DEATH* was as follows:
Heart disease, aortic stenosis,
(death sudden & without warning.)

(Duration) One yr. — mos. — ds.
Contributory Chronic nephritis,
(Secondary)

(Duration) (about) yrs. eight mos. — ds.
(Signed) H. H. Schuyler M. D.
Oct. 11 1913 (Address) Silver City, Idaho

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place In the
of death yrs. mos. ds. State yrs. mos. ds.
Where was disease contracted,
If not at place of death?
Former or
usual residence.

19. PLACE OF BURIAL OR REMOVAL DATE OF BURIAL
Masonic Cemetery Oct 7 1913

20. UNDERTAKER ADDRESS
John Grete Silver City, Ida

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Form V. S. No. 5 20M.1-16-12

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics
File No. **6133**

1. PLACE OF DEATH.

Registration District No. **58**County of **Blaine**Primary Registration District No. **2138**City of **Phil City**

(No. _____, St.)

Registered No. _____

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

Geo O Sanguins

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX

Male

4. COLOR OR RACE

White

5. ~~SINGLE, MARRIED, WID-
OWED OR DIVORCED.~~
(Write the word.)
Widowed

6. DATE OF BIRTH

2 **2** **1875**
(Month) (Day) (Year)

7. AGE

38 yrs. _____ mos. _____ ds.

IF LESS than 1 day
how many _____ hrs. or
_____ mins.?

8. OCCUPATION

(a) Trade, profession or
particular kind of work
(b) General nature of industry,
business, or establishment in
which employed (or employer)

Farmer

9. BIRTHPLACE

(State or Country)

Ontario Canada

10. NAME OF FATHER

William Sanguins

11. BIRTHPLACE OF FATHER

(State or Country)

Devonshire Eng.

12. MAIDEN NAME OF MOTHER

Anna Johns

13. BIRTHPLACE OF MOTHER

(State or Country)

Devonshire Eng

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

(Address)

B Sanguins
Shoupton Park Ca.

15.

Filed

Oct 27 191 **Dec 10 1913**

Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH

Oct 24 1913
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from

_____ 191____, to _____ 191____,

that I last saw h. _____ alive on _____ 191____,

and that death occurred on the date stated above, at _____ M.

The CAUSE OF DEATH* was as follows:

Accidental-runaway team**Died instantly**

(Duration) _____ yrs. _____ mos. _____ ds.

Contributory **Fract of ribs, puncture of lung**
(Secondary)

(Duration) _____ yrs. _____ mos. _____ ds.

(Signed) **CR Bloom** M. D.

1913 (Address) **Phil City**

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL OR HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death _____ yrs. _____ mos. _____ days. In the State _____ yrs. _____ mos. _____ days.

Where was disease contracted
if not at place of death?

Former or
usual residence

19. PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

Shoupton Park Ida**Oct 30** 1913

20. UNDERTAKER

ADDRESS

Ralph D Harris**Hailey**

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. N. B.—Every item of information should be carefully supplied. AGE should be state EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Form V. S. No. 5. 10M. 6-20-11.

CERTIFICATE OF DEATH

1. PLACE OF DEATH. Registration District No.
 County of Minidoka Primary Registration District No.
 City of Rupert (No., St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

Jarvis R Crawford

State of Idaho
 BOARD OF HEALTH
 Bureau of Vital Statistics
 File No. 6134

Registered No.

If death occurred in a hospital, institution or camp give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX Male 4. COLOR OR RACE White 5. SINGLE, MARRIED, WIDOWED OR DIVORCED. Married
 (Write the word.)

6. DATE OF BIRTH

Oct 1 1892
 (Month) (Day) (Year)

7. AGE

61 yrs. 22 ds.

IF LESS than 1 day
 how many hrs. or
 min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work

Farmer

(b) General nature of industry business or establishment in which employed (or employer)

9. BIRTHPLACE

(State or Country)

Wisconsin

10. NAME OF FATHER

Leonard Crawford

11. BIRTHPLACE OF FATHER

(State or Country)

12. MAIDEN NAME OF MOTHER

Lydia Sweet

13. BIRTHPLACE OF MOTHER

(State or Country)

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

H. Harris

(Address)

Rupert

15.

Filed

191P. H. Scott

Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

Sept
 (Month)

23
 (Day)

1913
 (Year)

17. I HEREBY CERTIFY, That I attended deceased from

Sept 1913, to Sept 23 1913

that I last saw him alive on Sept 23 1913

and that death occurred on the date stated above, at 9:30 A. M.

The CAUSE OF DEATH* was as follows:

Gas poisoning of the stomach

(Duration) yrs. 10 mos. ds.

Contributory (Secondary)

(Duration) yrs. mos. ds.

(Signed) J. B. K... M. D.

19. (Address) Rupert

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted.

If not at place of death?

Former or

usual residence.

19. PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

Rupert

Oct 5 1913

20. UNDERTAKER

ADDRESS

W. A. Goodman Rupert

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics1. PLACE OF DEATH.
County of Minidoka
City of RupertRegistration District No.
Primary Registration District No.
(No. St.)File No. 6135
Registered No.

If death occurred in a hospital, institution or camp give its NAME instead of street and number.

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

Mary C Flook

PERSONAL AND STATISTICAL PARTICULARS

3. SEX 4. COLOR OR RACE 5. SINGLE, MARRIED, WID-
OWED OR DIVORCED.Female White Widowed

6. DATE OF BIRTH

Sept 10 1892
(Month) (Day) (Year)

7. AGE

71 yrs. 1 mos. 24 ds.
IF LESS than 1 day
how many hrs. or
..... min.?

8. OCCUPATION

- (a) Trade, profession or particular kind of work
-
- (b) General nature of industry business or establishment in which employed (or employer)

9. BIRTHPLACE
(State or Country)Missouri

10. NAME OF FATHER

John Phillips11. BIRTHPLACE OF FATHER
(State or Country)North Carolina

12. MAIDEN NAME OF MOTHER

Hosier13. BIRTHPLACE OF MOTHER
(State or Country)North Carolina

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Alla G Goodman
(Address) Rupert Idaho

15.

Filed 191O. H. Scott
Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

Nov 3 1913
(Month) (Day) (Year)17. I HEREBY CERTIFY, That I attended deceased from
Oct 9 1913, to Nov 1 1913that I last saw her alive on Nov 1 1913,
and that death occurred on the date stated above, at 4:20 A.M.

The CAUSE OF DEATH* was as follows:

Senile gangrene(Duration) 2 yrs. 6 mos. ds.Contributory
(Secondary)

(Duration) yrs. mos. ds.

(Signed) J. B. Kennedy M. D.
10/4 1913 (Address) Rupert

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death yrs. mos. ds. State yrs. mos. ds.
Where was disease contracted,
If not at place of death?
Former or usual residence.

19. PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

Garden City Mo Nov 8 1913

20. UNDERTAKER

ADDRESS

W. G. Goodman Rupert Idaho

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Form V. S. No. 5 20M.1-16-12

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH
County of Canyon Registration District No. _____
City of New Plymouth Primary Registration District No. _____
(No. _____) (St. _____)

File No. 6136

Registered No. _____

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Martha Virginia Strong

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX Female 4. COLOR OR RACE White 5. SINGLE, MARRIED, WIDOWED OR DIVORCED. Married
(Write the word.)

6. DATE OF BIRTH Mar 19 1862
(Month) (Day) (Year)

7. AGE 51 yrs. 7 mos. — ds.
How many _____ days _____ mos. _____ yrs.

8. OCCUPATION
(a) Trade, profession or particular kind of work Housewife
(b) General nature of industry, business, or establishment in which employed (or employer) _____

9. BIRTHPLACE Penn.
(State or Country)

10. NAME OF FATHER Geo. H. Geller

11. BIRTHPLACE OF FATHER Penn.
(State or Country)

12. MAIDEN NAME OF MOTHER Sarah Kleinhause

13. BIRTHPLACE OF MOTHER Penn.
(State or Country)

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) _____
(Address) Chara. Strong

15. Filed _____ 191 Nov 7 _____
Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH Oct 19 1913
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from Lab 1913, to Oct 19 1913, that I last saw him alive on " " 1913, and that death occurred on the date stated above, at 5:30 PM.

The CAUSE OF DEATH* was as follows:
mitral regurgitation

(Duration) several yrs. mos. ds.

Contributory (Secondary) Anemia

(Duration) 1 yrs. mos. ds.

(Signed) Wm J. Drusdale M. D.
Oct 19 1913 (Address) New Plymouth, Ida

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death _____ yrs. _____ mos. _____ days. In the State _____ yrs. _____ mos. _____ days.

Where was disease contracted if not at place of death? _____

Former or usual residence _____

19. PLACE OF BURIAL OR REMOVAL DATE OF BURIAL New Plymouth Oct 25 1913

20. UNDERTAKER J. A. Adair ADDRESS Laysville, Ida

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Form V. S. No. 5. 12½ M. 7-24-11

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics
File No. 6137
Registered No. _____

1. PLACE OF DEATH. Registration District No. 30
County of Owyhee Primary Registration District No. 2123
City of Reynolds Creek (No. _____, _____ St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

Ulyssis Bernard

If death occurred in a hospital, institution or camp give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX Male 4. COLOR OR RACE Cauc. 5. SINGLE, MARRIED, WIDOWED OR DIVORCED. Married.
(Write the word.)

6. DATE OF BIRTH Feb. 10 1867
(Month) (Day) (Year)

7. AGE 46 yrs. 2 mos. 25 ds. IF LESS than 1 day how many hrs. or min?

8. OCCUPATION

(a) Trade, profession or particular kind of work.
(b) General nature of industry business or establishment in which employed (or employer)

Farmer

9. BIRTHPLACE
(State or Country)

Idaho

10. NAME OF FATHER

J. B. Bernard

11. BIRTHPLACE OF FATHER
(State or Country)

Ills.

12. MAIDEN NAME OF MOTHER

Cox

13. BIRTHPLACE OF MOTHER
(State or Country)

Ills.

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

(Address)

Ruben Jefford
Reynolds Creek

15.

Filed

May 19 1913

T. D. Forrester
Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH

May 6 1913
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from _____ 191____, to _____ 191____

that I last saw him _____ alive on _____ 191____
and that death occurred on the date stated above, at 5 P. M.

The CAUSE OF DEATH* was as follows:

Alcoholism

_____ (Duration) _____ yrs. _____ mos. _____ ds.

Contributory
(Secondary)

_____ (Duration) _____ yrs. _____ mos. _____ ds.

(Signed) T. D. Forrester M. D.

May 19 1913 (Address) Reynolds Creek, Idaho

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place _____ In the _____
of death _____ yrs. _____ mos. _____ ds. State _____ yrs. _____ mos. _____ ds.

Where was disease contracted,

If not at place of death?

Former or

usual residence.

19. PLACE OF BURIAL OR REMOVAL DATE OF BURIAL

Upper Reynolds Creek Cemetery May 8 1913

20. UNDERTAKER ADDRESS

A. B. Shullabarger Hamper
Idaho

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Form V. S. No. 5 20M.1-16-12

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics
File No. 6101613
Registered No. 215

1. PLACE OF DEATH.

Registration District No. 2

County of Ida

Primary Registration District No. 1004

City of Boise

(No. 410, State Idaho St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Rebekah Davis

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX

Female

4. COLOR OR RACE

Col.

5. SINGLE, MARRIED, WIDOWED OR DIVORCED.

Widow
(Write the word.)

6. DATE OF BIRTH

Not obtainable

(Month)

(Day)

(Year)

7. AGE

About 41 years
..... yrs. mos. ds.

IF LESS than 1 day
how many hrs. or
..... mins.?

8. OCCUPATION

(a) Trade, profession or particular kind of work

Book

(b) General nature of industry business, or establishment in which employed (or employer)

9. BIRTHPLACE

(State or Country)

Tenn.

10. NAME OF FATHER

Not obtainable

11. BIRTHPLACE OF FATHER

(State or Country)

"

"

12. MAIDEN NAME OF MOTHER

"

"

13. BIRTHPLACE OF MOTHER

(State or Country)

"

"

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

Mrs. Edwin Davis

(Address)

525 Warm Spgs. Ave.

15.

Filed

9-23

1913

M. S. Parker
Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH

Sept.

22

1913

(Month)

(Day)

(Year)

17. I HEREBY CERTIFY, That I attended deceased from

Sept. 4

1913, to

Sept. 22

1913,

that I last saw him alive on Sept. 21 1913,

and that death occurred on the date stated above, at 4 A. M.

The CAUSE OF DEATH* was as follows:

Cardiac Dropsy

(Duration)

yrs.

mos.

ds.

Contributory
(Secondary)

(Duration)

yrs.

mos.

ds.

(Signed)

Joseph R. Newkys

M. D.

Sept. 22, 1913

(Address)

Boise Idaho

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place

of death..... yrs. mos. days.

In the

State..... yrs. mos. days.

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

Monticello Cemetery

Sept. 23 1913

20. UNDERTAKER

ADDRESS

Schreiber & Lidenfaden

Boise

Numbers.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Form V. S. No. 5. 12½ M. 7-24-11

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics
File No. 6139
Registered No.

1. PLACE OF DEATH. Registration District No. 25
County of Shoshone Primary Registration District No. 2108
City of Mullan (No. , St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

Infant of Chas Lehta

If death occurred in a hospital, institution or camp give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX Male 4. COLOR OR RACE white 5. SINGLE, MARRIED, WIDOWED OR DIVORCED. single
(Write the word.)
6. DATE OF BIRTH August 1st 1913
(Month) (Day) (Year)

7. AGE 7 yrs. 7 mos. 7 ds. If LESS than 1 day how many hrs. or min?

8. OCCUPATION

(a) Trade, profession or particular kind of work.
(b) General nature of industry business or establishment in which employed (or employer)

None

9. BIRTHPLACE

(State or Country)

Ida

10. NAME OF FATHER

Chas Lehta

11. BIRTHPLACE OF FATHER

(State or Country)

Sweden

12. MAIDEN NAME OF MOTHER

Emma Lumberg

13. BIRTHPLACE OF MOTHER

(State or Country)

Sweden

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

(Address)

Chas Lehta
Mullan Ida

15.

Filed Aug 9 1913

F. W. Rolf

Local Registrar

Dr. Charles C. Wetteman

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH

August 7 1913
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from August 1st 1913, to August 7 1913

that I last saw her alive on August 7 1913 and that death occurred on the date stated above, at 9⁰⁰ M.

The CAUSE OF DEATH* was as follows:

Pneumonia

(Duration) yrs. mos. 3 ds.

Contributory
(Secondary)

(Duration) yrs. mos. ds.

(Signed) James B. Bean M. D.

Aug 8 1913 (Address) Mullan

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place In the
of death yrs. mos. ds. State yrs. mos. ds.
Where was disease contracted,
If not at place of death?
Former or
usual residence.

19. PLACE OF BURIAL OR REMOVAL DATE OF BURIAL

New City Cemetery

Aug 9 1913

20. UNDERTAKER

ADDRESS

Thompson

Wallace Ida

County of Beaumont
City of MontpelierPrimary Registration District No. 2732
(No. _____, _____ St.)File No. 6140
Registered No. _____If death occurs away from us-
ual residence, give facts called
for under special information.

2. FULL NAME

Reina SchuchertIf death occurred in
stitution or camp
instead of street and

PERSONAL AND STATISTICAL PARTICULARS

3. SEX

4. COLOR OR RACE

5. SINGLE, MARRIED, WID-
OWED OR DIVORCED.Female WhiteMarried
(Write the word.)

6. DATE OF BIRTH

February, 4, 1855
(Month) (Day) (Year)

7. AGE

58 yrs. 8 mos. 12 ds.IF LESS than 1 day
how many hrs. or
..... min?

8. OCCUPATION

(a) Trade, profession or
particular kind of work.
(b) General nature of industry
business or establishment in
which employed (or employer)Housewife

9. BIRTHPLACE

(State or Country)

Eggwyl, Sigmarsburg10. NAME OF
FATHERFriedrich Fischer11. BIRTHPLACE
OF FATHER

(State or Country)

Lindern, Bern, Switz.12. MAIDEN NAME
OF MOTHERAnna Schenk13. BIRTHPLACE
OF MOTHER

(State or Country)

Lindern, Bern, Switz.

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

Chris. Schuchert(Address) Montpelier, Ida

15.

Filed

10/18/1913NOT Stengma

Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

Oct, 16
(Month) (Day)17. I HEREBY CERTIFY, That I attended deceased from
Oct 11, 1913, to Oct 16,
that I last saw him alive on Oct 16

and that death occurred on the date stated above, at _____

The CAUSE OF DEATH* was as follows:

Apoplexy

(Duration) yrs. mos.

Contributory
(Secondary)

(Duration) yrs. mos.

(Signed)

R. A. Ashley

19 (Address)

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSE
MEANS OF INJURY; (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.18. LENGTH OF RESIDENCE (For Hospitals, In-
Transients or Recent Residents.)At place In the
of death 12 yrs. mos. ds. State 12 yrs.

Where was disease contracted,

If not at place of death?

Former or

usual residence

Switzerland

19. PLACE OF BURIAL OR REMOVAL

DATE OF

Montpelier10/19/

20. UNDERTAKER

ADDRESS

None

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Form V. S. No. 5 20M.1-16-12

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH

Registration District No. 2

County of AdaPrimary Registration District No. 1004City of Bonanza(No. 1315 N 1st St. St.)File No. 611Registered No. 26

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

James Magee

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX

Male

4. COLOR OR RACE

White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED.

Single
(Write the word)

6. DATE OF BIRTH

Jan25 1 85
(Month) (Day) (Year)

7. AGE

39 yrs. 9 mos. 2 ds.

IF LESS than 1 day
how many hrs. or
..... mins.?

8. OCCUPATION

(a) Trade, profession or particular kind of work

Good Miner

(b) General nature of industry business, or establishment in which employed (or employer)

9. BIRTHPLACE

(State or Country)

Philadelphia Penn

10. NAME OF FATHER

Thomas Magee

11. BIRTHPLACE OF FATHER

(State or Country)

Ireland

12. MAIDEN NAME OF MOTHER

Elisabeth Jones

13. BIRTHPLACE OF MOTHER

(State or Country)

Penn.

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

W. W. Evans

(Address)

715 N 1st St

15.

Filed

10-311913M. S. Parker

Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH

Oct. 29
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from

Oct 15 1913, to Oct 29 1913
that I last saw him alive on Oct 28 1913and that death occurred on the date stated above, at 6 A. M.

The CAUSE OF DEATH* was as follows:

Pneumonia

(Duration) yrs. mos. ds.

Contributory
(Secondary)

(Duration) yrs. mos. ds.

(Signed)

W. S. Evans

M. D.

(Address) Bonanza

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death yrs. mos. days. In the State yrs. mos. days.

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

Morris & Humphreys Oct 31 1913

20. UNDERTAKER

ADDRESS

J. & J. Humphreys Bonanza

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Form V. S. No. 5 20M.1-16-12

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH.

Registration District No. 2

County of Ada

Primary Registration District No. 1004

City of Boise

(No. 110, East Ransom St.)

File No. 6142

Registered No. 267

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Marguerite Chapman

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX Female

4. COLOR OR RACE White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED. Single
(Write the word.)

6. DATE OF BIRTH Aug 27 1900

(Month)

(Day)

(Year)

7. AGE 13 yrs. 1 mos. 29 ds.

IF LESS than 1 day
how many hrs. or
..... mins.?

8. OCCUPATION

- (a) Trade, profession or particular kind of work
(b) General nature of industry business, or establishment in which employed (or employer)

9. BIRTHPLACE Payette, Idaho.

(State or Country)

10. NAME OF FATHER Walter F Chapman

11. BIRTHPLACE OF FATHER Kansas.

(State or Country)

12. MAIDEN NAME OF MOTHER Hannie Erving

13. BIRTHPLACE OF MOTHER Oregon

(State or Country)

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) R. L. Erving.

(Address)

15.

Filed 10 - 30 1913

M. C. Parker
Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH Oct 29 1913

(Month)

(Day)

(Year)

I HEREBY CERTIFY, That I attended deceased from Oct 16 1913, to Oct 29 1913,

that I last saw her alive on Oct 29 1913,

and that death occurred on the date stated above, at 3 A.M.

THE CAUSE OF DEATH* was as follows:

Gen Peritonitis

(Duration)

yrs.

mos. 3

ds.

Contributory Appendicitis
(Secondary)

(Duration)

yrs.

mos. 4

ds.

(Signed) D. W. Forney

(Address) Boise

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death

..... yrs. mos. days.

In the State

..... yrs. mos. days.

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL | DATE OF BURIAL

Waver Hill Cemetery Oct 31 1913

20. UNDERTAKER

ADDRESS

Schreiber & Sidenup Boise

Forney

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Form V. S. No. 5 20M.1-16-12

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH.

Registration District No. 2

County of Ada

Primary Registration District No. 1004

City of Boise

(No. 410 State

St.)

File No. 6143

Registered No. 258

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

Laura Hudson

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX

Female

4. COLOR OR RACE

White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED.

Single
(Write the word.)

6. DATE OF BIRTH

Aug

18

1876

(Month)

(Day)

(Year)

7. AGE

37 yrs. 2 mos. 10 ds.

IF LESS than 1 day
how many hrs. or
..... mins.?

8. OCCUPATION

(a) Trade, profession or particular kind of work

Housekeeper

(b) General nature of industry business, or establishment in which employed (or employer)

9. BIRTHPLACE

(State or Country)

Ohio

10. NAME OF FATHER

G. M. Corder

11. BIRTHPLACE OF FATHER

(State or Country)

Ohio

12. MAIDEN NAME OF MOTHER

Jessie Barber

13. BIRTHPLACE OF MOTHER

(State or Country)

Ohio

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

Geo. Corder

(Address)

Boise

15.

Filed 10-30 1913

M. S. Parker

Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH

Oct

29

1913

(Month)

(Day)

(Year)

17. I HEREBY CERTIFY, That I attended deceased from

Oct

1912

to Oct 29

1913

that I last saw her alive on Oct 26 1913

and that death occurred on the date stated above, at 6:40 M.

The CAUSE OF DEATH* was as follows:

Apoplexy

(Duration)

yrs.

mos.

ds.

Contributory
(Secondary)

(Duration)

yrs.

mos.

ds.

(Signed)

Maurice Henry Zellman M. D.

10-27-1913

(Address) Boise, Idaho

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place

of death

yrs.

mos.

days.

In the

State

Where was disease contracted if not at place of death?

Former or usual residence

274 Hazel (Boise)

19. PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

Harris Hill

10/30 1913

20. UNDERTAKER

ADDRESS

Schreiber & Widengren Boise, Ida

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Form V. S. No. 5 20M.1-16-12

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics
File No. 6144
Registered No. 257

1. PLACE OF DEATH.

Registration District No. 2

County of Ada

Prim Registration District No. 1004

City of Boise

(No. 1420 Grand Ave St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

Ellen Dora Fellows

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX

Female

4. COLOR OR RACE

White American

5. SINGLE, MARRIED, WIDOWED OR DIVORCED.

Single (Write the word.)

6. DATE OF BIRTH

March 16 - 1913
(Month) (Day) (Year)

7. AGE

7 yrs. 13 mos. 13 ds.

IF LESS than 1 day
how many hrs. or mins?

8. OCCUPATION

(a) Trade, profession or particular kind of work

None (Infant)

(b) General nature of industry business, or establishment in which employed (or employer)

9. BIRTHPLACE

(State or Country)

Boise

10. NAME OF FATHER

J. H. Fellows.

11. BIRTHPLACE OF FATHER

(State or Country)

Idaho

12. MAIDEN NAME OF MOTHER

Bertha Dillfill

13. BIRTHPLACE OF MOTHER

(State or Country)

Kas.

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

James H. Fellows

(Address)

1420 Grand Ave

15.

Filed 10 - 29

1913

M. J. Parker

Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH

Oct 29 1913
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from

191... to 191...

that I last saw him alive on 191...

and that death occurred on the date stated above, at 9 A.M.

The CAUSE OF DEATH* was as follows:

Dysentery.

(Duration) yrs. mos. 17 hrs.

Contributory (Secondary)

(Duration) yrs. mos. ds.

(Signed)

Dr. J. H. Doney

M. D.

10/29 1913 (Address) Boise

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death... yrs. mos. days. In the State... yrs. mos. days.

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL

Mountain Hill Cem.

DATE OF BURIAL

Oct 30 1913

20. UNDERTAKER

Fry & Hummer Co

ADDRESS

Boise

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Form V. S. No. 5 20M.1-16-12

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH

Registration District No.

County of

Primary Registration District No.

City of

(No. 1602 N. S. & 91 St.)

File No.

Registered No.

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX

4. COLOR OR RACE

5. SINGLE, MARRIED, WIDOWED OR DIVORCED.

6. DATE OF BIRTH

7. AGE

IF LESS than 1 day
how many hrs. or mins.

8. OCCUPATION

(a) Trade, profession or particular kind of work

(b) General nature of industry business, or establishment in which employed (or employer)

9. BIRTHPLACE

(State or Country)

10. NAME OF FATHER

11. BIRTHPLACE OF FATHER

(State or Country)

12. MAIDEN NAME OF MOTHER

13. BIRTHPLACE OF MOTHER

(State or Country)

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

(Address)

15.

Filed 10-29 1913

Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH

17. I HEREBY CERTIFY, That I attended deceased from

that I last saw him alive on

and that death occurred on the date stated above, at

The CAUSE OF DEATH* was as follows:

Contributory (Secondary)

(Signed)

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death. yrs. mos. days. In the State. yrs. mos. days.

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

20. UNDERTAKER

ADDRESS

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Form V. S. No. 5 20M.1-16-12

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH.

Registration District No. 2

County of Ada

Primary Registration District No. 1004

City of Bosse

(No. 901, Harrison Blvd. St.)

If death occurs away from usual residence, give facts called for under special information.

2.

FULL NAME

Royal S. Stearns

File No. 6145

Registered No. 255

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX

4. COLOR OR RACE

5. SINGLE, MARRIED, WIDOWED OR DIVORCED

Male White

Married
(Write the word.)

6. DATE OF BIRTH

June 20 1844
(Month) (Day) (Year)

7. AGE

69 yrs. 4 mos. 6 ds.

IF LESS than 1 day
how many hrs. or
..... mins.?

8. OCCUPATION

(a) Trade, profession or particular kind of work

Lawyer

(b) General nature of industry business, or establishment in which employed (or employer)

9. BIRTHPLACE

(State or Country)

Illinois

10. NAME OF FATHER

Samuel S. Stearns

11. BIRTHPLACE OF FATHER

(State or Country)

Ohio

12. MAIDEN NAME OF MOTHER

Elaine J. Follett

13. BIRTHPLACE OF MOTHER

(State or Country)

Ohio

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

M. Royal S. Stearns

(Address)

Bosse 201

15.

Filed 10-28 1913 M. S. Parker
Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH

Oct 26 1913
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from Oct 1 1913, to Oct 26 1913,

that I last saw him alive on Oct 26 1913,

and that death occurred on the date stated above, at 7 P.M.

The CAUSE OF DEATH* was as follows:

Scarlet fever

(Duration) yrs. mos. ds.

Contributory
(Secondary)

(Duration) yrs. mos. ds.

(Signed) Geo. Calverly M. D.

19. (Address)

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death yrs. mos. days. In the State yrs. mos. days.

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

Lincolnville Burial Oct 31 1913

20. UNDERTAKER

ADDRESS

T. J. Summers Boise, Idaho

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Form V. S. No. 5 20M.1-16-12

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH.

Registration District No. 2

County of

Ada

Primary Registration District No. 1004

City of

Boise

(No. _____)

St.)

File No. 6147

Registered No. 254

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

Hugh Mulke

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX

Male

4. COLOR OR RACE

White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED.

Single
(Write the word.)

6. DATE OF BIRTH

Not obtainable

(Month)

(Day)

(Year)

7. AGE

74

yrs.

mos.

ds.

IF LESS than 1 day
how many hrs. or
..... mins.?

8. OCCUPATION

(a) Trade, profession or particular kind of work

Stone cutter

(b) General nature of industry business, or establishment in which employed (or employer)

9. BIRTHPLACE

(State or Country)

Iceland

10. NAME OF FATHER

Not obtainable

11. BIRTHPLACE OF FATHER

(State or Country)

"

12. MAIDEN NAME OF MOTHER

"

13. BIRTHPLACE OF MOTHER

(State or Country)

"

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

Adolph Schuber

(Address)

Boise

15.

Filed

Oct 27

1913

M. S. Parker

Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH

Oct 24

(Month)

(Day)

1913

(Year)

17. I HEREBY CERTIFY, That I attended deceased from

April 1, 1913, to Oct 24, 1913,

that I last saw him alive on 24th, 1913,

and that death occurred on the date stated above, at P. M.

The CAUSE OF DEATH* was as follows:

Intermittent tuberculosis

(Duration)

yrs.

6 mos.

ds.

Contributory
(Secondary)

(Duration)

yrs.

mos.

ds.

(Signed)

R. E. Shurtz

M. D.

19

(Address)

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place

of death yrs. mos. days.

In the

State yrs. mos. days.

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL

St. Johns cemetery

DATE OF BURIAL

Oct. 27, 1913

20. UNDERTAKER

Schuber & Widupson

ADDRESS

Boise

Form V. S. No. 5 20M.1-16-12

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH

Registration District No.

2

County of

Ada

Primary Registration District No.

1004

File No.

6143

City of

Boise

(No.

410

State

St.)

Registered No.

253

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

A. J. James

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX

4. COLOR OR RACE

5. SINGLE, MARRIED, WIDOWED OR DIVORCED.

Male

White

Married

6. DATE OF BIRTH

Nov 26

1913

(Month)

(Day)

(Year)

7. AGE

75

yrs.

11

mos.

3 ds.

IF LESS than 1 day
how many hrs. or
..... mins.

8. OCCUPATION

(a) Trade, profession or particular kind of work

Pinner

(b) General nature of industry business, or establishment in which employed (or employer)

9. BIRTHPLACE

(State or Country)

Illinois

10. NAME OF FATHER

Not obtainable

11. BIRTHPLACE OF FATHER

(State or Country)

Illinois

12. MAIDEN NAME OF MOTHER

James

13. BIRTHPLACE OF MOTHER

(State or Country)

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

John Van Horn

(Address)

Boise

15.

Filed 10 - 24

1913

M. S. Parker

Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH

Oct

23

1913

(Month)

(Day)

(Year)

17. I HEREBY CERTIFY, That I attended deceased from

Sept

1913, to

Oct 23, 1913

that I last saw him alive on Oct 22, 1913

and that death occurred on the date stated above, at 4 A.M.

The CAUSE OF DEATH* was as follows:

Vascular disease
heart

(Duration) 5 yrs. mos. ds.

Contributory
(Secondary)

(Duration) yrs. mos. ds.

(Signed)

Robert L. Gregory M. D.

19

(Address)

The Medical

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death

.....yrs.....mos.....days.

In the State

.....yrs.....mos.....days.

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

St John Cemetery

Oct 24, 1913

20. UNDERTAKER

ADDRESS

Schreiber & Sidenfeld

Boise

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Form V. S. No. 5 20M.1-16-12

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics
File No. **6150**

1. PLACE OF DEATH

Registration District No. 2County of AdaPrimary Registration District No. 1004City of Boise(No. 419 B. 4 St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

Rhoda A. WallisRegistered No. 250

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX

4. COLOR OR RACE

5. SINGLE, MARRIED, WID-
OWED OR DIVORCED.Female WhiteWidow
(Write the word.)

6. DATE OF BIRTH

August 16 1849
(Month) (Day) (Year)

7. AGE

4 yrs. 4 mos. 6 ds.

IF LESS than 1 day
how many hrs. or
..... min.?

8. OCCUPATION

(a) Trade, profession or
particular kind of work
(b) General nature of industry
business, or establishment in
which employed (or employer)

Retired

9. BIRTHPLACE

(State or Country)

Canada10. NAME OF
FATHERJoseph Watier11. BIRTHPLACE
OF FATHER

(State or Country)

Not obtainable12. MAIDEN NAME
OF MOTHERGertrude Partridge13. BIRTHPLACE
OF MOTHER

(State or Country)

Canada

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

(Address)

Boise, Idaho.

15.

Filed 10-231913M. S. Parker

Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

Oct 22nd 1913
(Month) (Day) (Year)17. I HEREBY CERTIFY, That I attended deceased from
year 1910, to Oct 22nd 1913that I last saw her alive on Oct 20th 1913and that death occurred on the date stated above, at 2 P.M.

The CAUSE OF DEATH* was as follows:

Dropsy & gangrene(Duration) 2 months ds.Contributory Diabetes mellitus(Secondary) and gangrene(Duration) 1 yr. mos. ds.(Signed) John D. B.19 (Address) Boise, Idaho

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death yrs. mos. days. In the State yrs. mos. days.

Where was disease contracted
if not at place of death?

Former or
usual residence

19. PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

Morris Hill Cemetery 10/24 1913

20. UNDERTAKER

ADDRESS

Chapman & Chidney Boise, IdahoDr. Brock.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Form V. S. No. 5. 12½ M. 7-24-11

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics
File No. 561 0151
Registered No. 35

1. PLACE OF DEATH
County of Benewah
City of Pais
Registration District No. 24
Primary Registration District No. 2092
(No. _____ St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

John Clifton

If death occurred in a hospital, institution or camp give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX Male 4. COLOR OR RACE W. 5. SINGLE, MARRIED, WIDOWED OR DIVORCED. Married
(Write the word.)

6. DATE OF BIRTH Mar 31 1897
(Month) (Day) (Year)

7. AGE 34 yrs. 3 mos. 24 ds. IF LESS than 1 day how many _____ hrs. or _____ min?

8. OCCUPATION

(a) Trade, profession or particular kind of work
(b) General nature of industry business or establishment in which employed (or employer)

Farmer

9. BIRTHPLACE

(State or Country)

England

10. NAME OF FATHER

John Clifton

11. BIRTHPLACE OF FATHER

(State or Country)

England

12. MAIDEN NAME OF MOTHER

Mary Jane

13. BIRTHPLACE OF MOTHER

(State or Country)

England

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) John Clifton

(Address) Pais, Idaho

15. July 22 1913

Filed July 22 1913

Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH

July 25 1913
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from _____ 191____, to _____ 191____

that I last saw him alive on July 25 1913
and that death occurred on the date stated above, at 1:30 P.M.

The CAUSE OF DEATH* was as follows:

Old Age

_____ (Duration) _____ yrs. _____ mos. _____ ds.

Contributory
(Secondary)

_____ (Duration) _____ yrs. _____ mos. _____ ds.

(Signed) John Clifton M. D.

July 22 1913 (Address) Pais, Idaho

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT OR OTHER MEANS OF INJURY; (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place _____ In the _____
of death _____ yrs. _____ mos. _____ ds. State _____ yrs. _____ mos. _____ ds.

Where was disease contracted,

If not at place of death?

Former or

usual residence.

19. PLACE OF BURIAL OR REMOVAL DATE OF BURIAL

Pais, Idaho July 22 1913
20. UNDERTAKER ADDRESS

Will Casey

Form V. S. No. 5 20M.1-16-12

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH.

Registration District No.

County of Paine

Primary Registration District No.

City of American Falls

(No., St.)

File No. 6152

Registered No.

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Ethel Jane Schwarz

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX

Female

4. COLOR OR RACE

White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED.

Single (Write the word.)

6. DATE OF BIRTH

Oct 22 1913
(Month) (Day) (Year)

7. AGE

yrs. 11 mos. 3 ds.IF LESS than 1 day
how many hrs. or
..... mins.?

8. OCCUPATION

(a) Trade, profession or particular kind of work

(b) General nature of industry business, or establishment in which employed (or employer)

9. BIRTHPLACE

(State or Country) Wisconsin

10. NAME OF FATHER

Frank Schwarz

11. BIRTHPLACE OF FATHER

(State or Country) Wisconsin

12. MAIDEN NAME OF MOTHER

Frances Main

13. BIRTHPLACE OF MOTHER

(State or Country) Wisconsin

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Frank Schwarz(Address) American Falls

15.

Filed Sept 27th 1913 R. F. Mott
Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH

Sept 25 1913
(Month) (Day) (Year)17. I HEREBY CERTIFY, That I attended deceased from Sept 23 1913, to Sept 25 1913 that I last saw him alive on Sept 25 1913, and that death occurred on the date stated above, at 7 P.M.

The CAUSE OF DEATH* was as follows:

Gastro enteritis(Duration) yrs. mos. 7 ds.Contributory Bronchopneumonia
(Secondary)(Duration) yrs. mos. 7 ds.(Signed) N. R. Kallantall M. D.19 (Address) American Falls, Ida.

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death yrs. mos. days. In the State yrs. mos. days

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL

American Falls

DATE OF BURIAL

Sept 27 1913

20. UNDERTAKER

H. R. Hager

ADDRESS

Am Falls

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Form V. S. No. 5. 10M. 6-20-11.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics
File No. 1 6153

1. PLACE OF DEATH. Registration District No. 124
County of Ada Primary Registration District No. 2202
City of Kuna (No. _____, St.)

Registered No. 1
If death occurred in a hospital, institution or camp give its NAME instead of street and number.

If death occurs away from usual residence, give facts called for under special information. 2. FULL NAME Marion Walker

PERSONAL AND STATISTICAL PARTICULARS

3. SEX Female 4. COLOR OR RACE White 5. SINGLE, MARRIED, WID-
OWED OR DIVORCED. Divorced
(Write the word.)

6. DATE OF BIRTH August 16th 1876
(Month) (Day) (Year)

7. AGE 37 yrs. 2 mos. 19 ds. IF LESS than 1 day
how many hrs. or min.?

8. OCCUPATION
(a) Trade, profession, or particular kind of work Miner
(b) General nature of industry, business, or establishment in which employed (or employer)

9. BIRTHPLACE (State or Country) Wis.

10. NAME OF FATHER Silas Walker

11. BIRTHPLACE OF FATHER (State or Country) N.Y.

12. MAIDEN NAME OF MOTHER Sarah Noale

13. BIRTHPLACE OF MOTHER (State or Country) Wis.

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) G. R. Walker
(Address) Kuna, Idaho

15. Filed Nov. 4th 1913 T. E. Martin
Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH November 4th 1913
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from Nov. 2nd 1913, to Nov. 4th 1913, that I last saw her alive on Nov. 3rd 1913, and that death occurred on the date stated above, at 7 A. M.

The CAUSE OF DEATH* was as follows:
Acute Nephritis
(Duration) yrs. mos. 4 ds.

Contributory (Secondary) Chronic Nephritis
(Duration) 2 yrs. mos. ds.
(Signed) T. E. Martin M. D.
Nov. 4 1913 (Address) Kuna, Idaho

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place In the
of death 3 yrs. mos. ds. State yrs. mos. ds.
Where was Disease contracted, at home
If not at place of death?
Former or
usual residence Kuna, Idaho

19. PLACE OF BURIAL OR REMOVAL Boise, Ida. DATE OF BURIAL Nov. 5th 1913

20. UNDERTAKER J. H. Edgar ADDRESS Kuna

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Form V. S. No. 5 20M.1-16-12

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH. Registration District No. 5-1
County of Canyon Primary Registration District No. 2130
City of Frankland (No. St.)

File No. 1 6154

Registered No. 1

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

Leitha V. Hoff

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX Female 4. COLOR OR RACE White 5. SINGLE, MARRIED, WIDOWED OR DIVORCED. Married
(Write the word.)

6. DATE OF BIRTH

Mar 17 1843
(Month) (Day) (Year)

7. AGE

70 yrs. 7 mos. 21 ds.

IF LESS than 1 day
how many hrs. or
..... mins.?

8. OCCUPATION

(a) Trade, profession or particular kind of work Housewife
(b) General nature of industry, business, or establishment in which employed (or employer)

9. BIRTHPLACE

(State or Country) Mich

10. NAME OF FATHER

Hunt

11. BIRTHPLACE OF FATHER

(State or Country) Perm

12. MAIDEN NAME OF MOTHER

Not known

13. BIRTHPLACE OF MOTHER

(State or Country) Not known

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) J Hoff

(Address)

15.

Filed Nov. 8th 1913

Crispin Wright
Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

Nov 8 1913
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from

Oct 29th 1913, to Nov 8 1913,

that I last saw her alive on Nov 7 1913,

and that death occurred on the date stated above, at 79th M.

The CAUSE OF DEATH* was as follows:

Chronic nephritis with myocarditis
(Cardio-renal)

(Duration) 4 yrs. mos. ds.

Contributory
(Secondary)

(Duration) yrs. mos. ds.

(Signed) Jacob Prunty M. D.

Nov 8 1913 (Address) Ontario, Ore.

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death yrs. mos. days. In the State yrs. mos. days.

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL DATE OF BURIAL

Payette Ida Nov 9 1913

20. UNDERTAKER

ADDRESS

W. A. Adair Payette Ida

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Form V. S. No. 5 20M.1-16-12

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics
File No. 6150

1. PLACE OF DEATH.

Registration District No. 99

County of Fremont

Primary Registration District No. 2177

City of St. Anthony

(No. , St.)

Registered No.

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Barbara A. Nichols

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX

Female

4. COLOR OR RACE

White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED.

Widowed
(Write the word.)

6. DATE OF BIRTH

Dec 14 1833
(Month) (Day) (Year)

7. AGE

79 yrs. 10 mos. 16 ds.

IF LESS than 1 day
how many hrs. or
mins.?

8. OCCUPATION

(a) Trade, profession or particular kind of work.

(b) General nature of industry business, or establishment in which employed (or employer)

Housekeeping

9. BIRTHPLACE

(State or Country)

Ohio

10. NAME OF FATHER

J. Thorp

11. BIRTHPLACE OF FATHER

(State or Country)

New York

12. MAIDEN NAME OF MOTHER

Rachel Colvin

13. BIRTHPLACE OF MOTHER

(State or Country)

Ohio

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

A. Morgfield

(Address)

St. Anthony

15.

Filed Nov 8

1913

Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

Oct 30 1913
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from

Aug 28 1913, to Oct 30 1913,

that I last saw her alive on Oct 30 1913,

and that death occurred on the date stated above, at 9:30 P. M.

The CAUSE OF DEATH* was as follows:

Pneumonia

(Duration) 3 yrs. 6 mos. — ds.

Contributory (Secondary)

Senility

(Duration) — yrs. — mos. — ds.

(Signed)

A. Morgfield

M. D.

19

(Address) St. Anthony

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death

— yrs. — mos. — days.

In the State

— yrs. — mos. — days.

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

St. Anthony Cemetery

Nov 1st 1913

20. UNDERTAKER

ADDRESS

Wm. Jager

St. Anthony
Param.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Form V. S. No. 5 20M.1-16-12

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH.

Registration District No. 99

County of Fremont

Primary Registration District No. 2177

City of St. Anthony

(No. _____, St.)

File No. 6153

Registered No. _____

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

Lavan Thompson

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX

Female

4. COLOR OR RACE

White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED.

Single
(Write the word.)

6. DATE OF BIRTH

Sept 28 1913
(Month) (Day) (Year)

7. AGE

_____ yrs. _____ mos. 7 ds.

IF LESS than 1 day
how many _____ hrs. or
_____ mins.?

8. OCCUPATION

(a) Trade, profession or particular kind of work

None

(b) General nature of industry business, or establishment in which employed (or employer)

9. BIRTHPLACE

(State or Country)

Idaho

10. NAME OF FATHER

Robert Thompson

11. BIRTHPLACE OF FATHER

(State or Country)

Utah

12. MAIDEN NAME OF MOTHER

Margaret Madison

13. BIRTHPLACE OF MOTHER

(State or Country)

Utah

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

A. Morfield M.D.

(Address)

St. Anthony Ida

15.

Filed Nov 8 1913

W. S. S. S.

Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

Oct 5 1913
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from

Sept 28 1913, to Oct 5 1913,

that I last saw her alive on Oct 4 1913,

and that death occurred on the date stated above, at 10 A.M.

The CAUSE OF DEATH* was as follows:

Asphyxia

(Duration) _____ yrs. _____ mos. 1 1/2 ds.

Contributory (Secondary) Hypertrophied heart

(Duration) _____ yrs. _____ mos. 4 ds.

(Signed) A. Morfield M. D.

19 (Address) St. Anthony Ida

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death _____ yrs. _____ mos. _____ days. In the State _____ yrs. _____ mos. _____ days.

Where was disease contracted if not at place of death? _____

Former or usual residence _____

19. PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

Hilford Cemetery

Oct 7 1913

20. UNDERTAKER

ADDRESS

None

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Form V. S. No. 5 20M.1-16-12

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH.

Registration District No. 87County of WashingtonPrimary Registration District No. 2034City of Medwall 24

(No. _____, _____ St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

John Miles HubbardFile No. 6151

Registered No. _____

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX

4. COLOR OR RACE

5. SINGLE, MARRIED, WID-
OWED OR DIVORCED.MaleWhiteMarried
(Write the word.)

6. DATE OF BIRTH

Feb 27 1851
(Month) (Day) (Year)

7. AGE

62 yrs. 8 mos. 11 ds.IF LESS than 1 day
how many _____ hrs. or
_____ mins.?

8. OCCUPATION

(a) Trade, profession or
particular kind of workBarber(b) General nature of industry
business, or establishment in
which employed (or employer)

9. BIRTHPLACE

(State or Country)

Iowa10. NAME OF
FATHERJohn Hubbard11. BIRTHPLACE
OF FATHER

(State or Country)

NY12. MAIDEN NAME
OF MOTHERCatherine Lowe13. BIRTHPLACE
OF MOTHER

(State or Country)

Ky

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

John M. Coleman

(Address)

Boise Idaho

15.

Filed

Nov 4 1913F. Schmitt

Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH

Nov 8 1913
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from

April 10 1913, to Nov 8 1913,that I last saw him alive on Nov 8 1913,and that death occurred on the date stated above, at 6:00 P.M.

The CAUSE OF DEATH* was as follows:

Carcinoma of Pylorus(Duration) 6 yrs. 6 mos. 6 ds.Contributory Causing obstruction
(Secondary)(Duration) 6 yrs. 6 mos. 6 ds.(Signed) F. Schmitt M. D.19 (Address) Medwall 24

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death 6 yrs. 6 mos. 6 days. In the State 6 yrs. 6 mos. 6 days.

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

Pullman WnNov 11 1913

20. UNDERTAKER

ADDRESS

R. W. BowenKeiser, Ida

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Form V. S. No. 5 20M.1-16-12

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH

Registration District No.

County of Washington

Primary Registration District No.

City of

(No., St.)

File No. 6153

Registered No.

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

Harry V. Wilson

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX

4. COLOR OR RACE

5. SINGLE, MARRIED, WID-
OWED OR DIVORCEDmalewhitemarried
(Write the word.)

6. DATE OF BIRTH

(Month)

(Day)

(Year)

7. AGE

53 yrs. mos. ds.IF LESS than 1 day
how many hrs. or
..... mins.?

8. OCCUPATION

(a) Trade, profession or
particular kind of work(b) General nature of industry
business, or establishment in
which employed (or employer)Rancher

9. BIRTHPLACE

(State or Country)

New Jersey10. NAME OF
FATHERJohn Wilson11. BIRTHPLACE
OF FATHER

(State or Country)

New Jersey12. MAIDEN NAME
OF MOTHEREdith Grewett13. BIRTHPLACE
OF MOTHER

(State or Country)

New Jersey

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

Alb. Hays

(Address)

Medvale Ida

15.

Filed

Oct 221913Ta Schmitt

Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH

Oct211913

(Month)

(Day)

(Year)

17. I HEREBY CERTIFY, That I attended deceased from

Oct 1 - 1913, to April 1 1913that I last saw him alive on Jan 20 1913and that death occurred on the date stated above, at 3 M.

The CAUSE OF DEATH* was as follows:

Bright's Disease(Duration) 1 yrs. 6 mos. ds.Contributory
(Secondary)

(Duration) yrs. mos. ds.

(Signed)

Ta Schmitt

M. D.

Oct 1913 (Address) Medvale

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death yrs. mos. days. In the State yrs. mos. days.

Where was disease contracted
if not at place of death?Former or
usual residence

19. PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

Medvale IdahoOct 22 1913

20. UNDERTAKER

ADDRESS

L. G. RayMedvale

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
N. B.—Every item of information should be carefully supplied. AGE should be state EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Form V. S. No. 5. 10M. 6-20-11.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH.

Registration District No. 2101County of Idaho

Primary Registration District No. _____

City of Kootenai

(No. _____, _____ St.)

File No. 6159Registered No. 10

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Bernice Alma Hendren

If death occurred in a hospital, institution or camp give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX

Female

4. COLOR OR RACE 5. SINGLE, MARRIED, WIDOWED OR DIVORCED.

WhiteSingle
(Write the word.)

6. DATE OF BIRTH

April
(Month)26 1913
(Day) (Year)

7. AGE

_____ yrs. _____ mos. _____ ds.

IF LESS than 1 day
how many _____ hrs. or
_____ min.?

8. OCCUPATION

- (a) Trade, profession or particular kind of work
(b) General nature of industry business or establishment in which employed (or employer)

9. BIRTHPLACE

(State or Country)

Kootenai - Idaho

10. NAME OF FATHER

Albert Hendren

11. BIRTHPLACE OF FATHER

(State or Country)

Idaho Co. - Idaho

12. MAIDEN NAME OF MOTHER

Bertha Morse

13. BIRTHPLACE OF MOTHER

(State or Country)

Canyon Co Idaho

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Bertie Hendren(Address) Kootenai Idaho

15.

Filed Oct-10 1913J. M. Verbruggen
Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

Oct
(Month)9
(Day)1913
(Year)

17. I HEREBY CERTIFY, That I attended deceased from

Oct. 7 1913, to Oct-9 1913that I last saw him alive on Oct-9 1913,and that death occurred on the date stated above, at 7 P. M.

The CAUSE OF DEATH* was as follows:

Acute Rheo Carditis

(Duration) _____ yrs. _____ mos. _____ ds.

Contributory
(Secondary)

(Duration) _____ yrs. _____ mos. _____ ds.

(Signed) J. M. Verbruggen M. D.Oct-9 1913 (Address) Kootenai Idaho

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death _____ yrs. _____ mos. _____ ds. State _____ yrs. _____ mos. _____ ds.

Where was disease contracted.

If not at place of death?

Former or usual residence.

19. PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

Kootenai CemeteryOct-10 1913

20. UNDERTAKER

ADDRESS

C. J. JohnsonKootenai Idaho

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. N. B.—Every item of information should be carefully supplied. AGE should be state EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Form V. S. No. 5. 10M. 6-20-11.

CERTIFICATE OF

of Idaho
HEALTH
Vital Statistics

1. PLACE OF DEATH.

Registration District No. 210County of IdahoPrimary Registration District No. 17City of Kosskia(No. 17)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

William A. Sullivan

If death occurred in a hospital, institution or camp give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX

Male

4. COLOR OR RACE 5. SINGLE, MARRIED, WIDOWED OR DIVORCED.

WhiteWidower
(Write the word.)

6. DATE OF BIRTH

Nov
(Month)6
(Day)1888
(Year)

7. AGE

74 yrs. 11 mos. 14 ds.IF LESS than 1 day
how many.....hrs. or
.....min.?

8. OCCUPATION

- (a) Trade, profession or particular kind of work
(b) General nature of industry business or establishment in which employed (or employer)

Farmer

9. BIRTHPLACE

(State or Country)

Marquette Co Penn.

10. NAME OF FATHER

Nathan Sutton

11. BIRTHPLACE OF FATHER

(State or Country)

New Jersey

12. MAIDEN NAME OF MOTHER

Dont Kuan

13. BIRTHPLACE OF MOTHER

(State or Country)

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

Henry T. Melhuish

(Address)

Kosskia Idaho

15.

Filed Oct-21 1913Jm. Verberknaes
Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

Oct-
(Month)20
(Day)1913
(Year)

17. I HEREBY CERTIFY, That I attended deceased from

Oct-15 1913., to Oct-20 1913.that I last saw him alive on Oct-18 1913,and that death occurred on the date stated above, at 3 P.M.

The CAUSE OF DEATH* was as follows:

Chronic Interstitial Nephritis

(Duration) yrs. mos. ds.

Contributory
(Secondary)Chronic Cystitis, Arterio Sclerosis

(Duration) yrs. mos. ds.

(Signed)

Jm. Verberknaes

M. D.

Oct-21 1913. (Address) Kosskia Idaho

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place yrs. mos. ds. State yrs. mos. ds.

Where was disease contracted,

If not at place of death?

Former or

usual residence.

19. PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

Idaho CemeteryOct-21 1913

20. UNDERTAKER

ADDRESS

Henry T. MelhuishKosskia

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. N. B.—Every item of information should be carefully supplied. AGE should be state EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Form V. S. No. 5. 10M. 6-20-11.

CERTIFICATE OF DEATH

 State of Idaho
 BOARD OF HEALTH
 Bureau of Vital Statistics

1. PLACE OF DEATH.

Registration District No. 2101County of Idaho

Primary Registration District No. _____

City of Kootenai

(No. _____, St.)

File No. 6161Registered No. 16

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

Mary Jane Hillon

If death occurred in a hospital, institution or camp give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX

Female

4. COLOR OR RACE

White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED.

Widowed
(Write the word.)

6. DATE OF BIRTH

Dec41851

(Month)

(Day)

(Year)

7. AGE

62 yrs. 10 mos. 8 ds.
 IF LESS than 1 day
 how many hrs. or
 min.

8. OCCUPATION

- (a) Trade, profession or particular kind of work
 (b) General nature of industry business or establishment in which employed (or employer)

Housewife

9. BIRTHPLACE

(State or Country)

Utah New York

10. NAME OF FATHER

Randal

11. BIRTHPLACE OF FATHER

(State or Country)

New York

12. MAIDEN NAME OF MOTHER

Putnam

13. BIRTHPLACE OF MOTHER

(State or Country)

New York

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

Mrs. Geo. Hovey

(Address)

Kootenai-Idaho

15.

Filed Oct-13 1913Jm. Verbeekmaes
Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

Oct-
(Month)12
(Day)1913
(Year)

17. I HEREBY CERTIFY, That I attended deceased from

Oct-10 1913, to Oct-12 1913.that I last saw her alive on Oct-12 1913,and that death occurred on the date stated above, at 5 P. M.

The CAUSE OF DEATH* was as follows:

Idio Scler

(Duration) yrs. mos. ds.

Contributory (Secondary)

Initial degeneration, Anaemia

(Duration) yrs. mos. ds.

(Signed) Jm. Verbeekmaes M. D.Oct-12 1913 (Address) Kootenai-Idaho

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death yrs. mos. ds. State yrs. mos. ds.

Where was disease contracted.

If not at place of death?

Former or

usual residence

19. PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

Kootenai CemeteryOct-13 1913

20. UNDERTAKER

ADDRESS

C. J. JohnsonKootenai

WRITE PLAINLY, IN INK—THIS IS A PERMANENT RECORD. N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Form V. S. No. 5. 12½ M. 7-24-11

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH.
County of Boyer
City of Idaho

Registration District No. 30
Primary Registration District No. 2136
(No. _____, St.)

File No. 6162
Registered No. _____

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

Abrentino Corosua

If death occurred in a hospital, institution or camp give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX Male 4. COLOR OR RACE White 5. SINGLE, MARRIED, WIDOWED OR DIVORCED. Single
(Write the word.)
6. DATE OF BIRTH 14th 20 1913
(Month) (Day) (Year)

7. AGE 24 yrs. 0 mos. 0 ds. IF LESS than 1 day how many _____ hrs. or _____ min?

8. OCCUPATION
(a) Trade, profession or particular kind of work. Laborer
(b) General nature of industry business or establishment in which employed (or employer)

9. BIRTHPLACE
(State or Country) Spain

10. NAME OF FATHER Abrentino Corosua

11. BIRTHPLACE OF FATHER
(State or Country) Spain

12. MAIDEN NAME OF MOTHER Paula

13. BIRTHPLACE OF MOTHER
(State or Country) Spain

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Domingo Herri
(Address) De Ramon Idaho

15. J. D. Jones
Filed Oct 29 1913 Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH June 4 1913
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from June 1 1913, to 191 that I last saw him alive on June 1 1913 and that death occurred on the date stated above, at 5 P.M.
The CAUSE OF DEATH* was as follows:
Coronary Stenosis

(Duration) Unknown yrs. _____ mos. _____ ds.
Contributory Excessive use of tobacco
(Secondary) all his life
(Duration) _____ yrs. _____ mos. _____ ds.
(Signed) W. H. Schuyler M. D.
June 5, 1913 (Address) Silver City Idaho

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; (2) whether ACCIDENTAL, SUICIDAL OR HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place _____ yrs. _____ mos. _____ ds. In the _____ State _____ yrs. _____ mos. _____ ds.
of death _____
Where was disease contracted, _____
If not at place of death? _____
Former or usual residence _____

19. PLACE OF BURIAL OR REMOVAL Catholic cemetery at DATE OF BURIAL June 8th 1913
Idaho

20. UNDERTAKER John Grote ADDRESS Idaho City Idaho

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Form V. S. No. 5 20M.1-16-12

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics
File No. 6153

1. PLACE OF DEATH. Registration District No. 30
County of Owyhee Primary Registration District No. 2123
City of Near Homedale (No. _____ St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME John Dykes

Registered No. _____

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX M. 4. COLOR OR RACE W. 5. SINGLE, MARRIED, WIDOWED OR DIVORCED. _____

(Write the word.)

6. DATE OF BIRTH _____

(Month) (Day) (Year)

7. AGE _____

57 yrs. _____ mos. _____ ds.

IF LESS than 1 day
how many _____ hrs. or
_____ mins.

8. OCCUPATION

(a) Trade, profession or particular kind of work Sheep Herder & Farmer
(b) General nature of industry business, or establishment in which employed (or employer) _____

9. BIRTHPLACE

(State or Country) Philadelphia Pa

10. NAME OF FATHER

Dykes -

11. BIRTHPLACE OF FATHER

(State or Country) England

12. MAIDEN NAME OF MOTHER

13. BIRTHPLACE OF MOTHER

(State or Country) _____

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) John Horr

(Address) Homedale, Ida.

15.

Filed Oct 29 1913

J. L. Jones

Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH

Oct 21 1913
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from

10/21/13 1913, to 10/21/13 1913,

that I last saw h.h alive on 10/21/13 1913,

and that death occurred on the date stated above, at 12 M.

The CAUSE OF DEATH* was as follows:

Stroke, In Stab. (wound)

(Duration) _____ yrs. _____ mos. 12 hrs.

Contributory (Secondary) _____

(Duration) _____ yrs. _____ mos. _____ ds.

(Signed) W. C. Dyer M. D.

10/21/13 (Address) Calderwell Ida.

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death _____ yrs. _____ mos. _____ days. In the State _____ yrs. _____ mos. _____ days.

Where was disease contracted if not at place of death? _____

Former or usual residence _____

19. PLACE OF BURIAL OR REMOVAL DATE OF BURIAL

Homedale Idaho Oct 24 1913

20. UNDERTAKER ADDRESS

W. C. Dyer Calderwell Idaho

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. N. B.—Every item of information should be carefully supplied. AGE should be state EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Form V. S. No. 5. 10M. 6-20-11.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH.

Registration District No. 20County of DwyerPrimary Registration District No. 2021City of King Hill Precinct

(No. _____ St.)

File No. 6157

Registered No. _____

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME William H. Huthal

If death occurred in a hospital, institution or camp give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX

4. COLOR OR RACE 5. SINGLE, MARRIED, WIDOWED OR DIVORCED.

Male WhiteWidowed
(Write the word.)

6. DATE OF BIRTH

April 17th 1913
(Month) (Day) (Year)

7. AGE

66 yrs. - mos. - ds. IF LESS than 1 day
how many hrs. or min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work

Rancher

(b) General nature of industry business or establishment in which employed (or employer)

9. BIRTHPLACE

(State or Country)

America

10. NAME OF FATHER

Mr. Huthal

11. BIRTHPLACE OF FATHER

(State or Country)

America

12. MAIDEN NAME OF MOTHER

Not known

13. BIRTHPLACE OF MOTHER

(State or Country)

America

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Mr. Davis(Address) King Hill Idaho

15.

Filed April 17 1913 J. W. Davis
Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

April 17th 1913
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from

July 4th 1909, to April 17th 1913that I last saw him alive on April 16th 1913and that death occurred on the date stated above, at 9 P. M.

The CAUSE OF DEATH* was as follows:

Cardiac dilatation(Duration) From yrs. - mos. - ds.Contributory
(Secondary)Rheumatism(Duration) 10 yrs. - mos. - ds.(Signed) J. W. Davis M. D.April 17 1913 (Address) Shinn's Ferry

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death yrs. mos. ds. State yrs. mos. ds.

Where was disease contracted.

If not at place of death?

Former or

usual residence.

19. PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

King Hill Idaho1913

20. UNDERTAKER

ADDRESS

A. E. ThompsonGooding Ida

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Form V. S. No. 5. 10M. 6-20-11.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics1. PLACE OF DEATH
County of *Canyon*
City of *Emmett*Registration District No. *2010*
Primary Registration District No. *1010*
(No. _____ St.)File No. *6165*

Registered No. _____

If death occurred in a hospital, institution or camp give its NAME instead of street and number.

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME *Irma Ellen Hayes*

PERSONAL AND STATISTICAL PARTICULARS

3. SEX *female* 4. COLOR OR RACE *white* 5. SINGLE, MARRIED, WIDOWED OR DIVORCED. *Single*
(Write the word.)6. DATE OF BIRTH *Apr 21 1895*
(Month) (Day) (Year)7. AGE *18 yrs. 5 mos. 21 ds.* IF LESS than 1 day how many _____ hrs. or _____ min.?

8. OCCUPATION

(a) Trade, profession, or particular kind of work *none*
(b) General nature of industry business, or establishment in which employed (or employer) _____

9. BIRTHPLACE

(State or Country) *Idaho*10. NAME OF FATHER *Edward K. Hayes*11. BIRTHPLACE OF FATHER *Maine*
(State or Country)12. MAIDEN NAME OF MOTHER *Elsie Wardwell*13. BIRTHPLACE OF MOTHER *Idaho*
(State or Country)

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) *E. K. Hayes*
(Address) *Emmett Ida*

15.

Filed *11-4* 191*3* *J. L. Reynolds*
Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH *Oct 12 1913*
(Month) (Day) (Year)17. I HEREBY CERTIFY, That I attended deceased from *Sept 24 1913* to *Oct 12 1913*
that I last saw him alive on *Oct 12 1913*,
and that death occurred on the date stated above, at *1 P.* M.
The CAUSE OF DEATH* was as follows:*Pulmonary Tuberculosis*(Duration) *Six* yrs. _____ mos. _____ ds.

Contributory (Secondary)

(Duration) _____ yrs. _____ mos. _____ ds.

(Signed) *J. L. Reynolds* M. D.
Nov 4 1913 (Address) *Emmett Ida*

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place _____ In the _____
of death _____ yrs. _____ mos. _____ ds. State _____ yrs. _____ mos. _____ ds.
Where was Disease contracted,
If not at place of death? _____
Former or
usual residence.

19. PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

Emmett Cemetery *Oct 13 1913*

20. UNDERTAKER

ADDRESS

C. D. Bucknum *Emmett*

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Form V. S. No. 5. 10M. 6-20-11.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

File No. 6166

Registered No. _____

If death occurred in a hospital, institution or camp give its NAME instead of street and number.

1. PLACE OF DEATH.
County of Canyon
City of Emmett

Registration District No. 2010

Primary Registration District No. _____

(No. _____ St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

Anna Charity Aston

PERSONAL AND STATISTICAL PARTICULARS

3. SEX female 4. COLOR OR RACE white 5. SINGLE, MARRIED, WIDOWED OR DIVORCED married
(Write the word.)6. DATE OF BIRTH Nov 14 1878
(Month) (Day) (Year)

7. AGE 34 yrs. 11 mos. 2 ds. IF LESS than 1 day how many hrs. or min.?

8. OCCUPATION

(a) Trade, profession, or particular kind of work
(b) General nature of industry business, or establishment in which employed (or employer)

housewife

9. BIRTHPLACE

(State or Country)

Nebraska

10. NAME OF FATHER

John Hyatt

11. BIRTHPLACE OF FATHER

(State or Country)

Iowa

12. MAIDEN NAME OF MOTHER

Josephine Bly

13. BIRTHPLACE OF MOTHER

(State or Country)

Penn.

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

Olga Aston

(Address)

Emmett Idaho

15.

Filed 11-4 1913

J. L. Reynolds
Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

Oct 16 1913
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from Sept 9 1913, to Oct 16 1913

that I last saw her alive on Oct 16 1913, and that death occurred on the date stated above, at 7 P. M.

The CAUSE OF DEATH* was as follows:

Chronic Exudative nephritis

(Duration) 12 yrs. mos. ds.

Contributory (Secondary)

(Duration) yrs. mos. ds.

(Signed) E. H. Cummings
Oct 16 1913 (Address) Emmett Idaho

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL,

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place In the
of death. yrs. mos. ds. State. yrs. mos. ds.

Where was Disease contracted,

If not at place of death?

Former or

usual residence.

19. PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

Emmett Cemetery

Oct 19 1913

20. UNDERTAKER

ADDRESS

O. T. Ducknum

Emmett

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Form V. S. No. 5 20M.1-16-12

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH. Registration District No. _____
County of Bonner Primary Registration District No. _____
City of Bonner Ferry, Ida. (State) _____
If death occurs away from usual residence, give facts called for under special information. 2. FULL NAME E. E. Elliott (child)

File No. 6167
Registered No. _____
If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX Male 4. COLOR OR RACE White 5. SINGLE, MARRIED, WIDOWED OR DIVORCED. Single (Write the word.)
6. DATE OF BIRTH October 24 1913
(Month) (Day) (Year)
7. AGE _____ yrs. _____ mos. _____ ds.
IF LESS than 1 day how many _____ hrs. or _____ mins.

8. OCCUPATION
(a) Trade, profession or particular kind of work _____
(b) General nature of industry business, or establishment in which employed (or employer) _____

9. BIRTHPLACE
(State or Country) Bonner County Ida.

10. NAME OF FATHER E. E. Elliott

11. BIRTHPLACE OF FATHER Ohio
(State or Country)

12. MAIDEN NAME OF MOTHER Virginia McIntosh

13. BIRTHPLACE OF MOTHER Oregon
(State or Country)

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) E. E. Elliott
(Address) Bonner Ferry, Ida.

15. Filed Oct. 25 1913
Local Registrar E. E. Elliott

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH October 25 1913
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from 1913, to 1913, that I last saw him alive on Oct. 25 - 1913, and that death occurred on the date stated above, at 3 A.M.
The CAUSE OF DEATH* was as follows: Difficult labor.

(Duration) _____ yrs. _____ mos. 7 hours
Contributory (Secondary) _____
(Duration) _____ yrs. _____ mos. _____ ds.
(Signed) E. E. Elliott M. D.
10/25 1913 (Address) Bonner Ferry, Ida.

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death _____ yrs. _____ mos. _____ days. In the State _____ yrs. _____ mos. _____ days.
Where was disease contracted if not at place of death? _____
Former or usual residence _____

19. PLACE OF BURIAL OR REMOVAL Bonner Ferry Ida. DATE OF BURIAL 10/25 1913
20. UNDERTAKER John J. Moran ADDRESS Bonner Ferry, Ida.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Form V. S. No. 5 20M.1-16-12

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH.

Registration District No.

County *Bonner*

Primary Registration District No.

City of *Bonanza* (State)File No. *6108*

Registered No.

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME *Bongetta Roberto*

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX *Female*4. COLOR OR RACE *White*5. SINGLE, MARRIED, WIDOWED OR DIVORCED. *married*

(Write the word.)

6. DATE OF BIRTH *March 16th 1860*

(Month)

(Day)

(Year)

7. AGE *53* yrs. mos. ds.

IF LESS than 1 day
how many hrs. or
..... mins.?

8. OCCUPATION

(a) Trade, profession or particular kind of work
(b) General nature of industry, business, or establishment in which employed (or employer)

Housewife

9. BIRTHPLACE

(State or Country)

*Italy*10. NAME OF FATHER *Linara Roberto*

11. BIRTHPLACE OF FATHER

(State or Country)

*Italy*12. MAIDEN NAME OF MOTHER *Cassimena Mangano*

13. BIRTHPLACE OF MOTHER

(State or Country)

Italy

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) *A Roberto*(Address) *Meadow Creek*

15.

Filed *Oct. 3rd. 1913.*

1913.

Local Registrar *E. E. Brown*

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH *Oct 3rd 1913*

(Month)

(Day)

(Year)

17. I HEREBY CERTIFY, That I attended deceased from 191... to 191...

that I last saw her alive on *Oct. 3rd 1913.*and that death occurred on the date stated above, at *5 AM.*

The CAUSE OF DEATH* was as follows:

acute nephritis (uraemia)

(Duration) yrs. mos. ds.

Contributory (Secondary)

(Duration) yrs. mos. ds.

(Signed) *E. E. Brown* M. D.*10/3 1913* (Address) *Bonner Ferry, Ida.*

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death yrs. mos. days. In the State yrs. mos. days.

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL *Idaho*DATE OF BURIAL *10/5 1913*20. UNDERTAKER *J. Moore*ADDRESS *Bonanza*

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Form V. S. No. 5 20M.1-16-12

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH. Registration District No.
County of Bonner Primary Registration District No.
City of Bonner Ferry, Idaho (St.)

File No. 6159
Registered No.

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Adolf Person

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX Male 4. COLOR OR RACE White 5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.)

6. DATE OF BIRTH April 12 1876
(Month) (Day) (Year)

7. AGE 37 yrs. 5 mos. 27 ds. IF LESS than 1 day how many hrs. or mins.?

8. OCCUPATION
(a) Trade, profession or particular kind of work Miner.
(b) General nature of industry business, or establishment in which employed (or employer)

9. BIRTHPLACE (State or Country) Sweden

10. NAME OF FATHER Per Johan Johnson

11. BIRTHPLACE OF FATHER (State or Country) Sweden

12. MAIDEN NAME OF MOTHER Carolina Olson

13. BIRTHPLACE OF MOTHER (State or Country) Sweden

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Mrs Herman Vogt
(Address) Prescott, Arizona

15. Filed 10/14 1913 E.E. Fox Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH Oct 2nd 1913
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from Oct. 2nd 1913, to Oct. 3rd 1913, that I last saw him alive on Oct. 3rd 1913, and that death occurred on the date stated above, at 4 A.M.

The CAUSE OF DEATH* was as follows: myocarditis.

(Duration) yrs. mos. 7 ds.

Contributory (Secondary)

(Duration) yrs. mos. ds.

(Signed) E.E. Fox M. D. 10/14 1913 (Address) Bonner Ferry, Idaho

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death yrs. mos. days. In the State yrs. mos. days.

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL DATE OF BURIAL

Bonner Ferry Idaho 10/8 1913

20. UNDERTAKER ADDRESS

John J. Moore Bonner Ferry, Idaho

Form V. S. No. 5 20M.1-16-12

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH. Registration District No.
County of Bonner Primary Registration District No.
City of Bonner Ferry, Ida. (No. St.)

File No. 6170
Registered No.

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME William Whitman Gray
If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX Male 4. COLOR OR RACE White 5. SINGLE, MARRIED, WIDOWED OR DIVORCED. Married
(Write the word.)

6. DATE OF BIRTH November 2nd 1888
(Month) (Day) (Year)

7. AGE 24 yrs. 10 mos. 21 ds.
IF LESS than 1 day how many hrs. or mins.?

8. OCCUPATION
(a) Trade, profession or particular kind of work Saw mill Land
(b) General nature of industry business, or establishment in which employed (or employer)

9. BIRTHPLACE (State or Country) Whitman Wash.

10. NAME OF FATHER Albus H. Gray

11. BIRTHPLACE OF FATHER (State or Country) Lin. Oregon

12. MAIDEN NAME OF MOTHER Lara Belle Strange

13. BIRTHPLACE OF MOTHER (State or Country) Lane Oregon

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) W. H. Gray
(Address) Bonner Ferry Ida.

15. Filed Sept. 24th 1913
E. E. Smith Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH Sept. 23rd 1913
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from 191... to 191...
that I last saw him alive on Sept. 23 - 1913
and that death occurred on the date stated above, at 2 A. M.

The CAUSE OF DEATH* was as follows:
Gunshot wound of skull.
(accidental)

(Duration) yrs. mos. 10 ds.

Contributory (Secondary)

(Duration) yrs. mos. 10 ds.

(Signed) E. E. Smith M. D.
9/23 1913 (Address) Bonner Ferry, Ida.

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death. 6 hours. In the State. yrs. mos. days.

Where was disease contracted if not at place of death?

Former or usual residence Bonner Ferry, Ida.

19. PLACE OF BURIAL OR REMOVAL Bonner Ferry Ida DATE OF BURIAL 9/25 1913

20. UNDERTAKER J. Moore ADDRESS Bonner Ferry Ida

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Form V. S. No. 5 20M.1-16-12

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH.

Registration District No.

County of Bonner

Primary Registration District No.

City of Bonner Ferry

(No., St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Fred FarraroFile No. 0171

Registered No.

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX

Male

4. COLOR OR RACE

White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED.

Single
(Write the word.)

6. DATE OF BIRTH

February 7th 1913
(Month) (Day) (Year)

7. AGE

7 yrs. 9 mos. 9 ds.

IF LESS than 1 day
how many hrs. or
..... mins.?

8. OCCUPATION

(a) Trade, profession or particular kind of work

(b) General nature of industry business, or establishment in which employed (or employer)

9. BIRTHPLACE

(State or Country)

Bonner Ferry Ida

10. NAME OF FATHER

Frank Farraro

11. BIRTHPLACE OF FATHER

(State or Country)

Italy

12. MAIDEN NAME OF MOTHER

M. Minabilla

13. BIRTHPLACE OF MOTHER

(State or Country)

Italy

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

Frank Farraro

(Address)

Bonner Ferry Ida

15.

Filed Sept. 18th 1913

E. J. Moore
Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH

Sept 17 - 1913
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from

Aug. 15 - 1913, to Sept. 17 - 1913,
that I last saw him alive on Sept. 16 1913

and that death occurred on the date stated above, at 5 A.M.

The CAUSE OF DEATH was as follows:

Cholera infantum.(Duration) yrs. mos. 32 ds.Contributory
(Secondary)

(Duration) yrs. mos. ds.

(Signed)

E. J. Moore M. D.
9/18 1913 (Address) Bonner Ferry Ida

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death yrs. mos. days. In the State yrs. mos. days.

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

Bonner FerrySept 18 1913

20. UNDERTAKER

ADDRESS

E. J. MooreBonner Ferry Ida

Form V. S. No. 5. 12½ M. 7-24-11

CERTIFICATE OF DEATH

State of Idaho
 BOARD OF HEALTH
 Bureau of Vital Statistics
 File No. 6172
 Registered No. _____

1. PLACE OF DEATH. Registration District No. 53
 County of Bear Lake Primary Registration District No. 2432
 City of Paris (No. _____, St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Mary Ellen Woolley

If death occurred in a hospital, institution or camp give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX Female 4. COLOR OR RACE white 5. SINGLE, MARRIED, WIDOWED OR DIVORCED. widowed
 (Write the word.)

6. DATE OF BIRTH April 8 1919
 (Month) (Day) (Year)

7. AGE 94 yrs. 4 mos. 27 ds. IF LESS than 1 day how many _____ hrs. or _____ min?

8. OCCUPATION
 (a) Trade, profession or particular kind of work. Housekeeper
 (b) General nature of industry business or establishment in which employed (or employer)

9. BIRTHPLACE Preston Lance England
 (State or Country)

10. NAME OF FATHER Thomas Wilding

11. BIRTHPLACE OF FATHER England
 (State or Country)

12. MAIDEN NAME OF MOTHER Mary Wilding

13. BIRTHPLACE OF MOTHER England
 (State or Country)

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
 (Informant) E. T. Woolley

(Address) 625 S. 2nd E. Salt Lake, Utah

15. Filed Oct 7 1913 Wm L Rich
 Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH October 5 1913
 (Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from Oct 5 1913, to Oct 5 1913
 that I last saw her alive on Oct 5 1913
 and that death occurred on the date stated above, at 10 p. M.

The CAUSE OF DEATH* was as follows:
Acute Gastro intestinalile o-
colitis

(Duration) _____ yrs. _____ mos. 5 ds.
 Contributory old age
 (Secondary)

(Duration) _____ yrs. _____ mos. _____ ds.
 (Signed) Wm L Rich M. D.
Oct 7 1913 (Address) Paris, Idaho

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place _____ In the _____
 of death _____ yrs. _____ mos. _____ ds. State _____ yrs. _____ mos. _____ ds.
 Where was disease contracted,
 If not at place of death? _____
 Former or
 usual residence _____

19. PLACE OF BURIAL OR REMOVAL DATE OF BURIAL
Salt Lake City, Utah Oct 9 1913

20. UNDERTAKER ADDRESS
Larkin Hume Undertaking Co Salt Lake, Utah

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Form V. S. No. 5 20M.1-16-12

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH

Registration District No.

County of

Primary Registration District No.

City of

(No.

St.)

Registered No.

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX

4. COLOR OR RACE

5. SINGLE, MARRIED, WIDOWED OR DIVORCED.

6. DATE OF BIRTH

7. AGE

IF LESS than 1 day
how many hrs. or mins.?

8. OCCUPATION

(a) Trade, profession or particular kind of work
(b) General nature of industry business, or establishment in which employed (or employer)

9. BIRTHPLACE

(State or Country)

10. NAME OF FATHER

11. BIRTHPLACE OF FATHER

(State or Country)

12. MAIDEN NAME OF MOTHER

13. BIRTHPLACE OF MOTHER

(State or Country)

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

(Address)

15.

Filed

191

Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH

17. I HEREBY CERTIFY, That I attended deceased from

191, to 191,

that I last saw h — alive on 191

and that death occurred on the date stated above, at 5:30 P.M.

The CAUSE OF DEATH* was as follows:

senile decay (reported)

(Duration) yrs. mos. ds.

Contributory (Secondary)

(Duration) yrs. mos. ds.

(Signed) M. D.

19 (Address)

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death yrs. mos. days. In the State yrs. mos. days.

Where was disease contracted if not at place of death?

Former or usual residence.

19. PLACE OF BURIAL OR REMOVAL DATE OF BURIAL

Zion cemetery Oct. 7 191

20. UNDERTAKER

ADDRESS

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Form V. S. No. 5 20M.1-16-12

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH

Registration District No. 100

County of Fremont

Primary Registration District No. 2178

City of Rexburg

(No. _____, _____ St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

Harlow Webster

File No. 6175

Registered No. 18

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX

Male

4. COLOR OR RACE

White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED.

(Write the word.) Married

6. DATE OF BIRTH

Sept

5

1913

(Month)

(Day)

(Year)

7. AGE

_____ yrs. _____ mos. _____ ds.

IF LESS than 1 day
how many 13 hrs. or
_____ mins.

8. OCCUPATION

(a) Trade, profession or particular kind of work

(b) General nature of industry business, or establishment in which employed (or employer)

9. BIRTHPLACE

(State or Country) Idaho

10. NAME OF FATHER

Clara Webster

11. BIRTHPLACE OF FATHER

(State or Country) Idaho

12. MAIDEN NAME OF MOTHER

Lavinia Walker

13. BIRTHPLACE OF MOTHER

(State or Country) Idaho

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

Clara Webster
Rex

(Address)

15.

Filed 9-6

1913

G. G. Espe

Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH

Sept

5

1913

(Month)

(Day)

(Year)

17. I HEREBY CERTIFY, That I attended deceased from

191 , to

191 ,

that I last saw h. alive on

191 ,

and that death occurred on the date stated above, at

M.

The CAUSE OF DEATH* was as follows:

Premature birth

(Duration) _____ yrs. _____ mos. _____ ds.

Contributory
(Secondary)

(Duration) _____ yrs. _____ mos. _____ ds.

(Signed) G. G. Espe M. D.

19 _____ (Address)

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death _____ yrs. _____ mos. _____ days. In the State _____ yrs. _____ mos. _____ days.

Where was disease contracted if not at place of death?

Former or usual residence.

19. PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

Rexburg

9/6 1913

20. UNDERTAKER

ADDRESS

John Phillips

Rexburg

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Form V. S. No. 5 20M.1-16-12

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics
File No. 6175
Registered No. 18

1. PLACE OF DEATH. Registration District No. 100
County of Fremont Primary Registration District No. 2178
City of Rehburg (No. _____ St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Fritz Pfot

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX M 4. COLOR OR RACE W 5. SINGLE, MARRIED, WIDOWED OR DIVORCED. married
(Write the word.)

6. DATE OF BIRTH 8 12 1862
(Month) (Day) (Year)

7. AGE 51 yrs. 28 mos. 28 ds. IF LESS than 1 day how many hrs. or mins.

8. OCCUPATION Farmer
(a) Trade, profession or particular kind of work
(b) General nature of industry business, or establishment in which employed (or employer)

9. BIRTHPLACE Germany
(State or Country)

10. NAME OF FATHER Christoff Pfot

11. BIRTHPLACE OF FATHER Germany
(State or Country)

12. MAIDEN NAME OF MOTHER Charlotte Klingler

13. BIRTHPLACE OF MOTHER Germany
(State or Country)

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Mrs Fritz Pfot

(Address)

15. 9-8 9-18 1913
Filed 9-18 Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH 9 8 1913
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from 191 to 191,
that I last saw h. alive on 191,
and that death occurred on the date stated above, at M.

The CAUSE OF DEATH was as follows:
Broken neck, thrown from wagon

(Duration) yrs. mos. ds.

Contributory (Secondary)

(Duration) yrs. mos. ds.

(Signed) M. D.

19 (Address)

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death yrs. mos. days. In the State yrs. mos. days.

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL Rehburg DATE OF BURIAL 9-11 1913

20. UNDERTAKER John Phillips ADDRESS Rehburg

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Form V. S. No. 5 20M.1-16-12

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics
File No. 6171
Registered No. 20

1. PLACE OF DEATH. Registration District No. 100
County of Fremont Primary Registration District No. 2178
City of Burton (No. _____, St.)
If death occurs away from usual residence, give facts called for under special information. 2. FULL NAME Sars M Bood

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX Male 4. COLOR OR RACE White 5. SINGLE, MARRIED, WIDOWED OR DIVORCED. Married (With the word.)

6. DATE OF BIRTH May 20 1841
(Month) (Day) (Year)

7. AGE 72 yrs. 3 mos. 35 ds. IF LESS than 1 day how many hrs. or mins.?

8. OCCUPATION (a) Trade, profession or particular kind of work Farmer (b) General nature of industry business, or establishment in which employed (or employer)

9. BIRTHPLACE Sweden (State or Country)

10. NAME OF FATHER Johnson Bood

11. BIRTHPLACE OF FATHER Sweden (State or Country)

12. MAIDEN NAME OF MOTHER + +

13. BIRTHPLACE OF MOTHER Sweden (State or Country)

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE (Informant) Mrs Sars M Bood (Address) Burton

15. Filed 9-17 1913 L. L. Epe Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH Sept. 15 1913
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from 1913, to 1913, that I last saw h. alive on 1913, and that death occurred on the date stated above, at M. The CAUSE OF DEATH* was as follows:

Int. Haemorrhage following accident

(Duration) yrs. mos. ds. Contributory (Secondary)

(Duration) yrs. mos. ds. (Signed) Palmer M. D. 19 (Address) Rigny

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death yrs. mos. days. In the State yrs. mos. days.

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL Burton DATE OF BURIAL 9/18 1913

20. UNDERTAKER John Phillips Address Rexburg

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Form V. S. No. 5 20M.1-16-12

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics
File No. 6178
Registered No. 7
If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

1. PLACE OF DEATH
County of Freemont
City of Salem
Registration District No. 15
Primary Registration District No. 2178
(No. _____, St.)
If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Dennis Grapear White

PERSONAL AND STATISTICAL PARTICULARS

3. SEX Male 4. COLOR OR RACE White 5. SINGLE, MARRIED, WIDOWED OR DIVORCED. Single.
(Write the word.)
6. DATE OF BIRTH Aug 2 1913
(Month) (Day) (Year)
7. AGE _____ yrs. _____ mos. _____ ds.
IF LESS than 1 day how many _____ hrs. or _____ mins.

8. OCCUPATION
(a) Trade, profession or particular kind of work
(b) General nature of industry business, or establishment in which employed (or employer)

9. BIRTHPLACE Idaho
(State or Country)

10. NAME OF FATHER Grapear & White

11. BIRTHPLACE OF FATHER Arizona
(State or Country)

12. MAIDEN NAME OF MOTHER Elbio Crona

13. BIRTHPLACE OF MOTHER Idaho
(State or Country)

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) John A. White
(Address) Salem

15. Filed 8-3 1913 L. G. Epe
Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH Aug 2 1913
(Month) (Day) (Year)
17. I HEREBY CERTIFY, That I attended deceased from 1913 to 1913, that I last saw h. alive on 1913, and that death occurred on the date stated above, at M.
The CAUSE OF DEATH* was as follows:

Abortion
(Duration) _____ yrs. _____ mos. _____ ds.
Contributory (Secondary) _____
(Duration) _____ yrs. _____ mos. _____ ds.
(Signed) Dr. Young M. D.
19 _____ (Address)

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death _____ yrs. _____ mos. _____ days. In the State _____ yrs. _____ mos. _____ days.
Where was disease contracted if not at place of death?
Former or usual residence _____

19. PLACE OF BURIAL OR REMOVAL Perbury DATE OF BURIAL Aug 4 1913

20. UNDERTAKER John Phillips ADDRESS Perbury

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Form V. S. No. 5 20M.1-16-12

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics
File No. 6179
Registered No. 8

1. PLACE OF DEATH
County of Fremont
City of Burton
Registration District No. 277100
Primary Registration District No. 2178
(No. _____, _____ St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Lawrence Hertzig

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX Boy 4. COLOR OR RACE White 5. SINGLE, MARRIED, WID-
OWED OR DIVORCED. Single
(Write the word.)

6. DATE OF BIRTH Aug 3 1913
(Month) (Day) (Year)

7. AGE _____ yrs. _____ mos. 1 ds.
IF LESS than 1 day
how many _____ hrs. or
_____ mins.?

8. OCCUPATION
(a) Trade, profession or particular kind of work At Home
(b) General nature of industry business, or establishment in which employed (or employer) _____

9. BIRTHPLACE
(State or Country) Burton

10. NAME OF FATHER Alma Hertzig

11. BIRTHPLACE OF FATHER
(State or Country) Utah

12. MAIDEN NAME OF MOTHER Nettie Chandler

13. BIRTHPLACE OF MOTHER
(State or Country) Idaho

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Alma Hertzig
(Address) Burton

15. Filed 8-4- 1913
L. L. Espe
Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH Aug 4 1913
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from 8-3 1913, to 8-4 1913,
that I last saw him alive on 8-4 1913,
and that death occurred on the date stated above, at 11 A.M.

The CAUSE OF DEATH* was as follows:

Stenosis

(Duration) _____ yrs. _____ mos. _____ ds.

Contributory
(Secondary) _____

(Duration) _____ yrs. _____ mos. _____ ds.

(Signed) L. L. Espe M. D.

19. (Address) _____

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death _____ yrs. _____ mos. _____ days. In the State _____ yrs. _____ mos. _____ days.

Where was disease contracted if not at place of death? _____

Former or usual residence _____

19. PLACE OF BURIAL OR REMOVAL DATE OF BURIAL

Burton Aug 5 1913

20. UNDERTAKER ADDRESS

John Phillips Rey

MARGIN RESERVED FOR BINDING
WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Form V. S. No. 5. 12½ M. 7-24-11

CERTIFICATE OF DEATH

State of Idaho

BOARD OF HEALTH
Bureau of Vital Statistics

File No. 6180

Registered No. 9

If death occurred in a hospital, institution or camp give its NAME instead of street and number.

1. PLACE OF DEATH. Registration District No. 100
County of Fremont Primary Registration District No. 2178
City of Platts, Ida (No. , St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Lizzie Pope

PERSONAL AND STATISTICAL PARTICULARS

3. SEX 4. COLOR OR RACE 5. SINGLE, MARRIED, WIDOWED OR DIVORCED.

Female White married (Write the word.)

6. DATE OF BIRTH January 13, 1878
(Month) (Day) (Year)

7. AGE 85 yrs. mos. ds. IF LESS than 1 day how many hrs. or min?

8. OCCUPATION

(a) Trade, profession or particular kind of work

(b) General nature of industry business or establishment in which employed (or employer)

housewife

9. BIRTHPLACE

(State or Country)

Russia

10. NAME OF FATHER

Olestin

11. BIRTHPLACE OF FATHER

(State or Country)

Russia

12. MAIDEN NAME OF MOTHER

Lizzie Olestin

13. BIRTHPLACE OF MOTHER

(State or Country)

Russia

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

(Address)

W. H. Pope

Platts, Idaho

15.

Filed 8-17 1913

L. G. Eise

Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH 8 16 1913
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from 191 to 191

that I last saw h alive on 191

and that death occurred on the date stated above, at M.

The CAUSE OF DEATH* was as follows:

No appreciable cause
just died between sun

(Duration) yrs. mos. ds.

Contributory (Secondary)

(Duration) yrs. mos. ds.

(Signed) Mr. Physician M. D.

19 (Address)

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place In the of death yrs. mos. ds. State yrs. mos. ds.

Where was disease contracted,

If not at place of death?

Former or

usual residence.

19. PLACE OF BURIAL OR REMOVAL DATE OF BURIAL

Platts

8-18 1913

20. UNDERTAKER

ADDRESS

J. R. Young

Ref. Young

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Form V. S. No. 5 20M.1-16-12

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics
File No. 6181
Registered No. 10

1. PLACE OF DEATH
County of Freemont
City of Reynolds
Registration District No. 100
Primary Registration District No. 2178
(No. _____ St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Jacob Henry Flamm

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX Male 4. COLOR OR RACE White 5. SINGLE, MARRIED, WIDOWED OR DIVORCED. Married.
(Write the word.)

6. DATE OF BIRTH November 27 1837
(Month) (Day) (Year)

7. AGE 75 yrs. 8 mos. 22 ds.
IF LESS than 1 day how many hrs. or mins.?

8. OCCUPATION
(a) Trade, profession or particular kind of work Merchant
(b) General nature of industry, business, or establishment in which employed (or employer)

9. BIRTHPLACE Switzerland
(State or Country)

10. NAME OF FATHER

11. BIRTHPLACE OF FATHER
(State or Country)

12. MAIDEN NAME OF MOTHER Helena Bock

13. BIRTHPLACE OF MOTHER Germany
(State or Country)

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Henry J. Flamm(Address) Reynolds

15. Filed 8-20 1913 L. L. Esposito
Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH Aug 18 1913
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from June 10 1913, to Aug 18 1913, that I last saw him alive on Aug 17 1913, and that death occurred on the date stated above, at M.

The CAUSE OF DEATH* was as follows:

Asthma following diabetic gangrene

(Duration) Yrs. mos. ds.
Contributory (Secondary) Diabetes

(Duration) Yrs. mos. ds.
(Signed) Dr. H. H. Esposito M. D.
19 (Address)

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death Yrs. mos. days. In the State Yrs. mos. days.

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL Reynolds DATE OF BURIAL Aug 24 1913

20. UNDERTAKER John Phillips ADDRESS Reynolds

CERTIFICATE OF DEATH

Dr. Shupe
State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics
File No. **6182**
Registered No. **11**

1. PLACE OF DEATH

Registration District No. **100**County of **Freemont**Primary Registration District No. **2178**City of **Idaho**(No. **Idaho** St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

Cliza Rebecca**Stans**

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX

Female

4. COLOR OF RACE

White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED.

Married
(Write the word.)

6. DATE OF BIRTH

Feb**14****1844**

(Month)

(Day)

(Year)

7. AGE

72 yrs.**7** mos.**4** ds.IF LESS than 1 day
how many hrs. or
..... mins.?

8. OCCUPATION

(a) Trade, profession or particular kind of work

House wife

(b) General nature of industry business, or establishment in which employed (or employer)

9. BIRTHPLACE

(State or Country)

United States (Iowa)

10. NAME OF FATHER

Lucious H. Scoville

11. BIRTHPLACE OF FATHER

(State or Country)

United States

12. MAIDEN NAME OF MOTHER

Quinton

13. BIRTHPLACE OF MOTHER

(State or Country)

United States

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

Mrs. S. O. Jensen

(Address)

Idaho

15.

Filed

8-19**1913****G. H. Epe**

Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH

Aug**18****1913**

(Month)

(Day)

(Year)

17. I HEREBY CERTIFY, That I attended deceased from

191, to **191**,**191**,that I last saw h. alive on **191**,and that death occurred on the date stated above, at **M.**

The CAUSE OF DEATH* was as follows:

Cancer(Duration) **1** yrs. **mos.** **ds.**Contributory
(Secondary)(Duration) **1** yrs. **mos.** **ds.**(Signed) **Dr. Young** M. D.**19** (Address) **Idaho**

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death yrs. mos. days. In the State yrs. mos. days.

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL

Idaho

DATE OF BURIAL

Aug 20 1913

20. UNDERTAKER

John Phillips

ADDRESS

Ref.

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Form V. S. No. 5 20M.1-16-12

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH
County of Fremont
City of Reynolds
Registration District No. 100
Primary Registration District No. 2178
(No. _____, St.)

File No. 6183
Registered No. 12

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Peter L. Latt

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX male 4. COLOR OR RACE white 5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.)

6. DATE OF BIRTH Aug 23 1989
(Month) (Day) (Year)

7. AGE 23 yrs. 0 mos. 0 ds.
IF LESS than 1 day how many 0 hrs. or 0 mins.)

8. OCCUPATION
(a) Trade, profession or particular kind of work Farmer
(b) General nature of industry business, or establishment in which employed (or employer)

9. BIRTHPLACE Utah
(State or Country)

10. NAME OF FATHER Salbert F. Latt

11. BIRTHPLACE OF FATHER Utah
(State or Country)

12. MAIDEN NAME OF MOTHER Susan J. Farnsworth

13. BIRTHPLACE OF MOTHER Utah
(State or Country)

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Salbert F. Latt
(Address) Reynolds

15. Filed 8-20-1913
Local Registrar P. L. Egan

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH Aug 23 1913
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from 1913, to 1913, that I last saw h. alive on 1913, and that death occurred on the date stated above, at M.

The CAUSE OF DEATH* was as follows:

typhoid

(Duration) 0 yrs. 0 mos. 0 ds.
Contributory (Secondary)
(Duration) 0 yrs. 0 mos. 0 ds.
(Signed) J. P. Shoup M. D.
(Address) 19

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death 0 yrs. 0 mos. 0 days. In the State 0 yrs. 0 mos. 0 days.
Where was disease contracted if not at place of death?
Former or usual residence

19. PLACE OF BURIAL OR REMOVAL Reynolds DATE OF BURIAL Aug 26 1913

20. UNDERTAKER John Phillips ADDRESS Reynolds

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Form V. S. No. 5. 12½ M. 7-24-11

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics
File No. 6184
Registered No. 13

1. PLACE OF DEATH
County of Franklin
City of Sugar
Registration District No. 100
Primary Registration District No. 2178
(No. John Philip St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

John Philip

If death occurred in a hospital, institution or camp give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX Male 4. COLOR OR RACE white 5. SINGLE, MARRIED, WIDOWED OR DIVORCED. Single
(Write the word.)

6. DATE OF BIRTH Do not know
(Month) (Day) (Year)

7. AGE about 54 IF LESS than 1 day
yrs. mos. ds. how many hrs. or min?

8. OCCUPATION
(a) Trade, profession or particular kind of work. Day Labour
(b) General nature of industry business or establishment in which employed (or employer)

9. BIRTHPLACE Do not know
(State or Country)

10. NAME OF FATHER Do not know

11. BIRTHPLACE OF FATHER "
(State or Country)

12. MAIDEN NAME OF MOTHER "

13. BIRTHPLACE OF MOTHER "
(State or Country)

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) W. E. Young
(Address) Box 100

15. 8-28 1913
Local Registrar L. G. Reese

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH Aug 26 1913
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from July 27 1913, to Aug 27 1913, that I last saw him alive on Aug 27 1913 and that death occurred on the date stated above, at 9:30 M. The CAUSE OF DEATH* was as follows: Infantile convulsions

6 (Duration) yrs. mos. ds.
Contributory (Secondary)
(Duration) yrs. mos. ds.
(Signed) J. P. Shupe M. D.
19 (Address)

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place In the
of death yrs. mos. ds. State yrs. mos. ds.
Where was disease contracted,
If not at place of death?
Former or
usual residence.

19. PLACE OF BURIAL OR REMOVAL Box 100 DATE OF BURIAL 8/28 1913

20. UNDERTAKER W. E. Young ADDRESS Box 100

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Form V. S. No. 5 20M.1-16-12

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH

Registration District No. 100County of JerseyPrimary Registration District No. 2178City of Reynoldsburg

(No. _____)

St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

Anna HuntFile No. 6185Registered No. 17

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX

4. COLOR OR RACE

5. SINGLE, MARRIED, WIDOWED OR DIVORCED.

Female White

(Write the word.)

6. DATE OF BIRTH

Aug 26 1913
(Month) (Day) (Year)

7. AGE

____ yrs. ____ mos. 1 ds.IF LESS than 1 day
how many ____ hrs. or
____ mins.?

8. OCCUPATION

- (a) Trade, profession or particular kind of work
(b) General nature of industry, business, or establishment in which employed (or employer)

9. BIRTHPLACE

(State or Country)

Idaho

10. NAME OF FATHER

John J. Hunt

11. BIRTHPLACE OF FATHER

(State or Country)

Utah

12. MAIDEN NAME OF MOTHER

Mary E. Busby

13. BIRTHPLACE OF MOTHER

(State or Country)

Utah

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

John J. Hunt

(Address)

Reynoldsburg

15.

Filed 8-27 1913H. C. Eise

Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH

August 27 1913
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from

Aug. 26 1913, to Aug. 27 1913,that I last saw her alive on Aug. 27 1913,and that death occurred on the date stated above, at 2 P.M.

The CAUSE OF DEATH* was as follows:

Premature delivery

(Duration) ____ yrs. ____ mos. ____ ds.

Contributory
(Secondary)

(Duration) ____ yrs. ____ mos. ____ ds.

(Signed)

W. T. Busby M. D.Aug 27, 1913 (Address) Reynoldsburg, Ida.

State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death ____ yrs. ____ mos. ____ days. In the State ____ yrs. ____ mos. ____ days.

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

ReynoldsburgAug. 28 1913

20. UNDERTAKER

ADDRESS

John PhillipsReynoldsburg

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Form V. S. No. 5a 20M1-16-12

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH.

Registration District No. 100County of FremontPrimary Registration District No. 2178City of Rehoboth

(No. _____ St.)

File No. 6188Registered No. 15

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME David Stoddard

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX M4. COLOR OR RACE W5. SINGLE, MARRIED, WIDOWED OR DIVORCED
Married
(Write the word.)

6. DATE OF BIRTH

June 2 1830
(Month) (Day) (Year)

7. AGE

83 yrs. 2 mos. 26 ds.IF LESS than 1 day
how many hrs. or
..... mins.?

8. OCCUPATION

(a) Trade, profession or particular kind of work
(b) General nature of industry business, or establishment in which employed (or employer)Farmer

9. BIRTHPLACE

(State or Country)

Scotland

10. NAME OF FATHER

John Stoddard

11. BIRTHPLACE OF FATHER

(State or Country)

Scotland

12. MAIDEN NAME OF MOTHER

Jennett Kerr

13. BIRTHPLACE OF MOTHER

(State or Country)

Scotland

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

Thos. Stoddard (son)

(Address)

Burton, Idaho

15.

Filed 8-28 1913L. L. Hope
Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH

8 28 1913
(Month) (Day) (Year)17. I HEREBY CERTIFY, That I attended deceased from July 28 1913, to Aug 28 1913, that I last saw him alive on Aug 25 1913, and that death occurred on the date stated above, at 4 A.M.

The CAUSE OF DEATH* was as follows:

Hypertensive pneumonia

(Duration) yrs. mos. ds.

Contributory (Secondary)

(Duration) yrs. mos. ds.

(Signed)

L. L. Hope

M. D.

19. (Address)

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death yrs. mos. days. In the State yrs. mos. days.

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

Rehoboth Aug 2 1913

20. UNDERTAKER

ADDRESS

John H. Hays Rehoboth

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Form V. S. No. 5 20M.1-16-12		CERTIFICATE OF DEATH		State of Idaho BOARD OF HEALTH Bureau of Vital Statistics	
1. PLACE OF DEATH.		Registration District No. 100		File No. 6187	
County of Fremont		Primary Registration District No. 2178		Registered No. 76	
City of Wilford		(No. , St.)		If death occurred in a hospital, institution or camp, give its NAME instead of street and number.	
If death occurs away from usual residence, give facts called for under special information.		2. FULL NAME John D. McArthur			
PERSONAL AND STATISTICAL PARTICULARS				MEDICAL CERTIFICATE OF DEATH.	
3. SEX M		4. COLOR OR RACE White		16. DATE OF DEATH	
		(Write the word.)		Aug - 30 1913	
				(Month) (Day) (Year)	
6. DATE OF BIRTH Jan. 16 1848				17. I HEREBY CERTIFY, That I attended deceased from 8/4 1913, to 8/30 1913,	
				that I last saw h. alive on 8/30 1913,	
7. AGE 68 yrs. 7 mos. 14 ds.				and that death occurred on the date stated above, at M.	
				The CAUSE OF DEATH* was as follows:	
8. OCCUPATION Farmer				General Peritonitis	
(a) Trade, profession or particular kind of work					
(b) General nature of industry business, or establishment in which employed (or employer)					
9. BIRTHPLACE Scotland				(Duration) yrs. mos. ds.	
(State or Country)				Contributory	
10. NAME OF FATHER James M. Arthur				(Secondary)	
11. BIRTHPLACE OF FATHER Scotland				(Duration) yrs. mos. ds.	
(State or Country)				(Signed) M. D.	
12. MAIDEN NAME OF MOTHER Elizabeth Dickson				19 (Address)	
13. BIRTHPLACE OF MOTHER Scotland					
(State or Country)				*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.	
14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE				18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)	
(Informant) John A. McArthur				At place of death.....yrs.....mos.....days. In the State.....yrs.....mos.....days.	
(Address) Paradise, Utah				Where was disease contracted if not at place of death?	
15. Filed 8-30 1913 L. C. Egan				Former or usual residence.....	
Local Registrar				19. PLACE OF BURIAL OR REMOVAL Wilford	
				DATE OF BURIAL Sept. 1 1913	
				20. UNDERTAKER John Phillips	
				ADDRESS Richburg	

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Form V. S. No. 5. 12½ M. 7-24-11

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH. Registration District No. 100
County of Sanborn Primary Registration District No. 2178
City of Rexburg (No. _____ St.)

File No. 6188
Registered No. 1

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

Albert E. Harrison

If death occurred in a hospital, institution or camp give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX Male 4. COLOR OR RACE White 5. SINGLE, MARRIED, WIDOWED OR DIVORCED. Boy
(Write the word.)

6. DATE OF BIRTH Feb 10 1903
(Month) (Day) (Year)

7. AGE 10 yrs. 5 mos. 3 ds. IF LESS than 1 day how many hrs. or min?

8. OCCUPATION

- (a) Trade, profession or particular kind of work.
(b) General nature of industry business or establishment in which employed (or employer)

Boy

9. BIRTHPLACE
(State or Country)

Salem

10. NAME OF FATHER

James Harrison

11. BIRTHPLACE OF FATHER
(State or Country)

Utah

12. MAIDEN NAME OF MOTHER

Mary A. Morrison

13. BIRTHPLACE OF MOTHER
(State or Country)

Utah

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

(Address)

J. Young
Rexburg

15.

Filed 7-22 1913

L. L. Espe

Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH

July 7 5 1913
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from June 20 1913, to June 6 1913 that I last saw him alive on July 5 1913 and that death occurred on the day stated above, at 9:00 M.

The CAUSE OF DEATH* was as follows:

Dysentery

6 (Duration) yrs. mos. days ds.

Contributory
(Secondary)

(Duration) yrs. mos. ds.
(Signed) J. R. Skiff M. D.

19. (Address) Rexburg

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place In the
of death yrs. mos. ds. State yrs. mos. ds.
Where was disease contracted,
If not at place of death?
Former or
usual residence.

19. PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

20. UNDERTAKER

ADDRESS

Rexburg
J. Young

7/6 1913
Rexburg

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Form V. S. No. 5 20M.1-16-12

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics
File No. 6189
Registered No. 2

1. PLACE OF DEATH

Registration District No. 100

County of Freemont

Primary Registration District No. 2176

City of Sugar

(No. _____ St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Ken Ito

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX

4. COLOR OR RACE

5. SINGLE, MARRIED, WIDOWED OR DIVORCED.

Male.

Japanese.

(Write the word.)

6. DATE OF BIRTH

_____ 1 _____
(Month) (Day) (Year)

7. AGE

_____ yrs. _____ mos. _____ ds.

IF LESS than 1 day
how many _____ hrs. or
_____ mins.?

8. OCCUPATION

(a) Trade, profession or particular kind of work

(b) General nature of industry business, or establishment in which employed (or employer)

9. BIRTHPLACE

(State or Country) Idaho

10. NAME OF FATHER T. Ito

11. BIRTHPLACE OF FATHER

(State or Country) Japan

12. MAIDEN NAME OF MOTHER I. Oono

13. BIRTHPLACE OF MOTHER

(State or Country) Japan

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) S. Sakuma

(Address) Sugar City

15.

Filed 7-12

1913

L. C. Esp
Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

July 10 1913
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from

_____ 191____, to _____ 191____,

that I last saw h_____ alive on _____ 191____,

and that death occurred on the date stated above, at _____ M.

The CAUSE OF DEATH* was as follows:

Cholera Infantum

(Duration) _____ yrs. _____ mos. _____ ds.

Contributory
(Secondary)

(Duration) _____ yrs. _____ mos. _____ ds.

(Signed) J. R. Shupe

M. D.

19

(Address) Sugar City

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death _____ yrs. _____ mos. _____ days. In the State _____ yrs. _____ mos. _____ days.

Where was disease contracted if not at place of death?

Former or usual residence.

19. PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

Sugar City

July 12 1913

20. UNDERTAKER

ADDRESS

John Phillips

Peepburg

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Form V. S. No. 5 20M.1-16-12

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH

Registration District No. 100

County of Freemont

Primary Registration District No. 2178

City of Burton

(No. _____ St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

John Alvan Watts

File No. 619

Registered No. 3

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX

Male

4. COLOR OR RACE

White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED.

Single
(Write the word.)

6. DATE OF BIRTH

June 7 1908
(Month) (Day) (Year)

7. AGE

5 yrs. 1 mos. 9 ds.

IF LESS than 1 day
how many _____ hrs. or
_____ mins.?

8. OCCUPATION

(a) Trade, profession or particular kind of work

(b) General nature of industry business, or establishment in which employed (or employer)

At Home

9. BIRTHPLACE

(State or Country)

Idaho

10. NAME OF FATHER

John Austin Watts

11. BIRTHPLACE OF FATHER

(State or Country)

Idaho

12. MAIDEN NAME OF MOTHER

Lucy Ellen Nichols

13. BIRTHPLACE OF MOTHER

(State or Country)

Idaho

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

Mary Ann Watts

(Address)

Reynburg

15.

Filed 7-17 1913

L. L. Espe

Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

July 16 1913
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from

June 3 1913, to July 16 1913,

that I last saw him alive on July 15 1913,

and that death occurred on the date stated above, at _____ M.

The CAUSE OF DEATH* was as follows:

Endocarditis

(Duration) _____ yrs. _____ mos. _____ ds.

Contributory
(Secondary)

Rheumatism

(Duration) _____ yrs. _____ mos. _____ ds.

(Signed)

L. L. Espe

M. D.

19. (Address)

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death _____ yrs. _____ mos. _____ days. In the State _____ yrs. _____ mos. _____ days.

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

Burton

July 18 1913

20. UNDERTAKER

ADDRESS

John Phillips

Reynburg

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Form V. S. No. 5 20M.1-16-12

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH.

Registration District No. 100County of FremontPrimary Registration District No. 2178City of Rexburg

(No. _____, _____ St.)

File No. 6191Registered No. 4

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

Emma Mathews

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX

Female

4. COLOR OR RACE

White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED.

Unmarried
(Write the word.)

6. DATE OF BIRTH

June 2 1838
(Month) (Day) (Year)

7. AGE

75 yrs. 1 mo. 20 ds.

IF LESS than 1 day
how many hrs. or
..... mins.?

8. OCCUPATION

(a) Trade, profession or particular kind of work

Housewife

(b) General nature of industry business, or establishment in which employed (or employer)

9. BIRTHPLACE

(State or Country)

England

10. NAME OF FATHER

Joseph Butler

11. BIRTHPLACE OF FATHER

(State or Country)

England

12. MAIDEN NAME OF MOTHER

Charlott Amelia Hempsell

13. BIRTHPLACE OF MOTHER

(State or Country)

England

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

Asenath Jarvis

(Address)

Rexburg Idaho

15.

Filed

7-241913L. L. Espe

Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH

July 22 1913
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from

March 1913, to July 22 1913,that I last saw her alive on July 22 1913,and that death occurred on the date stated above, at 7 P.M.

The CAUSE OF DEATH* was as follows:

Heart Failure

(Duration) yrs. mos. ds.

Contributory
(Secondary)

(Duration) yrs. mos. ds.

(Signed)

J. P. Shupe

M. D.

July 23 1913 (Address) Sugar City

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death yrs. mos. days. In the State yrs. mos. days.

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

RexburgJuly 25 1913

20. UNDERTAKER

ADDRESS

John PhillipsRexburg

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Form V. S. No. 5. 12½ M. 7-24-11

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics
File No. 6192
Registered No. 5

1. PLACE OF DEATH
County of Blaine Registration District No. 100
City of Blaine Primary Registration District No. 2128
(No. _____, _____ St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

James Steel

If death occurred in a hospital, institution or camp give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX Male 4. COLOR OR RACE White 5. SINGLE, MARRIED, WIDOWED OR DIVORCED. Widowed
(Write the word.)

6. DATE OF BIRTH Sept 23 - 1887
(Month) (Day) (Year)

7. AGE 76 yrs. 10 mos. 8 ds. IF LESS than 1 day how many.....hrs. or.....min?

8. OCCUPATION

(a) Trade, profession or particular kind of work.....
(b) General nature of industry business or establishment in which employed (or employer).....

Farm

9. BIRTHPLACE

(State or Country)

Ayrshire Scotland

10. NAME OF FATHER

Hamilton Steel

11. BIRTHPLACE OF FATHER

(State or Country)

Scotland

12. MAIDEN NAME OF MOTHER

Jane Morton

13. BIRTHPLACE OF MOTHER

(State or Country)

Scotland

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

(Address)

Richard Hurshy
Salt Lake City Utah

15.

Filed 7-28 1913

L. G. Espe

Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH

July 24 1913
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from July 21 1913, to July 24 1913

that I last saw him alive on July 24 1913 and that death occurred on the date stated above, at 8 P. M.

The CAUSE OF DEATH* was as follows:

Heart failure from general debility of old age

(Duration)yrs.mos.ds.

Contributory
(Secondary)

(Duration)yrs.mos.ds.

(Signed) T. G. Heine M. D.

July 25 1913 (Address) Reber, Idaho

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; (2) whether ACCIDENTAL, SUICIDAL OR HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At placeyrs.mos.ds. In the State.....yrs.mos.ds.

Where was disease contracted,

If not at place of death?

Former or

usual residence.....

19. PLACE OF BURIAL OR REMOVAL DATE OF BURIAL

Parker 7/29 1913

20. UNDERTAKER

ADDRESS

W. Young Reber, Idaho

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Form V. S. No. 5 20M.1-16-12

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH

Registration District No.

County of

Primary Registration District No.

City of

(No.

St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

File No.

Registered No.

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX

4. COLOR OR RACE

5. SINGLE, MARRIED, WIDOWED OR DIVORCED.

6. DATE OF BIRTH

7. AGE

IF LESS than 1 day
how many hrs. or
..... mins.

8. OCCUPATION

(a) Trade, profession or particular kind of work

(b) General nature of industry business, or establishment in which employed (or employer)

9. BIRTHPLACE

(State or Country)

10. NAME OF FATHER

11. BIRTHPLACE OF FATHER

(State or Country)

12. MAIDEN NAME OF MOTHER

13. BIRTHPLACE OF MOTHER

(State or Country)

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

(Address)

15.

Filed

Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH

17. I HEREBY CERTIFY, That I attended deceased from

that I last saw her alive on

and that death occurred on the date stated above, at

The CAUSE OF DEATH* was as follows:

(Duration) yrs. mos. ds.

Contributory (Secondary)

(Duration) yrs. mos. ds.

(Signed) M. D.

19 (Address)

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death yrs. mos. days. In the State yrs. mos. days.

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

20. UNDERTAKER

ADDRESS

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Form V. S. No. 5. 12½ M. 7-24-11

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH
County of Bear Lake
City of Paris

Registration District No. 24
Primary Registration District No. 2092
(No. _____ St.)

File No. 6195
Registered No. 81

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

John Allard Sutton

If death occurred in a hospital, institution or camp give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX male 4. COLOR OR RACE White 5. SINGLE, MARRIED, WIDOWED OR DIVORCED. widower
(Write the word.)
6. DATE OF BIRTH July 11th 1895
(Month) (Day) (Year)

7. AGE 78 yrs. 5 mos. 25 ds. IF LESS than 1 day how many _____ hrs. or _____ min?

8. OCCUPATION
(a) Trade, profession or particular kind of work. Retired Blacksmith
(b) General nature of industry business or establishment in which employed (or employer).

9. BIRTHPLACE Lair, Westshire, England
(State or Country)

10. NAME OF FATHER John Allard Sutton

11. BIRTHPLACE OF FATHER Lair, England
(State or Country)

12. MAIDEN NAME OF MOTHER Ann Sutton

13. BIRTHPLACE OF MOTHER Lair, England
(State or Country)

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Ed Sutton
(Address) Paris

15. June 9 1913 W. H. Rooley
Filed _____ Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH May 11 - 1913
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from Dec 30 1913, to May 11 - 1913, that I last saw him alive on May 11 - 1913, and that death occurred on the date stated above, at 3 P.M.

The CAUSE OF DEATH* was as follows:

Bronchopneumonia

(Duration) _____ yrs. _____ mos. 7 ds.
Contributory Chronic Interstitial Nephritis
(Secondary)

(Duration) _____ yrs. 5 mos. 11 ds.
(Signed) Wm. L. Rich M. D.
May 13 1913 (Address) Paris, Idaho

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; (2) whether ACCIDENTAL, SUICIDAL OR HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place _____ In the _____
of death _____ yrs. _____ mos. _____ ds. State _____ yrs. _____ mos. _____ ds.
Where was disease contracted,
If not at place of death? _____
Former or
usual residence. _____

19. PLACE OF BURIAL OR REMOVAL Paris DATE OF BURIAL 15 1913

20. UNDERTAKER _____ ADDRESS _____

MARGIN RESERVED FOR BINDING
WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Form V. S. No. 5. 12½M.7-24-11

CERTIFICATE OF DEATH

1. PLACE OF DEATH.
County of Bear Lake
City of Montpelier

Registration District No. 24
Primary Registration District No. 2098
(No. _____, St.)

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics
File No. 6195
Registered No. _____

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

Baby Brennan

If death occurred in a hospital, institution or camp give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX Male 4. COLOR OR RACE White 5. SINGLE, MARRIED, WIDOWED OR DIVORCED. Single
(Write the word.)

6. DATE OF BIRTH Apr. 29 1913
(Month) (Day) (Year)

7. AGE _____ yrs. _____ mos. 5 ds. IF LESS than 1 day how many _____ hrs. or _____ min?

8. OCCUPATION
(a) Trade, profession or particular kind of work. None
(b) General nature of industry business or establishment in which employed (or employer) _____

9. BIRTHPLACE Montpelier Idaho
(State or Country)

10. NAME OF FATHER John R. Brennan

11. BIRTHPLACE OF FATHER New York: U.S.A.
(State or Country)

12. MAIDEN NAME OF MOTHER Barbara Edwards

13. BIRTHPLACE OF MOTHER Wyoming U.S.A.
(State or Country)

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) M. J. Davis
(Address) Montpelier

15. May 3 1913
Filed May 3 1913
Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH May 3 1913
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from May 3rd 1913, to May 3rd 1913 that I last saw him alive on May 3rd 1913 and that death occurred on the date stated above, at 3:00 P.M.

The CAUSE OF DEATH* was as follows:
Unkown - Dysentery - Convulsions - Respiratory center depressed
(Duration) _____ yrs. _____ mos. 12 hrs. ds.

Contributory (Secondary) _____
(Duration) _____ yrs. _____ mos. _____ ds.
(Signed) D. O. Pugh M. D.
5-3-1913 (Address) Montpelier Idaho

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place _____ In the _____
of death _____ yrs. _____ mos. _____ ds. State _____ yrs. _____ mos. _____ ds.
Where was disease contracted, _____
If not at place of death? _____
Former or _____
usual residence _____

19. PLACE OF BURIAL OR REMOVAL Montpelier DATE OF BURIAL 5-4 1913

20. UNDERTAKER Vineyard Bros. ADDRESS Montpelier

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Form V. S. No. 5. 12½ M. 7-24-11

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH
County of Clear Lake
City of Montpelier

Registration District No. 24
Primary Registration District No. 2098
(No. _____ St.)

File No. 619
Registered No. _____

If death occurred in a hospital, institution or camp give its NAME instead of street and number.

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Anna MaLoney

PERSONAL AND STATISTICAL PARTICULARS

3. SEX Female 4. COLOR OR RACE White 5. SINGLE, MARRIED, WIDOWED OR DIVORCED. Single
(Write the word.)

6. DATE OF BIRTH May 3 1913
(Month) (Day) (Year)

7. AGE 18 yrs. IF LESS than 1 day how many 18 hrs. or min?
yrs. mos. ds.

8. OCCUPATION
(a) Trade, profession or particular kind of work none
(b) General nature of industry business or establishment in which employed (or employer)

9. BIRTHPLACE
(State or Country) Montpelier, Ben Lueco, Ind.

10. NAME OF FATHER Frank Daniel MaLoney

11. BIRTHPLACE OF FATHER
(State or Country) Ill.

12. MAIDEN NAME OF MOTHER Anna O'Neil

13. BIRTHPLACE OF MOTHER
(State or Country) Cheyenne Wyo.

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Flora D. MaLoney
(Address) Montpelier

15. Filed May 5th 1913
Local Registrar W. H. King

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH May 3 1913
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from May 3 1913, to May 3rd 1913, that I last saw her alive on May 3rd 1913, and that death occurred on the date stated above, at M.

The CAUSE OF DEATH* was as follows:
Premature Birth

(Duration) _____ yrs. _____ mos. _____ ds.

Contributory (Secondary)

(Duration) _____ yrs. _____ mos. _____ ds.

(Signed) Dr. J. P. Taylor M. D.
5-3-1913 (Address) Montpelier, Ind.

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place In the
of death _____ yrs. _____ mos. _____ ds. State _____ yrs. _____ mos. _____ ds.
Where was disease contracted,
If not at place of death?
Former or
usual residence _____

19. PLACE OF BURIAL OR REMOVAL Montpelier DATE OF BURIAL 5-6-1913

20. UNDERTAKER Nelson ADDRESS Montpelier

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Form V. S. No. 5. 12½ M. 7-24-11

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH. Registration District No.
County of Blaine Lake Primary Registration District No.
City of Ovid (No., St.)

File No. 619

Registered No.

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Willmont Peterson

If death occurred in a hospital, institution or camp give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX Male 4. COLOR OR RACE white 5. SINGLE, MARRIED, WIDOWED OR DIVORCED. Single
(Write the word.)

6. DATE OF BIRTH Aug 22 1913
(Month) (Day) (Year)

7. AGE 7 yrs. 6 mos. 6 ds. IF LESS than 1 day how many 6 hrs. or 6 min?

8. OCCUPATION

(a) Trade, profession or particular kind of work. None
(b) General nature of industry business or establishment in which employed (or employer)

9. BIRTHPLACE

(State or Country) Ovid, Idaho

10. NAME OF FATHER

Andrew Parley Peterson

11. BIRTHPLACE OF FATHER

(State or Country) Bloomington, Idaho

12. MAIDEN NAME OF MOTHER

Mary Annette Johnson

13. BIRTHPLACE OF MOTHER

(State or Country) Ovid, Idaho

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Andrew Parley Peterson(Address) Ovid, Idaho

15.

Filed 191Wm L Rich

Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH

August 23 1913
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from Aug 22 1913, to Aug 23 1913

that I last saw him alive on Aug 22 1913 and that death occurred on the date stated above, at 12:00 M.

The CAUSE OF DEATH* was as follows:

Premature 7 months(Duration) 7 yrs. 0 mos. 0 ds.

Contributory (Secondary)

(Duration) 7 yrs. 0 mos. 0 ds.(Signed) Wm L Rich M. D.Aug 23 1913 (Address) Paris, Idaho

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place In the
of death 7 yrs. 0 mos. 0 ds. State 7 yrs. 0 mos. 0 ds.

Where was disease contracted,

If not at place of death?

Former or

usual residence.

19. PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

191

20. UNDERTAKER

ADDRESS

Wm L Rich

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Form V. S. No. 5 20M.1-16-12

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics
File No. 6199

1. PLACE OF DEATH Bear Lake Registration District No. 52
County of Bear Lake Primary Registration District No. 2136
City of Jepple (No. _____ St.)

Registered No. _____
If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Mrs Peter Hansen

PERSONAL AND STATISTICAL PARTICULARS

3. SEX Female 4. COLOR OR RACE White 5. SINGLE, MARRIED, WIDOWED OR DIVORCED. Married
(Write the word.)

6. DATE OF BIRTH December 23 1857
(Month) (Day) (Year)

7. AGE 61 yrs. 8 mos. 28 ds.
IF LESS than 1 day how many hrs. or mins.?

8. OCCUPATION
(a) Trade, profession or particular kind of work Housewife
(b) General nature of industry business, or establishment in which employed (or employer)

9. BIRTHPLACE
(State or Country) Igen Denmark

10. NAME OF FATHER Thomas Hansen

11. BIRTHPLACE OF FATHER Igen Denmark
(State or Country)

12. MAIDEN NAME OF MOTHER Anna Hansen

13. BIRTHPLACE OF MOTHER Igen Denmark
(State or Country)

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Peter Hansen
(Address) Jepple

15. Filed 9/22/1913 W. H. King
Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH Sept. 20 1913
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from July 1913, to Sept. 20 1913, that I last saw her alive on Sept. 19 1913, and that death occurred on the date stated above at 8 P. M.

The CAUSE OF DEATH* was as follows:

Apoplexy
(Duration) 3 yrs. 3 mos. 3 ds.

Contributory (Secondary)
(Duration) 3 yrs. 3 mos. 3 ds.
(Signed) Shirley Woodruff M. D.
(Address) Jepple

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death 21 yrs. 3 mos. 3 days. In the State 3 yrs. 3 mos. 3 days.
Where was disease contracted if not at place of death?
Former or usual residence

19. PLACE OF BURIAL OR REMOVAL Montpelier DATE OF BURIAL 9/23/1913

20. UNDERTAKER Vincent Bros ADDRESS Montpelier

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. MARGIN RESERVED FOR BINDING. N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Form V. S. No. 5. 12½ M. 7-24-11

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics
File No. 620
Registered No.

1. PLACE OF DEATH Registration District No. 52
County of Bear Lake Primary Registration District No. 2136
City of Montpelier (No. , St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

Leona Sommers

If death occurred in a hospital, institution or camp give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX Female 4. COLOR OR RACE White 5. SINGLE, MARRIED, WIDOWED OR DIVORCED. Single
(Write the word.)

6. DATE OF BIRTH July 28 1912
(Month) (Day) (Year)

7. AGE 1 yrs. 1 mos. 29 ds. IF LESS than day how many yrs. or min?

8. OCCUPATION

(a) Trade, profession or particular kind of work. None
(b) General nature of industry business or establishment in which employed (or employer)

9. BIRTHPLACE (State or Country) Montpelier, Idaho

10. NAME OF FATHER Ernest Sommers, Jr.

11. BIRTHPLACE OF FATHER (State or Country) Langman Switzerland

12. MAIDEN NAME OF MOTHER Ida T. Sabach

13. BIRTHPLACE OF MOTHER (State or Country) Buffalo N. Y.

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Earnest Sommers
(Address) Montpelier, Ida

15. Filed 9/28 1913 St. R. King, M.D.
Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH Sept - 27 - 1913
(Month) (Day) (Year)

I HEREBY CERTIFY, That I attended deceased from 1913, to Sept 27 1913
that I last saw her alive on Sept 27 1913
and that death occurred on the date stated above, at 2:00 P. M.

The CAUSE OF DEATH* was as follows:

Phacitis

(Duration) yrs. mos. ds.
Contributory (Secondary) Comminution

(Duration) yrs. mos. ds.
(Signed) Achly and Cooley M. D.
Sept 30 1913 (Address) Montpelier

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death 14 yrs. 14 mos. 14 ds. In the State
Where was disease contracted, If not at place of death?
Former or usual residence

19. PLACE OF BURIAL OR REMOVAL DATE OF BURIAL
Montpelier 9/28 1913

20. UNDERTAKER ADDRESS
none

File No. 6201

Registered No. _____

If death occurred in a hospital, institution or camp give its NAME instead of street and number.

1. PLACE OF DEATH
County of Bear Lake
City of Warrior
(No. _____, St.)
Registration District No. _____
Primary Registration District No. 7134

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

James Schinick

PERSONAL AND STATISTICAL PARTICULARS

3. SEX

Male

4. COLOR OR RACE

White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED.

married
(Write the word.)

6. DATE OF BIRTH

July
(Month)18
(Day)1899
(Year)

7. AGE

24 yrs. 2 mos. 10 ds.IF LESS than 1 day
how many hrs. or
..... min?

8. OCCUPATION

- (a) Trade, profession or particular kind of work.
-
- (b) General nature of industry business or establishment in which employed (or employer)

Carpenter

9. BIRTHPLACE

(State or Country)

Hard Rock Co Ill.

10. NAME OF FATHER

Thomas Jefferson Dimer

11. BIRTHPLACE OF FATHER

(State or Country)

Oxford Co Mass

12. MAIDEN NAME OF MOTHER

Mary Ann

13. BIRTHPLACE OF MOTHER

(State or Country)

Sheffield Co Conn

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

Marenda Schinick

(Address)

Warrior Idaho

15.

Filed

10/10/1913

1913

Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

Oct
(Month)10
(Day)1913
(Year)

17. I HEREBY CERTIFY, That I attended deceased from

1913, toOct 18
(Month)1913

that I last saw him alive on

Oct 8
(Month)1913and that death occurred on the date stated above, at 89 M.

The CAUSE OF DEATH* was as follows:

Carcinoma of bladder

(Duration) yrs. mos. ds.

Contributory
(Secondary)

(Duration) yrs. mos. ds.

(Signed) Geo F Ashley M. D.19..... (Address) Warrior

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENCE, state (1) MEANS OF INJURY; (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place In the
of death 45 yrs. mos. ds. State 40 yrs. mos. ds.Where was disease contracted,
If not at place of death?
Former or
usual residence.

19. PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

Warrior Idaho Oct 12 1913

20. UNDERTAKER

ADDRESS

noneWRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. N. B.—Every item of information should be carefully supplied. AGE should be state EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Form V. S. No. 5. 10M. 6-20-11.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH.

Registration District No. 21

County of Blaine

Primary Registration District No. 2092

City of On Little Wood River

(No. St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

Thomas Shaw

File No. 6202

Registered No. 37

If death occurred in a hospital, institution or camp give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX

Male

4. COLOR OR RACE

White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED.

Single
(Write the word.)

6. DATE OF BIRTH

.....
(Month) (Day) (Year)

7. AGE

About
44 yrs. - mos. ds.

IF LESS than 1 day
how many hrs. or
min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work
(b) General nature of industry business or establishment in which employed (or employer)

Sheep Herder

9. BIRTHPLACE

(State or Country) Unknown

10. NAME OF FATHER

"

11. BIRTHPLACE OF FATHER

(State or Country) "

12. MAIDEN NAME OF MOTHER

"

13. BIRTHPLACE OF MOTHER

(State or Country) "

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Ans J. Gray

(Address) Blaine Idaho

15.

Filed Sept 75 1913 Robert H. Wright
Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

Sept 22 1913
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from

..... 191..... to 191.....
that I last saw h..... alive on 191.....
and that death occurred on the date stated above, at M.

The CAUSE OF DEATH* was as follows:

Gun shot wound
Killed Instantly

..... (Duration) yrs. mos. ds.

Contributory (Secondary)

..... (Duration) yrs. mos. ds.
(Signed) Robert H. Wright M. D.
Sept 22 1913 (Address) Coroner

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death..... yrs. mos. ds. State..... yrs. mos. ds.
Where was disease contracted,
If not at place of death?
Former or usual residence.....

19. PLACE OF BURIAL OR REMOVAL

Hailey Idaho

DATE OF BURIAL

Sept 24 1913

20. UNDERTAKER

B. W. Harris

ADDRESS

Hailey

Form V. S. No. 5. 10M. 6-20-11.

CERTIFICATE OF DEATH

1. PLACE OF DEATH.

Registration District No. 71County of BlainePrimary Registration District No. 7075City of Carey

(No. _____, _____ St.)

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics
File No. 620Registered No. 39

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME William Clark

If death occurred in a hospital, institution or camp give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX

Male

4. COLOR OR RACE

White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED.

widowed
(Write the word.)

6. DATE OF BIRTH

Sept. 23rd

(Month)

(Day)

1834
(Year)

7. AGE

79 yrs. one mos. 6 ds.IF LESS than 1 day
how many _____ hrs. or
_____ min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work
(b) General nature of industry business or establishment in which employed (or employer)Farmer

9. BIRTHPLACE

(State or Country)

Leicestershire
England

10. NAME OF FATHER

John Clark

11. BIRTHPLACE OF FATHER

(State or Country)

Leicestershire-Eng.

12. MAIDEN NAME OF MOTHER

Mary Wood Clark

13. BIRTHPLACE OF MOTHER

(State or Country)

Leicestershire

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

Joseph Clark

(Address)

Carey

15.

Filed 10-201913Robert H. Wright

Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

Oct 17th

(Month)

(Day)

1913
(Year)

17. I HEREBY CERTIFY, That I attended deceased from

1913 to1913that I last saw h_____ alive on _____ 1913,

and that death occurred on the date stated above, at _____ M.

The CAUSE OF DEATH* was as follows:

Senility

(Duration) _____ yrs. _____ mos. _____ ds.

Contributory
(Secondary)

(Duration) _____ yrs. _____ mos. _____ ds.

(Signed) Robert H. Wright M. D.
Oct 18 1913 (Address) Carey Ida

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and 2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death _____ yrs. _____ mos. _____ ds. In the State _____ yrs. _____ mos. _____ ds.

Where was disease contracted,

If not at place of death? _____

Former or usual residence _____

19. PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

Carey18 1913

20. UNDERTAKER

ADDRESS

No undertaker -
Friends acting -18th

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Form V. S. No. 5. 10M. 6-20-11.

CERTIFICATE OF DEATH

1. PLACE OF DEATH.
County of Blaine
City of Bellevue

Registration District No. 21
Primary Registration District No. 2022
(No. _____, St.)

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics
File No. 6203
Registered No. 40

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

Magdaline A. Daily

If death occurred in a hospital, institution or camp give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX Female 4. COLOR OR RACE Wht 5. SINGLE, MARRIED, WIDOWED OR DIVORCED. married
(Write the word.)

6. DATE OF BIRTH April 14 1843
(Month) (Day) (Year)

7. AGE 70 yrs. 6 mos. 16 ds. IF LESS than 1 day how many hrs. or min.)

8. OCCUPATION

(a) Trade, profession or particular kind of work
(b) General nature of industry business or establishment in which employed (or employer)

Housewife

9. BIRTHPLACE
(State or Country)

Missouri

10. NAME OF FATHER

✓

11. BIRTHPLACE OF FATHER
(State or Country)

—

12. MAIDEN NAME OF MOTHER

✓

13. BIRTHPLACE OF MOTHER
(State or Country)

✓

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) M. J. Daily
(Address) Bellevue Ida

15. Filed Nov 1 1913 Robert H. Wright
Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH Oct 30 1913
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from 191 to 191

that I last saw h. ✓ alive on 191, and that death occurred on the date stated above, at — M.

The CAUSE OF DEATH* was as follows:

Natural cause s. fr. death of Coroners jury
Found dead

(Duration) yrs. mos. ds.

Contributory (Secondary)

(Duration) yrs. mos. ds.

(Signed) Robert H. Wright M. D.
Oct 30 1913 (Address) Bellevue Ida

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted.

If not at place of death?

Former or

usual residence

19. PLACE OF BURIAL OR REMOVAL Bellevue Ida DATE OF BURIAL Nov 1 1913

20. UNDERTAKER R. D. Harris ADDRESS Hailey Ida

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. N. B.—Every item of information should be carefully supplied. AGE should be state EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Form V. S. No. 5. 10M. 6-20-11.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

File No. 6295

Registered No. 41

If death occurred in a hospital, institution or camp give its NAME instead of street and number.

1. PLACE OF DEATH.

Registration District No. 71

County of Blaine

Primary Registration District No. 7072

City of Sammett CO

(No. , St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

Mellie Southern

PERSONAL AND STATISTICAL PARTICULARS

3. SEX

Girl

4. COLOR OR RACE 5. SINGLE, MARRIED, WIDOWED OR DIVORCED.

white

(Write the word.)

6. DATE OF BIRTH

Aug

20

1910

(Month)

(Day)

(Year)

7. AGE

3

yrs.

2

mos.

ds.

IF LESS than 1 day
how many hrs. or
min.?

8. OCCUPATION

(a) Trade, profession, or particular kind of work

(b) General nature of industry business, or establishment in which employed (or employer)

9. BIRTHPLACE

(State or Country)

Blaine Co.

10. NAME OF FATHER

John Southern

11. BIRTHPLACE OF FATHER

(State or Country)

England

12. MAIDEN NAME OF MOTHER

Alice Rodgers

13. BIRTHPLACE OF MOTHER

(State or Country)

Utah

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

Jno Southern

(Address)

Sammett

15.

Filed

Oct 20 1913

Robert H. Wright

Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

Oct

19

1913

(Month)

(Day)

(Year)

17. I HEREBY CERTIFY, That I attended deceased from

Oct 18

1913

to Oct 18

1913

that I last saw her alive on Oct 18 1913

and that death occurred on the date stated above, at 8 a. M.

The CAUSE OF DEATH* was as follows:

Acute indigestion
with Convulsions

(Duration) yrs. mos. 24 ds.

Contributory
(Secondary)

(Duration) yrs. mos. ds.

(Signed) O. J. Allen M. D.

Oct 19 1913 (Address) O. J. Allen

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place

In the

of death yrs. mos. ds. State yrs. mos. ds.

Where was Disease contracted,

If not at place of death?

Former or

usual residence.

19. PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

Spring Creek Cemetery

Oct 20 1913

20. UNDERTAKER

ADDRESS

R. D. Harris

Pawley

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. N. B.—Every item of information should be carefully supplied. AGE should be state EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Form V. S. No. 5. 10M. 6-20-11.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics
File No. 620
Registered No. 42

1. PLACE OF DEATH.

Registration District No. 21County of BlainePrimary Registration District No. 7072City of Bellevue

(No. _____, St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

Elmer Williams

If death occurred in a hospital, institution or camp give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX

Male

4. COLOR OR RACE

White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED.

Single
(Write the word.)

6. DATE OF BIRTH

Aug. 27 1886
(Month) (Day) (Year)

7. AGE

27 yrs. 1 mos. 23 ds.

IF LESS than 1 day
how many _____ hrs. or
_____ min.

8. OCCUPATION

- (a) Trade, profession or particular kind of work
(b) General nature of industry business or establishment in which employed (or employer)

Labourer

9. BIRTHPLACE

(State or Country)

Ogden Utah

10. NAME OF FATHER

Jno. T. Williams

11. BIRTHPLACE OF FATHER

(State or Country)

Ogden, Utah

12. MAIDEN NAME OF MOTHER

Solly Ward

13. BIRTHPLACE OF MOTHER

(State or Country)

Green River, Wyo

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Mrs. Jno T. Williams(Address) Bellevue

15.

Filed Oct 20 1913 Robert H. Wright
Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

Oct 19 1913
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from

Oct 18 1913, to Oct 19 1913

that I last saw him alive on Oct 18 1913,
and that death occurred on the date stated above, at 12 P. M.

The CAUSE OF DEATH* was as follows:

acute septicaemia

(Duration) _____ yrs. _____ mos. 1 1/2 ds.

Contributory (Secondary) knife wound & wound
in chest

(Duration) _____ yrs. _____ mos. 1 1/2 ds.

(Signed) O. J. Allen M. D.

Oct 19 1913 (Address) Bellevue

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and 2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death _____ yrs. _____ mos. _____ ds. State _____ yrs. _____ mos. _____ ds.

Where was disease contracted,
If not at place of death?

Former or usual residence.

19. PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

Bellevue Ida Oct 21 1913

20. UNDERTAKER

ADDRESS

Ralph S. H. H. Healey

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Form V. S. No. 5. 12½ M. 7-24-11

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics
File No. 1629
Registered No. 4

1. PLACE OF DEATH. Registration District No. 116
County of Bingham Primary Registration District No. 2195
City of Aberdeen (No. _____, _____ St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Christine Wiener

If death occurred in a hospital, institution or camp give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX Female 4. COLOR OR RACE White 5. SINGLE, MARRIED, WIDOWED OR DIVORCED. Single
(Write the word.)
6. DATE OF BIRTH Oct 15 Sept 18 1913
(Month) (Day) (Year)

7. AGE _____ yrs. _____ mos. 27 ds. IF LESS than 1 day how many _____ hrs. or _____ min?

8. OCCUPATION

- (a) Trade, profession or particular kind of work _____
(b) General nature of industry business or establishment in which employed (or employer) _____

9. BIRTHPLACE

(State or Country) Aberdeen, Ida.

10. NAME OF FATHER

Father's name unknown

11. BIRTHPLACE OF FATHER

(State or Country) _____

12. MAIDEN NAME OF MOTHER

Agnes Wiener

13. BIRTHPLACE OF MOTHER

(State or Country) Russia

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) F. F. Burk
(Address) Aberdeen

15.

Filed Oct 16 1913 McMurtre
Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH

Oct 15 1913
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from _____ 191____, to _____ 191____

that I last saw h_____ alive on _____ 191____

and that death occurred on the date stated above, at _____ M.

The CAUSE OF DEATH* was as follows:

marasmus

Contributory (Secondary)

(Duration) Since birth yrs. _____ mos. _____ ds.

(Signed) McMurtre M. D.

Oct 16 1913 (Address) Aberdeen, Ida

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place _____ In the _____
of death _____ yrs. _____ mos. _____ ds. State _____ yrs. _____ mos. _____ ds.

Where was disease contracted,

If not at place of death? _____

Former or

usual residence. _____

19. PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

McMurtre Cemetery Oct 16 1913

20. UNDERTAKER

ADDRESS

Agnes Wiener Aberdeen
Idaho

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PE-
CIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact state-
ment of OCCUPATION is very important. See instructions on back of certificate.

Form V. S. No. 5. 12½ M. 7-24-11

CERTIFICATE OF DEATH

1. PLACE OF DEATH. Registration District No. 116
County of Bingham Primary Registration District No. 2193-
City of Yuma (No. _____, _____ St.)

If death occurs away from us-
ual residence, give facts called
for under special information.

2. FULL NAME

Mary Gough

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics
File No. 1 6209
Registered No. 5

If death occurred in a hospital, in-
stitution or camp give its NAME
instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX Female 4. COLOR OR RACE White 5. SINGLE, MARRIED, WID-
OWED OR DIVORCED. married
(Write the word.)

6. DATE OF BIRTH 1884
(Month) (Day) (Year)

7. AGE 20 yrs. — mos. — ds. IF LESS than 1 day
how many hrs. or
..... min?

8. OCCUPATION Housewife
(a) Trade, profession or
particular kind of work.
(b) General nature of industry
business or establishment in
which employed (or employer)

9. BIRTHPLACE England
(State or Country)

10. NAME OF FATHER Williams

11. BIRTHPLACE OF FATHER Don't know
(State or Country)

12. MAIDEN NAME OF MOTHER Don't know

13. BIRTHPLACE OF MOTHER Don't know
(State or Country)

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Henry Gough
(Address) Yuma, Ida.

15. Oct 28 1913 McMurtre
Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH Oct 28 1913
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from
Oct 26 1913, to Oct 26 1913
that I last saw her alive on Oct 26 1913
and that death occurred on the date stated above, at 70 M.
The CAUSE OF DEATH* was as follows:
my condition

(Duration) yrs. mos. 14 ds.
Contributory (Secondary)

(Duration) yrs. mos. ds.
(Signed) McMurtre M. D.
Oct 28 1913 (Address) Aberdeen, Ida.

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1)
MEANS OF INJURY; (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions,
Transients or Recent Residents.)

At place of death yrs. mos. ds. In the State yrs. mos. ds.
Where was disease contracted,
If not at place of death?
Former or usual residence

19. PLACE OF BURIAL OR REMOVAL DATE OF BURIAL
Yuma Cemetery Oct 30 1913
20. UNDERTAKER ADDRESS
Josiah Gough Yuma, Ida.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Form V. S. No. 5 20M.1-16-12

CERTIFICATE OF DEATH

1. PLACE OF DEATH

Registration District No. 90

County of Blaine

Primary Registration District No. 2168

City of Croftino

(No. _____, _____ St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

Viola TzraState of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

File No. 6219

Registered No. 16

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX

Female

4. COLOR OR RACE

White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED.

Single
(Write the word.)

6. DATE OF BIRTH

Sept
(Month)14
(Day)1910
(Year)

7. AGE

3 yrs. 1 mos. 0 ds.IF LESS than 1 day
how many hrs. or
..... mins.?

8. OCCUPATION

- (a) Trade, profession or particular kind of work
(b) General nature of industry, business, or establishment in which employed (or employer)

Baby

9. BIRTHPLACE

(State or Country)

Croftino Id.

10. NAME OF FATHER

D B Tzra

11. BIRTHPLACE OF FATHER

(State or Country)

Kentucky

12. MAIDEN NAME OF MOTHER

Olga M. Meifert

13. BIRTHPLACE OF MOTHER

(State or Country)

Wis

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

(Address)

D B Tzra

15.

Filed

Nov 1

191

J M Fairley
Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH

Oct
(Month)27
(Day)1912
(Year)

17. I HEREBY CERTIFY, That I attended deceased from

Sept 15 1913, to Oct 27 1913that I last saw her alive on Oct 27 1913and that death occurred on the date stated above, at 9 A M

The CAUSE OF DEATH* was as follows:

Dysentery-gastroenteritis & Melancholia

(Duration) yrs. mos. ds.

Contributory
(Secondary)

(Duration) yrs. mos. ds.

(Signed) E. H. Horvath M. D.Nov 10 1913 (Address) Croftino

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death yrs. mos. days. In the State yrs. mos. days.

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

Croftino Id.Oct 28 1913

20. UNDERTAKER

ADDRESS

W. B. StoddardGifford Id.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Form V. S. No. 5 20M.1-16-12

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH.

Registration District No. 90County of ClatsopPrimary Registration District No. 2168City of Orofino

(No. _____, St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

Miriam FrearFile No. 6211Registered No. 45

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX

Male

4. COLOR OR RACE

White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED.

Married
(Write the word.)

6. DATE OF BIRTH

Jan 17 1856
(Month) (Day) (Year)

7. AGE

57 yrs. 9 mos. 4 ds.IF LESS than 1 day
how many hrs. or
..... mins.

8. OCCUPATION

(a) Trade, profession or particular kind of work

Farmer

(b) General nature of industry business, or establishment in which employed (or employer)

9. BIRTHPLACE

(State or Country)

New York

10. NAME OF FATHER

Andrew Frear

11. BIRTHPLACE OF FATHER

(State or Country)

Conn

12. MAIDEN NAME OF MOTHER

Nauman

13. BIRTHPLACE OF MOTHER

(State or Country)

Conn

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

Charles Frear

(Address)

Orofino Ida

15.

Filed

Oct 20 1913

191

J. M. Gule

Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH

Oct 10 1913
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from

191 to 191,
that I last saw h e alive on 191,and that death occurred on the date stated above, at M.

The CAUSE OF DEATH* was as follows:

Pierced while lost in mountains

(Duration) yrs. mos. ds.

Contributory
(Secondary)

(Duration) yrs. mos. ds.

(Signed)

J. M. Gule M. D.

(Address)

Orofino Ida

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death yrs. mos. days. In the State yrs. mos. days.

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

Orofino IdaOct 21 1913

20. UNDERTAKER

ADDRESS

W. C. StoddardGifford

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Form V. S. No. 5 20M.1-16-12

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics
File No. **6212**
Registered No. **44**

1. PLACE OF DEATH.

Registration District No. **90**County of **Blaine**Primary Registration District No. **2168**City of **Frank**

(No. , St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

Mary Wilson

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX

4. COLOR OR RACE

5. SINGLE, MARRIED, WIDOWED OR DIVORCED.

Female**White**(Write the word.) **Married**

6. DATE OF BIRTH

Jan 16 1851
(Month) (Day) (Year)

7. AGE

62 yrs. **8** mos. **26** ds.

IF LESS than 1 day
how many hrs. or
..... mins.?

8. OCCUPATION

(a) Trade, profession or particular kind of work

House Wife

(b) General nature of industry business, or establishment in which employed (or employer)

9. BIRTHPLACE

(State or Country)

Ohio

10. NAME OF FATHER

Jordan

11. BIRTHPLACE OF FATHER

(State or Country)

New York

12. MAIDEN NAME OF MOTHER

13. BIRTHPLACE OF MOTHER

(State or Country)

New York

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

Arthur Thorne

(Address)

Profimo, Ida

15.

Filed

Oct 31

1913

J. M. Fairley
Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH

Oct 6 1913
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from

Sept 1 1913, to **Sept 25** 1913
that I last saw her alive on **Sept 23** 1913

and that death occurred on the date stated above, at **✓** M.

The CAUSE OF DEATH* was as follows:

Elephantiasis

(Duration) yrs. mos. ds.

Contributory

(Secondary)

(Duration) yrs. mos. ds.

(Signed) **E. M. Horswell** M. D.**Nov 16** 1913 (Address) **Frank**

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death yrs. mos. days. In the State yrs. mos. days.

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

Frank**Oct 8** 1913

20. UNDERTAKER

ADDRESS

✓**✓**

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Form V. S. No. 5. 12½M. 7-24-11

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics
File No. 6213
Registered No. 43

1. PLACE OF DEATH. Registration District No. 90
County of Clearwater Primary Registration District No. 2168
City of Orofino (No. N. I. Sanitarium St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

Anderson Giles

If death occurred in a hospital, institution or camp give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX 4. COLOR OR RACE 5. SINGLE, MARRIED, WIDOWED OR DIVORCED.

Male White married
(Write the word.)

6. DATE OF BIRTH

1859 1
(Month) (Day) (Year)

7. AGE

54 yrs. mos. ds.

IF LESS than 1 day
how many hrs. or min?

8. OCCUPATION

(a) Trade, profession or particular kind of work
(b) General nature of industry business or establishment in which employed (or employer)

Laborer

9. BIRTHPLACE

(State or Country)

America

10. NAME OF FATHER

M. N. Giles

11. BIRTHPLACE OF FATHER

(State or Country)

Iowa

12. MAIDEN NAME OF MOTHER

13. BIRTHPLACE OF MOTHER

(State or Country)

Iowa

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

O. A. Giles

(Address)

Orofino, Idaho

15.

Filed

Oct 3 1913

J. M. Fairley
Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH

Oct. 2. 1913.
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from
Oct 29. 1913, to Oct 2 1913.

that I last saw him alive on Oct 2 1913.

and that death occurred on the date stated above, at 4 P. M.

The CAUSE OF DEATH* was as follows:

Epilepsy

(Duration) 5 yrs. mos. ds.

Contributory (Secondary)

Insanity

(Duration) 15 yrs. mos. ds.

(Signed) John C. Williams M. D.

Oct 3 1913 (Address) Orofino, Idaho

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place In the
of death yrs. mos. ds. State yrs. mos. ds.

Where was disease contracted,
If not at place of death?

Former or usual residence...

19. PLACE OF BURIAL OR REMOVAL DATE OF BURIAL

Moscow Oct 4 1913

20. UNDERTAKER

ADDRESS

Moscow, Idaho

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Form V. S. No. 5 20M.1-16-12

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH.

Registration District No. 90

County of Blaine

Primary Registration District No. 2168

City of Frazar

(No. _____, _____ St.)

File No. 621

Registered No. 2

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

George A. Barrow

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX

Male

4. COLOR OR RACE

White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED.

Married
(Write the word.)

6. DATE OF BIRTH

June
(Month)

12
(Day)

1844
(Year)

7. AGE

69 yrs. 3 mos. 20 ds.

IF LESS than 1 day
how many _____ hrs. or
_____ mins.

8. OCCUPATION

(a) Trade, profession or particular kind of work

Farmer

(b) General nature of industry business, or establishment in which employed (or employer)

9. BIRTHPLACE

(State or Country)

Id.

10. NAME OF FATHER

11. BIRTHPLACE OF FATHER

(State or Country)

12. MAIDEN NAME OF MOTHER

13. BIRTHPLACE OF MOTHER

(State or Country)

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

(Address)

Ede W. Harrison
Frazar, Ida

15.

Filed

Oct 31 1913

J. M. Fairley
Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH

Oct
(Month)

1
(Day)

1913
(Year)

17. I HEREBY CERTIFY, That I attended deceased from

July 1913, to Oct 1913

that I last saw him alive on Sept 24 1913

and that death occurred on the date stated above, at 8 A M.

The CAUSE OF DEATH* was as follows:

curbours of Liver

(Duration) _____ yrs. _____ mos. _____ ds.

Contributory
(Secondary)

(Duration) _____ yrs. _____ mos. _____ ds.

(Signed) Ede W. Harrison M. D.

Nov 16 1913 (Address) Pro Frazar

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death _____ yrs. _____ mos. _____ days. In the State _____ yrs. _____ mos. _____ days.

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

Frazar Cemetery

Oct 3 1913

20. UNDERTAKER

ADDRESS

W. C. Stradard

Gifford Ida

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Form V. S. No. 5 20M.1-16-12

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH.

County of Tremont
City of RubyRegistration District No. 98Primary Registration District No. 2176

(No. _____) (St. _____)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

Julia E. BatesFile No. 6215Registered No. 17

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX

F

4. COLOR OR RACE

W

5. SINGLE, MARRIED, WIDOWED OR DIVORCED.

Married
(Write the word.)

6. DATE OF BIRTH

Jan 1 1859
(Month) (Day) (Year)

7. AGE

54 yrs. 9 mos. 20 ds.IF LESS than 1 day
how many hrs. or
..... mins.?

8. OCCUPATION

(a) Trade, profession or particular kind of work

(b) General nature of industry business, or establishment in which employed (or employer)

Housewife

9. BIRTHPLACE

(State or Country)

Ind.

10. NAME OF FATHER

Joe Lister

11. BIRTHPLACE OF FATHER

(State or Country)

America

12. MAIDEN NAME OF MOTHER

13. BIRTHPLACE OF MOTHER

(State or Country)

America

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

John Stutzner

(Address)

Ruby, P. D. 2.

15.

Filed

Nov. 10 19131913Ray Stutzner
By

Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH

Oct 20 1913
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from

June 5 1912, to Oct 20 1913that I last saw him alive on Sept 27 1913and that death occurred on the date stated above, at 59 M.

The CAUSE OF DEATH* was as follows:

Myocarditis

(Duration) yrs. mos. ds.

Contributory
(Secondary)

(Duration) yrs. mos. ds.

(Signed)

Ray Stutzner M. D.
Oct 13 (Address) Ruby, Ind.

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death yrs. mos. days. In the State yrs. mos. days.

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

Shelton Cemetery Oct. 23 1913

20. UNDERTAKER

ADDRESS

M. T. Peck & Son Ruby, Ind.

Form V. S. No. 5 20M.1-16-12

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics
File No. **6216**
Registered No. **15**

1. PLACE OF DEATH.

Registration District No. **98**

County of **Idaho**

Primary Registration District No. **2176**

City of **Idaho**

(No. _____)

St. _____

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

John Hansen

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX

MALE

4. COLOR OR RACE

WHITE

5. SINGLE, MARRIED, WIDOWED OR DIVORCED.

MARRIED
(Write the word.)

6. DATE OF BIRTH

Aug 12

1864

(Month)

(Day)

(Year)

7. AGE

49 yrs. 2 mos. 7 ds.

IF LESS than 1 day
how many _____ hrs. or
_____ mins.?

8. OCCUPATION

(a) Trade, profession or particular kind of work

(b) General nature of industry, business, or establishment in which employed (or employer)

Farmer

9. BIRTHPLACE

(State or Country)

Idaho

10. NAME OF FATHER

Nels Hansen

11. BIRTHPLACE OF FATHER

(State or Country)

Don't know

12. MAIDEN NAME OF MOTHER

" "

13. BIRTHPLACE OF MOTHER

(State or Country)

" "

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

Dwight Henry

(Address)

Idaho Falls, Ida.

15.

Filed

Nov 10

1913

Ray H. Fisher

Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH

Oct 20 1913
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from

Oct 20 1913, to **Oct 30** 1913

that I last saw him alive on **Oct 20** 1913

and that death occurred on the date stated above, at **4 P. M.**

The CAUSE OF DEATH* was as follows:

Found shot in head above right eye with .22 bullet.

Coroner's verdict
Contributory (Secondary) **accidental shooting injury to brain case**

(Signed)

Dr. H. A. Anderson, M. D.

Oct 24 1913 (Address) **Idaho Falls, Ida.**

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death

_____ yrs. _____ mos. _____ days.

In the State

_____ yrs. _____ mos. _____ days.

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

Little Butte Cemetery

Oct 23 1913

20. UNDERTAKER

ADDRESS

Dwight Henry

Idaho Falls, Ida.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Form V. S. No. 5 20M.1-16-12

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH

Registration District No. 98

County of Lemmon

Primary Registration District No. 2176

City of Idaho

(No. , St.)

File No. 6217

Registered No. 16

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

Asa S. Thomas

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX

M

4. COLOR OR RACE

W.

5. SINGLE, MARRIED, WIDOWED OR DIVORCED

Single
(Write the word.)

6. DATE OF BIRTH

Sept 9th 1886
(Month) (Day) (Year)

7. AGE

27 yrs. 1 mos. 17 ds.

IF LESS than 1 day
how many hrs. or mins.?

8. OCCUPATION

(a) Trade, profession or particular kind of work
(b) General nature of industry business, or establishment in which employed (or employer)

Farming

9. BIRTHPLACE

(State or Country)

Idaho

10. NAME OF FATHER

Asa Thomas

11. BIRTHPLACE OF FATHER

(State or Country)

England

12. MAIDEN NAME OF MOTHER

Anna Hansen

13. BIRTHPLACE OF MOTHER

(State or Country)

Denmark

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

A. A. Thomas

(Address)

Lewisville, Ida.

15.

Filed

Nov 10 1913 Ray H. Hise

Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

Oct 26th 1913
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from

1913, to 1913,

that I last saw him alive on 1913,

and that death occurred on the date stated above, at M.

The CAUSE OF DEATH* was as follows:

No physician.
Shot by one of two men, in the back and abused instantly killed. Cause under legal arrangement.

Contributory (Secondary) no physician until after death.

(Duration) yrs. mos. ds.

(Signed) Ray H. Hise M. D.

Nov 10 1913 (Address) Regley, Ida

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death yrs. mos. days. In the State yrs. mos. days.

Where was disease contracted if not at place of death?

Former or usual residence.

19. PLACE OF BURIAL OR REMOVAL, DATE OF BURIAL

Lewisville, Idaho 10/30/13

20. UNDERTAKER

ADDRESS

C. E. Dimwoody, Ida Falls

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Form V. S. No. 57-20M.1-16-12

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH.

Registration District No. 15-

County of Blaine

Primary Registration District No.

City of Alpha

(No. , St.)

File No. 6218

Registered No. 3

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME William Andrew Bacon

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX

4. COLOR OR RACE

5. SINGLE, MARRIED, WIDOWED OR DIVORCED.

Male

White

Married
(Write the word.)

6. DATE OF BIRTH

Feb.
(Month)22
(Day)1859
(Year)

7. AGE

57 yrs. 8 mos. 19 ds.

IF LESS than 1 day
how many hrs. or
mins.?

8. OCCUPATION

(a) Trade, profession or particular kind of work

Farmer

(b) General nature of industry business, or establishment in which employed (or employer)

9. BIRTHPLACE

(State or Country)

Fayetteville Ark.

10. NAME OF FATHER

Joseph Bacon

11. BIRTHPLACE OF FATHER

(State or Country)

Unknown

12. MAIDEN NAME OF MOTHER

Eliza Harris

13. BIRTHPLACE OF MOTHER

(State or Country)

Idaho

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

S. L. Contrall

(Address)

Alpha Idaho

15.

Filed

Oct. 12 - 1913

D. W. Conpton

Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH

Oct.
(Month)11
(Day)1913
(Year)

17. I HEREBY CERTIFY, That I attended deceased from

He died before I arrived and had been dead thirty minutes that I last saw him alive on 1913

and that death occurred on the date stated above, at 4:30 P.M.

The CAUSE OF DEATH* was as follows:

He had Paralysis of right upper extremity and left lower limb waist line below the dividing line
(Duration) yrs. 1 mos. 7 ds.Contributory History of Thrombosis 20 years (Secondary) Obstruction of bowels for 16 days
(Duration) yrs. mos. ds.

(Signed) D. W. Conpton M. D.

Oct. 12 1913 (Address) Roseburg Idaho

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL OR HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death yrs. mos. days. In the State yrs. mos. days.

Where was disease contracted if not at place of death?

Former or usual residence.

19. PLACE OF BURIAL OR REMOVAL DATE OF BURIAL

Alpha Cemetery

Oct. 14 1913

20. UNDERTAKER

S. L. Contrall

ADDRESS

Alpha Idaho

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Form V. S. No. 5 20M.1-16-12

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH

Registration District No. 49County of IdahoPrimary Registration District No. 2128File No. 6219City of Harrisburg

(No. _____, _____ St.)

Registered No. _____

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Lenna Agnes Gallacher

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX

Female

4. COLOR OR RACE

White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED.

Single
(Write the word.)

6. DATE OF BIRTH

February 14 1911
(Month) (Day) (Year)

7. AGE

2 yrs. 9 mos. 11 ds.IF LESS than 1 day
how many _____ hrs. or
_____ mins.?

8. OCCUPATION

(a) Trade, profession or particular kind of work

That of a child.

(b) General nature of industry business, or establishment in which employed (or employer)

9. BIRTHPLACE

(State or Country)

Idaho.

10. NAME OF FATHER

E. L. Gallacher

11. BIRTHPLACE OF FATHER

(State or Country)

Oregon

12. MAIDEN NAME OF MOTHER

Laura Calvert.

13. BIRTHPLACE OF MOTHER

(State or Country)

Washington

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Myrtle Gallacher(Address) Harrisburg Ida.

15.

Filed Nov 8 1913E. Taylor M.
Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

Oct. 26th 1913
(Month) (Day) (Year)17. I HEREBY CERTIFY, That I attended deceased from Oct. 25th 1913, to Oct. 26th 1913,that I last saw her alive on Oct. 26th 1913, and that death occurred on the date stated above, at 10:10 A.M.

The CAUSE OF DEATH* was as follows:

Acute Intestinal Intoxication(Duration) _____ yrs. _____ mos. 5 ds.Contributory
(Secondary)

(Duration) _____ yrs. _____ mos. _____ ds.

(Signed) W. B. Bryan M. D.Oct. 19 1913 (Address) Kamiah Idaho

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death _____ yrs. _____ mos. _____ days. In the State _____ yrs. _____ mos. _____ days.

Where was disease contracted if not at place of death?

Former or usual residence _____

19. PLACE OF BURIAL OR REMOVAL

Headland

DATE OF BURIAL

Oct 27 1913

20. UNDERTAKER

E. Johnson

ADDRESS

Kamiah

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate. WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

Form V. S. No. 5. 12½ M. 7-24-11

CERTIFICATE OF DEATH

1. PLACE OF DEATH.

Registration District No. 45

County of Idaho

Primary Registration District No. 2125

City of Kamiah

(No. , St.)

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

File No. 5-6220

Registered No. .

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

Harry E. Comer Comer

If death occurred in a hospital, institution or camp give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX

female

4. COLOR OR RACE

Indian

5. SINGLE, MARRIED, WIDOWED OR DIVORCED.

Married
(Write the word.)

6. DATE OF BIRTH

July (Month) 11 (Day) 1913 (Year)

7. AGE

22 yrs. 4 mos. 4 ds.

IF LESS than 1 day
how many . . . hrs. or
min?

8. OCCUPATION

(a) Trade, profession or particular kind of work. housekeeper
(b) General nature of industry business or establishment in which employed (or employer) cooking

9. BIRTHPLACE

(State or Country) Kamiah

10. NAME OF FATHER

Wemoondakin Edwards

11. BIRTHPLACE OF FATHER

(State or Country) Kamiah

12. MAIDEN NAME OF MOTHER

Evelott Samuel

13. BIRTHPLACE OF MOTHER

(State or Country) Absaroka

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Katherine Edwards (Indian)
(Address) Kamiah Idaho

15.

Filed Nov 15 1913

E. Taylor
Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH

11 / 6 1913
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from

Nov 6th 1913, to same 1913

that I last saw her alive on Nov. 6th 1913

and that death occurred on the date stated above, at 12:15 AM.

The CAUSE OF DEATH* was as follows:

Rupture of intestine

(Duration) yrs. mos. 4 ds.

Contributory Pregnancy (negligence)
(Secondary)

(Duration) yrs. mos. ds.

(Signed) W. E. Edwards M. D.

Nov 6th 1913 (Address) Kamiah

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place In the
of death yrs. mos. ds. State yrs. mos. ds.

Where was disease contracted,
If not at place of death?

Former or
usual residence

19. PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

Kamiah

Nov 7 1913

20. UNDERTAKER

ADDRESS

E. Johnson

Kamiah

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Form V. S. No. 5. 12½ M. 7-24-11

CERTIFICATE OF DEATH

1. PLACE OF DEATH.

County of Lewis

City of Kamiah

Registration District No.

Primary Registration District No. 45

(No. 2125 St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Mabel L. Lind

State of Idaho

BOARD OF HEALTH
Bureau of Vital Statistics

File No. 6221

Registered No.

If death occurred in a hospital, institution or camp give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX

4. COLOR OR RACE

5. SINGLE, MARRIED, WIDOWED OR DIVORCED.

Female White

(Write the word.) Single

6. DATE OF BIRTH

April
May
(Month)

31st
(Day)

1913
(Year)

7. AGE

5 yrs. 12 mos. 12 ds.

IF LESS than 1 day
how many hrs. or min?

8. OCCUPATION

(a) Trade, profession or particular kind of work.

(b) General nature of industry business or establishment in which employed (or employer)

that of a child

9. BIRTHPLACE

(State or Country)

Kamiah

10. NAME OF FATHER

Theo. Lind

11. BIRTHPLACE OF FATHER

(State or Country)

Sweden

12. MAIDEN NAME OF MOTHER

Torlen Bergman

13. BIRTHPLACE OF MOTHER

(State or Country)

Minn.

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

Theo. Lind
(Address) Kamiah, Idaho

15.

Filed Nov 8 1913

W. Taylor
Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH

Oct. 13 1913
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from Oct. 13th 3 P.M. 1913, to Oct. 13th 8 P.M. 1913.

that I last saw her alive on Oct. 13th 1913 and that death occurred on the date stated above, at 8:00 P.M.

The CAUSE OF DEATH* was as follows:

Inanition

(Duration) yrs. mos. ds.

Contributory Cholera infantum
(Secondary)

(Duration) yrs. mos. 7 ds.

(Signed) Wilber F. McMahon M. D.
Oct. 14th 1913 (Address) Kamiah, Idaho

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death yrs. mos. ds. State yrs. mos. ds.

Where was disease contracted.

If not at place of death?

Former or usual residence.

19. PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

Kamiah

Oct. 14 1913

20. UNDERTAKER

ADDRESS

C. Johnson

Kamiah

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Form V. S. No. 5. 12½ M. 7-24-11

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics
File No. 6222
Registered No. 2

1. PLACE OF DEATH. Registration District No. 48
County of Lewis Primary Registration District No. 2127
City of Winchester (No. _____, _____ St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Nada Ruth Sock

If death occurred in a hospital, institution or camp give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX 4. COLOR OR RACE 5. SINGLE, MARRIED, WIDOWED OR DIVORCED.

Female White

Single
(Write the word.)

6. DATE OF BIRTH

Nov 4th 1910
(Month) (Day) (Year)

7. AGE

2 yrs. 10 mos. 28 ds.

IF LESS than 1 day
how many hrs. or
..... min?

8. OCCUPATION

(a) Trade, profession or particular kind of work. none

(b) General nature of industry business or establishment in which employed (or employer)

9. BIRTHPLACE

(State or Country)

Winchester, Idaho

10. NAME OF FATHER

Wm M. Sock

11. BIRTHPLACE OF FATHER

(State or Country)

Kabr

12. MAIDEN NAME OF MOTHER

Elaine King

13. BIRTHPLACE OF MOTHER

(State or Country)

Mo.

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

(Address)

Jasper King
Four Falls, Idaho

15.

Filed 10-4- 1917

Elmer B. Rogers
Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH

Oct 2nd 1913
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from Sept 28 1913, to Oct 2nd 1913that I last saw her alive on Oct 1st 1913and that death occurred on the date stated above, at 4 A. M.

The CAUSE OF DEATH* was as follows:

Mucous Colitis(Duration) yrs. mos. 6 ds.

Contributory (Secondary)

(Duration) yrs. mos. ds.

(Signed) Elmer B. Rogers M. D.10-6- 1913 (Address) Winchester

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place In the
of death yrs. mos. ds. State yrs. mos. ds.

Where was disease contracted,

If not at place of death?

Former or

usual residence.....

19. PLACE OF BURIAL OR REMOVAL DATE OF BURIAL

Woodlawn Cemetery Oct 3 1913

20. UNDERTAKER

ADDRESS

none

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Form V. S. No. 5 20M.1-16-12

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics
File No. 6223
Registered No. 36

1. PLACE OF DEATH. Registration District No. 96
County of Kootenai Primary Registration District No. 1009
City of Lewiston (No. , St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Bell H Love

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX ♀ 4. COLOR OR RACE W 5. SINGLE, MARRIED, WID-
OWED OR DIVORCED married
(Write the word.)

6. DATE OF BIRTH January 26 1891
(Month) (Day) (Year)

7. AGE 72 yrs. 9 mos. 3 ds.
IF LESS than 1 day
how many hrs. or mins.?

8. OCCUPATION
(a) Trade, profession or particular kind of work none
(b) General nature of industry business, or establishment in which employed (or employer)

9. BIRTHPLACE New York
(State or Country)

10. NAME OF FATHER Edward Henderson.

11. BIRTHPLACE OF FATHER
(State or Country)

12. MAIDEN NAME OF MOTHER Martha Johnson.

13. BIRTHPLACE OF MOTHER
(State or Country)

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Mrs. Frank Cattermole
(Address) 804 - 154 Ave. Lewiston, Idaho

15. Filed Nov. 10 1913 L. P. Perkins
Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH Oct 29 1913
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from Oct 16 1913 to Oct 21 1913
that I last saw her alive on Oct 21 1913

and that death occurred on the date stated above, at 10:59 AM

The CAUSE OF DEATH* was as follows:

Apoplexy

(Duration) yrs. 7 mos. ds.

Contributory (Secondary)

(Duration) yrs. mos. ds.

(Signed) John M. Church

19. (Address) Bunnell Bldg.

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death yrs. mos. days. In the State yrs. mos. days.

Where was disease contracted if not at place of death?

Former or usual residence.

19. PLACE OF BURIAL OR REMOVAL DATE OF BURIAL

Lewiston Oct 30 1913

20. UNDERTAKER ADDRESS

C. J. Vassar Lewiston

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. REGISTRARS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Form V. S. No. 5 20M.1-16-12

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH.

Registration District No. 96

County of *Bozeman*

Primary Registration District No. 1009

City of *Lewiston*

(No. *St. Joseph Hospital* St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

Nicholas Thoenicker

File No. 622-1

Registered No. 35

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX

M

4. COLOR OR RACE

W

5. SINGLE, MARRIED, WIDOWED OR DIVORCED.

Widow

(Write the word.)

6. DATE OF BIRTH

Unknown

1

(Month)

(Day)

(Year)

7. AGE

45 yrs. mos. ds.

IF LESS than 1 day
how many hrs. or
..... mins.?

8. OCCUPATION

(a) Trade, profession or particular kind of work

Mail contractor

(b) General nature of industry business, or establishment in which employed (or employer)

9. BIRTHPLACE

(State or Country)

Minim

10. NAME OF FATHER

Unknown

11. BIRTHPLACE OF FATHER

(State or Country)

Unknown

12. MAIDEN NAME OF MOTHER

Unknown

13. BIRTHPLACE OF MOTHER

(State or Country)

Unknown

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

(Address)

15.

Filed

Nov. 10

1918

L. J. Perkins

Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH

Oct

22

1913

(Month)

(Day)

(Year)

17. I HEREBY CERTIFY, That I attended deceased from

Oct 1

1913, to

Oct 21

1914

that I last saw him alive on *Oct 21* 191

and that death occurred on the date stated above, at *4* M.

The CAUSE OF DEATH* was as follows:

Pneumonia

(Duration)

yrs. *one*

mos.

ds.

Contributory (Secondary)

and

Pneumonia

(Duration)

yrs.

mos.

ds.

(Signed)

Oct 23 1913

(Address)

Lewiston

Idaho

M. D.

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place

of death yrs. mos. days.

In the

State yrs. mos. days.

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

Lewiston Idaho

Oct 23 1913

20. UNDERTAKER

ADDRESS

@ J. Vassar

Lewiston

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Form V. S. No. 5 20M.1-16-12

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH.

Registration District No. 96

County of *Franklin*

Primary Registration District No. 1009

City of *Franklin*(No. *501, 11/1/1913*)

St.)

File No. *6225*Registered No. *34*

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME *Mary E. Knapp*

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX *F*4. COLOR OR RACE *W*5. SINGLE, MARRIED, WIDOWED OR DIVORCED. *Widowed*
(Write the word.)6. DATE OF BIRTH *July 12 1913*
(Month) (Day) (Year)7. AGE *50* yrs. *3* mos. *3* ds. *12*IF LESS than 1 day
how many hrs. or
..... mins.?

8. OCCUPATION

(a) Trade, profession or particular kind of work *Retired*
(b) General nature of industry, business, or establishment in which employed (or employer)

9. BIRTHPLACE

(State or Country) *Ohio*10. NAME OF FATHER *Knob McLeenith*11. BIRTHPLACE OF FATHER *Ohio*
(State or Country)12. MAIDEN NAME OF MOTHER *Rebecca James*13. BIRTHPLACE OF MOTHER *Ohio*
(State or Country)

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) *E. G. Knapp*(Address) *2111 1/2 N. 1st St. Franklin, Ind.*

15.

Filed *Nov. 10* 191*3**L. J. Perkins*

Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH *October 20* 191*3*
(Month) (Day) (Year)17. I HEREBY CERTIFY, That I attended deceased from *9/22* 191*3*, to *10/19* 191*3*,
that I last saw *her* alive on *10/16* 191*3*,
and that death occurred on the date stated above, at *5 P.* M.The CAUSE OF DEATH* was as follows:
Blood poisoning(Duration) yrs. *5* mos. *12* ds.Contributory *Prophy*
(Secondary)

(Duration) yrs. mos. ds.

(Signed) *E. J. Dorman*19 (Address) *Lewiston, Idaho*

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death. yrs. mos. days. In the State. yrs. mos. days.

Where was disease contracted if not at place of death?

Former or usual residence.

19. PLACE OF BURIAL OR REMOVAL *Lewiston*DATE OF BURIAL *Oct 21* 191*3*20. UNDERTAKER *C. J. Vassar*ADDRESS *Lewiston*

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Form V. S. No. 5 20M.1-16-12

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH.

Registration District No. 96

County of Lewiston

Primary Registration District No. 1009

City of Lewiston

(No. 0206)

St. 2nd

File No. 6226

Registered No. 33

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

Wm D. Wright

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX

M.

4. COLOR OR RACE

W.

5. SINGLE, MARRIED, WIDOWED OR DIVORCED.

Widowed
(Write the word.)

6. DATE OF BIRTH

Jan
(Month)

24
(Day)

1857
(Year)

7. AGE

62 yrs. 9 mos. 24 ds.

IF LESS than 1 day
how many hrs. or
..... mins.?

8. OCCUPATION

(a) Trade, profession or particular kind of work

retired

(b) General nature of industry business, or establishment in which employed (or employer)

9. BIRTHPLACE

(State or Country)

Penn.

10. NAME OF FATHER

not known

11. BIRTHPLACE OF FATHER

(State or Country)

"

12. MAIDEN NAME OF MOTHER

"

13. BIRTHPLACE OF MOTHER

(State or Country)

"

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

J. H. Vassar
Lewiston

(Address)

15.

Filed

Nov. 10

1913

L. J. Perkins

Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH

Oct 18th

(Month)

(Day)

1913
(Year)

17. I HEREBY CERTIFY, That I attended deceased from

Sept 20 1913, to Oct 18th 1913

that I last saw him alive on Oct 17th 1913

and that death occurred on the date stated above, at 10 AM

The CAUSE OF DEATH* was as follows:

Chronic Interstitial Nephritis

(Duration) yrs. mos. ds.

Contributory

(Secondary)

(Duration) yrs. mos. ds.

(Signed)

J. H. Vassar

M. D.

19

(Address)

Lewiston Ida

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place

of death yrs. mos. days.

In the

State yrs. mos. days.

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL

Lewiston

DATE OF BURIAL

Oct-19 1913

20. UNDERTAKER

C. J. Vassar

ADDRESS

Lewiston

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Form V. S. No. 5 20M.1-16-12

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH.

Registration District No. 96

County of Key-Peese

Primary Registration District No. 1009

City of Leicester

(No. 320, New Eleventh St.)

File No. 6228

Registered No. 31

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME F Odell Breier

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX

M

4. COLOR OR RACE

W

5. SINGLE, MARRIED, WIDOWED OR DIVORCED.

Single
(Write the word.)

6. DATE OF BIRTH

Sept
(Month)

13
(Day)

1896
(Year)

7. AGE

18 yrs. 18 mos. - ds.

IF LESS than 1 day
how many hrs. or
..... mins.?

8. OCCUPATION

(a) Trade, profession or particular kind of work

Salesman

(b) General nature of industry business, or establishment in which employed (or employer)

9. BIRTHPLACE

(State or Country)

Mont

10. NAME OF FATHER

Claus J Breier

11. BIRTHPLACE OF FATHER

(State or Country)

Germany

12. MAIDEN NAME OF MOTHER

Elizabeth C Michle

13. BIRTHPLACE OF MOTHER

(State or Country)

Mont

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

C O Goswami

(Address)

La Grande Ave

15.

Filed

Nov 10

1913

L J Parker

Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH

Oct
(Month)

6
(Day)

1913
(Year)

17. I HEREBY CERTIFY, That I attended deceased from

Oct 4 1913, to Oct 6 1913,

that I last saw him alive on Oct 6 1913

and that death occurred on the date stated above, at 9 P. M.

The CAUSE OF DEATH* was as follows:

Interposition of bowell

(Duration) yrs. mos. 3 ds.

Contributory
(Secondary)

(Duration) yrs. mos. ds.

(Signed) L J Parker M. D.

10-7 1913 (Address) L J Parker

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death yrs. mos. days. In the State yrs. mos. days.

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

Leicester Ida

Oct 9 1913

20. UNDERTAKER

ADDRESS

C J Vassar

Leicester

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Form V. S. No. 5 20M.1-16-12

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH

Registration District No. 96

County of Latah

Primary Registration District No. 1009

City of Lewiston

(No. 137 St.)

File No. 6229

Registered No. 30

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

James W. Thomas

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX M

4. COLOR OR RACE W

5. SINGLE, MARRIED, WID-
OWED OR DIVORCED.
Married
(Write the word.)

6. DATE OF BIRTH

May 21 1913
(Month) (Day) (Year)

7. AGE

42 yrs. mos. ds.

IF LESS than 1 day
how many hrs. or
mins.?

8. OCCUPATION

(a) Trade, profession or
particular kind of work

Housewife

(b) General nature of industry
business, or establishment in
which employed (or employer)

9. BIRTHPLACE

(State or Country)

Calif.

10. NAME OF
FATHER

R. B. Hall

11. BIRTHPLACE
OF FATHER

(State or Country)

Kentucky

12. MAIDEN NAME
OF MOTHER

E. D. Hawkins

13. BIRTHPLACE
OF MOTHER

(State or Country)

Ut.

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

W. W. Thomas

(Address)

Lewiston

15.

Filed

Nov. 10

1913

P. J. Perkins

Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

Lewiston Idaho Oct 5 1913
5 (Month) 5 (Day) 1913 (Year)

17. I HEREBY CERTIFY, That I attended deceased from
Oct 4th 1913, to Oct 5th 1913

that I last saw him alive on Oct 5th 1913

and that death occurred on the date stated above, at 9:30 AM

The CAUSE OF DEATH* was as follows:

Compensated

(Duration) yrs. mos. 10 days

Contributory Pericardial constrictions
(Secondary)

(Duration) yrs. mos. 10 days

(Signed) J. P. Hourse M. D.

19 (Address) Lewiston Idaho

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death yrs. mos. days. In the State yrs. mos. days.

Where was disease contracted
if not at place of death?

Former or
usual residence

19. PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

Sacramento

Oct 1913

20. UNDERTAKER

ADDRESS

J. J. Cassor

Lewiston

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Form V. S. No. 5 20M.1-16-12

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics
File No. 6231
Registered No. 28

1. PLACE OF DEATH. Registration District No. 96
County of Nez Perce Primary Registration District No. 1009
City of Lewiston (No. Hospital St.)
If death occurs away from usual residence, give facts called for under special information. 2. FULL NAME J. G. Ball

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX M. 4. COLOR OR RACE W. 5. SINGLE, MARRIED, WIDOWED OR DIVORCED. Widow (Write the word.)

6. DATE OF BIRTH April 25 1913 (Month) (Day) (Year)

7. AGE 57 yrs. 6 mos. 10 ds. IF LESS than 1 day how many hrs. or mins.?

8. OCCUPATION (a) Trade, profession or particular kind of work Labour (b) General nature of industry business, or establishment in which employed (or employer)

9. BIRTHPLACE (State or Country) Wisconsin

10. NAME OF FATHER J. Ball

11. BIRTHPLACE OF FATHER Ohio (State or Country)

12. MAIDEN NAME OF MOTHER Not known

13. BIRTHPLACE OF MOTHER (State or Country)

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Orville Ball (Address) Cayton W. 2

15. Filed Nov. 10 1913 L. J. Perkins Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH Oct 4th 1913 (Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from Oct 3rd 1913, to Oct 4th 1913, that I last saw him alive on Oct 4th 1913, and that death occurred on the date stated above, at 10 A.M.

The CAUSE OF DEATH* was as follows: General infection peritonitis caused by perforation of bowel. (Duration) yrs. mos. 3 ds.

Contributory (Secondary) (Duration) yrs. mos. ds. (Signed) E. P. Boursee M. D. 19 (Address) Lewiston, Ida.

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death yrs. mos. 1 1/2 days. In the State yrs. mos. days. Where was disease contracted if not at place of death? Stein Ranch Former or usual residence Huntville Wash

19. PLACE OF BURIAL OR REMOVAL DATE OF BURIAL Lewiston, Ida. Oct 6 1913

20. UNDERTAKER ADDRESS J. H. Lassar Lewiston

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Form V. S. No. 5 20M.1-16-12		CERTIFICATE OF DEATH		State of Idaho BOARD OF HEALTH Bureau of Vital Statistics	
1. PLACE OF DEATH.		Registration District No. <u>117</u>		File No. <u>6232</u>	
County of <u>Cassia</u>		Primary Registration District No. <u>2196</u>		Registered No. <u>12</u>	
City of <u>Burley</u>		(No. _____, _____ St.)		If death occurred in a hospital, institution or camp, give its NAME instead of street and number.	
If death occurs away from usual residence, give facts called for under special information.					
2. FULL NAME <u>Baby Steigers</u>					
PERSONAL AND STATISTICAL PARTICULARS					
3. SEX		4. COLOR OR RACE		5. SINGLE, MARRIED, WIDOWED OR DIVORCED.	
<u>Male</u>		<u>white</u>		<u>Single</u> (Write the word.)	
6. DATE OF BIRTH					
<u>Sept</u>		<u>5</u>		<u>1910</u>	
(Month)		(Day)		(Year)	
7. AGE					
<u>3</u> yrs. <u>1</u> mos. <u>20</u> ds.		IF LESS than 1 day how many _____ hrs. or _____ mins.?			
8. OCCUPATION					
(a) Trade, profession or particular kind of work		<u>At home</u>			
(b) General nature of industry, business, or establishment in which employed (or employer)					
9. BIRTHPLACE					
(State or Country)		<u>Missouri</u>			
10. NAME OF FATHER					
		<u>Wm. Steigers</u>			
11. BIRTHPLACE OF FATHER					
(State or Country)		<u>Missouri</u>			
12. MAIDEN NAME OF MOTHER					
		<u>Elisebeth Schneider</u>			
13. BIRTHPLACE OF MOTHER					
(State or Country)		<u>Missouri</u>			
14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE					
(Informant)		<u>Wm. Steigers</u>			
(Address)		<u>Burley Ida</u>			
15.					
Filed <u>Oct 27</u> <u>1913</u>		<u>Wm. C. Patterson</u>			
		Local Registrar			
MEDICAL CERTIFICATE OF DEATH					
16. DATE OF DEATH					
<u>Oct</u>		<u>25</u>		<u>1913</u>	
(Month)		(Day)		(Year)	
17. I HEREBY CERTIFY, That I attended deceased from <u>Oct 25</u> 191 <u>3</u> to <u>Oct 25</u> 191 <u>3</u> , that I last saw him alive on <u>Oct</u> 191 <u>3</u> , and that death occurred on the date stated above, at <u>1 P.</u> M. The CAUSE OF DEATH* was as follows: <u>Enteritis</u>					
(Duration) _____ yrs. _____ mos. <u>7</u> ds.					
Contributory (Secondary)					
(Duration) _____ yrs. _____ mos. _____ ds.					
(Signed) <u>John M. Winter</u> M. D. <u>Oct 27 1913</u> (Address) <u>Burley Ida</u>					
*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.					
18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)					
At place of death _____ yrs. _____ mos. _____ days.		In the State _____ yrs. _____ mos. _____ days.			
Where was disease contracted if not at place of death?					
Former or usual residence _____					
19. PLACE OF BURIAL OR REMOVAL				DATE OF BURIAL	
<u>Burley Ida</u>				<u>Oct 27 1913</u>	
20. UNDERTAKER				ADDRESS	
<u>L. B. Gallagher</u>				<u>Burley Ida</u>	

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Form V. S. No. 5 20M.1-16-12

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH.

Registration District No. 117

County of Cassia

Primary Registration District No. 2196

City of Burley

(No. , St.)

File No. 6233

Registered No. 9

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Joseph W. Thompson

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX

4. COLOR OR RACE

5. SINGLE, MARRIED, WIDOWED OR DIVORCED.

Male

White

Single (Write the word.)

6. DATE OF BIRTH

March 31 1879

(Month)

(Day)

(Year)

7. AGE

34 yrs. 6 mos. 11 ds.

IF LESS than 1 day
how many hrs. or mins.

8. OCCUPATION

(a) Trade, profession or particular kind of work

Farmer

(b) General nature of industry business, or establishment in which employed (or employer)

9. BIRTHPLACE

(State or Country)

Utah

10. NAME OF FATHER

Joseph W. Thompson

11. BIRTHPLACE OF FATHER

(State or Country)

England

12. MAIDEN NAME OF MOTHER

Emma Yerbury

13. BIRTHPLACE OF MOTHER

(State or Country)

England

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

J. W. Thompson

(Address)

Burley Ida.

15.

Filed

Oct. 11 1913

1913

Dr. J. C. Patterson
Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH

Oct. 11 1913

(Month)

(Day)

(Year)

17. I HEREBY CERTIFY, That I attended deceased from June 1 1913, to Oct. 11 1913, that I last saw him alive on Oct. 11 1913, and that death occurred on the date stated above, at 11 A.M.

The CAUSE OF DEATH* was as follows:

Gastric Ulcer.

(Duration) 5 yrs. mos. ds.

Contributory (Secondary)

(Duration) yrs. mos. ds.

(Signed) J. C. Patterson M. D.

Oct. 11/1913 (Address) Burley, Ida.

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death yrs. mos. days. In the State yrs. mos. days.

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

Burley Ida

Oct. 12 1913

20. UNDERTAKER

ADDRESS

L. B. Gallagher

Burley Ida

Form V. S. No. 5 · 20M.1-16-12

CERTIFICATE OF DEATH

 State of Idaho
 BOARD OF HEALTH
 Bureau of Vital Statistics

1. PLACE OF DEATH.

Registration District No. 117County of CassiaPrimary Registration District No. 2196City of Burley

(No. _____ St.)

File No. 6234Registered No. 8

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Frank William Schneider

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX

4. COLOR OR RACE

5. SINGLE, MARRIED, WIDOWED OR DIVORCED.

Male white Married

6. DATE OF BIRTH

July 21 1926
 (Month) (Day) (Year)

7. AGE

37 yrs. 2 mos. 21 ds.

 IF LESS than 1 day
 how many _____ hrs. or
 _____ mins.?

8. OCCUPATION

(a) Trade, profession or particular kind of work

(b) General nature of industry business, or establishment in which employed (or employer)

Farmer

9. BIRTHPLACE

(State or Country)

Kennett Co., Missouri

10. NAME OF FATHER

Frank V. Schneider

11. BIRTHPLACE OF FATHER

(State or Country)

Germany

12. MAIDEN NAME OF MOTHER

Anna Nortman

13. BIRTHPLACE OF MOTHER

(State or Country)

Germany

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Hattie Schneider(Address) Burley Ida.

15.

Filed Oct 16 1913
H. J. C. Patterson
 Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH

Oct 5 1913
 (Month) (Day) (Year)

 17. I HEREBY CERTIFY, That I attended deceased from Oct 1 1913, to Oct 5 1913

 that I last saw him alive on Oct 5 1913

 and that death occurred on the date stated above, at 9 A.M.

The CAUSE OF DEATH* was as follows:

Capillary Bronchitis(Duration) _____ yrs. _____ mos. 10 ds.

Contributory (Secondary)

Tuberculosis

(Duration) _____ yrs. _____ mos. _____ ds.

(Signed)

Oct 5 1913 J. M. Winter M. D.
 (Address) Burley Ida.

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death _____ yrs. _____ mos. _____ days. In the State _____ yrs. _____ mos. _____ days.

Where was disease contracted if not at place of death? _____

Former or usual residence _____

19. PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

Burley Ida Oct 15 1913

20. UNDERTAKER

ADDRESS

L. B. Gallogly Burley Ida.

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Form V. S. No. 5 20M.1-16-12

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics
File No. 6235
Registered No. 8296

1. PLACE OF DEATH
County of Canyon
City of Poor Farm
Registration District No. 3
Primary Registration District No. 2005
(No. St.)
2. FULL NAME Thedor McGrew

If death occurs away from usual residence, give facts called for under special information.

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX M. 4. COLOR OR RACE W. 5. SINGLE, MARRIED, WIDOWED OR DIVORCED. Widower
(Write the word.)
6. DATE OF BIRTH
(Month) (Day) (Year)
7. AGE 73 yrs. - mos. - ds. IF LESS than 1 day how many hrs. or mins.

8. OCCUPATION
(a) Trade, profession or particular kind of work Labor
(b) General nature of industry business, or establishment in which employed (or employer)

9. BIRTHPLACE
(State or Country) Unknown

10. NAME OF FATHER

11. BIRTHPLACE OF FATHER
(State or Country)

12. MAIDEN NAME OF MOTHER

13. BIRTHPLACE OF MOTHER
(State or Country)

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) T. C. Pearson
(Address) Caldwell Idaho

15. Filed OCT. 14 - 1913 John J. Meyer Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH Oct. 7 1913
(Month) (Day) (Year)
17. I HEREBY CERTIFY, That I attended deceased from Sept 30 1913, to Oct 7 1913 that I last saw him alive on Oct 7 1913 and that death occurred on the date stated above, at 9 P.M.
The CAUSE OF DEATH* was as follows:

Cystitis
(Duration) yrs. mos. 10 ds.
Contributory Cause of Death
(Secondary)
(Duration) yrs. mos. ds.
(Signed) J. M. Caldwell M. D.
19 (Address) Caldwell Idaho

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death yrs. mos. days. In the State yrs. mos. days.
Where was disease contracted if not at place of death?
Former or usual residence.

19. PLACE OF BURIAL OR REMOVAL DATE OF BURIAL
Canyon Hill Oct 14 1913

20. UNDERTAKER ADDRESS
W. E. Dyer Caldwell

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Form V. S. No. 5 20M.1-16-12

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH

Registration District No. 3County of CanyonPrimary Registration District No. 2005File No. 623City of Caldwell

(No. _____ St.)

Registered No. 98

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME O. M. Shaffer

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX M4. COLOR OR RACE W.5. SINGLE, MARRIED, WID-
OWED OR DIVORCED.Married
(Write the word.)

6. DATE OF BIRTH

April
(Month)2
(Day)1861
(Year)

7. AGE

52 yrs. 6 mos. 7 ds.

IF LESS than 1 day
how many hrs. or
..... mins.?

8. OCCUPATION

(a) Trade, profession or
particular kind of workFarmer(b) General nature of industry
business, or establishment in
which employed (or employer)

9. BIRTHPLACE

(State or Country)

Mo.10. NAME OF
FATHERW. N. A. Shaffer11. BIRTHPLACE
OF FATHER

(State or Country)

Virginia12. MAIDEN NAME
OF MOTHERHarriett Stoffel13. BIRTHPLACE
OF MOTHER

(State or Country)

Mo.

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

Mrs. O. M. Shaffer

(Address)

Midleton, Mo.

15.

Filed Oct 10 19131913John L. Meyer
Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH

Oct
(Month)9
(Day)1913
(Year)

17. I HEREBY CERTIFY, That I attended deceased from

Oct 2 1913, to Oct 9 1913,that I last saw him alive on Oct 9 1913,and that death occurred on the date stated above, at 9 P. M.

The CAUSE OF DEATH* was as follows:

Peritonitis
Perforation of Intestine(Duration) yrs. mos. 8 ds.Contributory
(Secondary)

(Duration) yrs. mos. ds.

(Signed) J. L. Miller M. D.Oct 10 1913 (Address) Caldwell Idaho

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death yrs. mos. days. In the State yrs. mos. days.

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL

Star Cemetery

DATE OF BURIAL

Oct 11 1913

20. UNDERTAKER

W. E. Dye

ADDRESS

Caldwell

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Form V. S. No. 5 20M.1-16-12

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH.

Registration District No. 3County of CanyonPrimary Registration District No. 2005City of Caldwell

(No. _____, St.)

File No. 623Registered No. 100

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Infant Kumbrough

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX

F.

4. COLOR OR RACE

W.

5. SINGLE, MARRIED, WIDOWED OR DIVORCED.

Infant
(Write the word.)

6. DATE OF BIRTH

Oct151913

(Month)

(Day)

(Year)

7. AGE

1/2 yrs. 1/2 mos. 1/2 ds.IF LESS than 1 day
how many hrs. or
..... mins.?

8. OCCUPATION

(a) Trade, profession or particular kind of work

(b) General nature of industry business, or establishment in which employed (or employer) *

9. BIRTHPLACE

(State or Country)

Canyon HospitalCaldwell, Canyon Co, Idaho

10. NAME OF FATHER

E. L. Kumbrough

11. BIRTHPLACE OF FATHER

(State or Country)

Bells Texas

12. MAIDEN NAME OF MOTHER

Lewis Swafford

13. BIRTHPLACE OF MOTHER

(State or Country)

Bells Texas

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

W. R. Wickerson

(Address)

Caldwell Idaho

15.

Filed

Oct. 16 - 1913John H. Meyer
Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH

Oct161913

(Month)

(Day)

(Year)

17. I HEREBY CERTIFY, That I attended deceased from

Oct 151913to Oct 161913that I last saw her alive on Oct 16 1913and that death occurred on the date stated above, at 2:30 M.

The CAUSE OF DEATH* was as follows:

Premature birth

(Duration) yrs. mos. ds.

Contributory
(Secondary)

(Duration) yrs. mos. ds.

(Signed)

S. J. Miller M. D.Oct 16, 1913(Address) Caldwell Idaho

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death yrs. mos. days. In the State yrs. mos. days.

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

Canyon HillsOct 16, 1913

20. UNDERTAKER

ADDRESS

W. E. DyerCaldwell

CERTIFICATE OF DEATH.

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH.

Registration District No.

County of Adams

Primary Registration District No.

City of New Meadows

(No. St.)

File No. 6241

Registered No.

If death occurs away from
usual residence, give facts
called for under special
information.

2. FULL NAME

Hermie Elizabeth YakumIf death occurred in a hos-
pital, institution or camp,
give its NAME instead of
street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX

Female

4. COLOR OR RACE

White5. SINGLE, MARRIED, WID-
OWED OR DIVORCED.Infant

(Write the word.)

6. DATE OF BIRTH.

August 21 1913
(Month) (Day) (Year)

7. AGE

1 Yrs. 14 Mos. ds.IF LESS than 1 day
how many hrs. or
..... min.

8. OCCUPATION

(a) Trade, profession or
particular kind of work...
(b) General nature of in-
dustry, business, or estab-
lishment in which employ-
ed (or employer).....

9. BIRTHPLACE

(State or Country)

Adams Co. - New Meadows10. NAME OF
FATHERMarvin Yakum11. BIRTHPLACE
OF FATHER

(State or Country)

N. Meadows, Ida.12. MAIDEN NAME
OF MOTHERElva Jones13. BIRTHPLACE
OF MOTHER

(State or Country)

Billings - Missouri

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant)

Mrs. Marvin Yakum

(Address)

New Meadows

15.

Filed

Oct-101913R. Whitman

Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

Oct. 5 1913
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from

Oct. 3 1913 to Oct 5 1913that I last saw h. alive on Oct. 3 1913and that death occurred on the date stated above, at 12:20 P. M.

The CAUSE OF DEATH* was as follows:

Congenital Malformation of
Birth - "Pectus Mon-
strosus"(Duration) 1 Yrs. 14 Mos. ds.Contributory
(Secondary)Malnutrition(Duration) 1 Yrs. 14 Mos. ds.

(Signed)

R. Whitman M. D.

19 (Address)

New Meadows, Ida.*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1)
MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.18. LENGTH OF RESIDENCE (For Hospitals, Institutions,
Transients or Recent Residents.)At place of death.... yrs. 1 mos. 14 days. In the State.... yrs. 1 mos. 14 daysWhere was disease contracted Congenital
if not at place of death?.....Former or
usual residenceNew Meadows, Ida.

19. PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

New Meadows, Ida. 10/6 1913

20. UNDERTAKER

ADDRESS

W. E. WebbN. Meadows

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Form V. S. No. 5. 10M. 6-20-11.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics
File No. 6242
Registered No. 74177

1. PLACE OF DEATH. Registration District No. 2101 10
County of Idaho Primary Registration District No. 2101
City of Kootenai (No. _____, _____ St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Opal May Robinett

If death occurred in a hospital, institution or camp give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX Female 4. COLOR OR RACE White 5. SINGLE, MARRIED, WIDOWED OR DIVORCED. Single
(Write the word.)

6. DATE OF BIRTH Nov 1 1911
(Month) (Day) (Year)

7. AGE 1 yrs. 10 mos. 21 ds. IF LESS than 1 day how many _____ hrs. or _____ min.)

8. OCCUPATION

- (a) Trade, profession or particular kind of work _____
(b) General nature of industry business or establishment in which employed (or employer) _____

9. BIRTHPLACE Idaho
(State or Country)

10. NAME OF FATHER Oliver Robinett

11. BIRTHPLACE OF FATHER Oregon
(State or Country)

12. MAIDEN NAME OF MOTHER Annie Shaw

13. BIRTHPLACE OF MOTHER Idaho
(State or Country)

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Oliver Robinett
(Address) Kootenai Idaho

15. Filed Sept 30 1913 J. M. Verberkmoes
Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH Sept 22 1913
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from Sept 18 1913, to Sept 22 1913, that I last saw him alive on Sept 20 1913, and that death occurred on the date stated above, at 1:30 PM.

The CAUSE OF DEATH* was as follows:

acute ill Colitis

(Duration) _____ yrs. _____ mos. 5 ds.
Contributory (Secondary) _____

(Duration) _____ yrs. _____ mos. _____ ds.
(Signed) J. M. Verberkmoes M. D.
Sept 22 1913 (Address) Kootenai Idaho

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death _____ yrs. _____ mos. _____ ds. State _____ yrs. _____ mos. _____ ds.
Where was disease contracted, _____
If not at place of death? _____
Former or usual residence _____

19. PLACE OF BURIAL OR REMOVAL Kootenai Cemetery DATE OF BURIAL Sept 23 1913

20. UNDERTAKER J. B. York Pastor ADDRESS Kootenai Idaho

Form V. S. No. 5. 10M. 6-20-11.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics
File No. 6243

1. PLACE OF DEATH.

Registration District No. 2101County of IdahoPrimary Registration District No. 2101City of Kootenai

(No. _____, _____ St.)

Registered No. 176

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

Ellen Savannah Bowles

If death occurred in a hospital, institution or camp give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX

Female

4. COLOR OR RACE

White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED.

Single
(Write the word.)

6. DATE OF BIRTH

April
(Month)5
(Day)1912
(Year)

7. AGE

1 yrs. 5 mos. 5 ds.IF LESS than 1 day
how many _____ hrs. or
_____ min.?

8. OCCUPATION

- (a) Trade, profession or particular kind of work _____
-
- (b) General nature of industry business or establishment in which employed (or employer) _____

9. BIRTHPLACE

(State or Country)

Idaho

10. NAME OF FATHER

Jackson Bowles

11. BIRTHPLACE OF FATHER

(State or Country)

Marshalltown Iowa

12. MAIDEN NAME OF MOTHER

Maudie Tweedy

13. BIRTHPLACE OF MOTHER

(State or Country)

Kansas

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Jackson Bowles(Address) Kootenai Idaho

15.

Filed Sept. 30 1913 J. M. Verbeek

Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

Sept.
(Month)10
(Day)1913
(Year)

17. I HEREBY CERTIFY, That I attended deceased from

191____, to 191____

that I last saw h_____ alive on 191____

and that death occurred on the date stated above, at 8 a.m.

The CAUSE OF DEATH* was as follows:

Cholera Infantum

(Duration) _____ yrs. _____ mos. _____ ds.

Contributory
(Secondary)

(Duration) _____ yrs. _____ mos. _____ ds.

(Signed) J. M. Verbeek M. D.Sept. 10, 1913 (Address) Kootenai Idaho

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death _____ yrs. _____ mos. _____ ds. State _____ yrs. _____ mos. _____ ds.

Where was disease contracted,

If not at place of death? _____

Former or usual residence _____

19. PLACE OF BURIAL OR REMOVAL

Tahoe Cemetery

DATE OF BURIAL

Sept. 11 1913

20. UNDERTAKER

Emma Batheman

ADDRESS

Tahoe

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Form V. S. No. 5 20M.1-16-12

CERTIFICATE OF DEATH

1. PLACE OF DEATH.

County of IdahoCity of Cottawood

If death occurs away from usual residence, give facts called for under special information.

Registration District No. 10Primary Registration District No. to 7042

(No. _____, _____ St.)

2. FULL NAME Leonard E BowlesState of Idaho
BOARD OF HEALTH
Bureau of Vital StatisticsFile No. 0244Registered No. 175

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX

Male

4. COLOR OR RACE

White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED.

Single
(Write the word.)

6. DATE OF BIRTH

Not Known
(Month) (Day) (Year)

7. AGE

28 yrs.Not Known mos. ds.IF LESS than 1 day
how many _____ hrs. or
_____ mins.?

8. OCCUPATION

(a) Trade, profession or particular kind of work

Bookkeeper

(b) General nature of industry business, or establishment in which employed (or employer)

9. BIRTHPLACE

(State or Country)

Not Known

10. NAME OF FATHER

Not Known

11. BIRTHPLACE OF FATHER

(State or Country)

Not Known

12. MAIDEN NAME OF MOTHER

Not Known

13. BIRTHPLACE OF MOTHER

(State or Country)

Not Known

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

Charles L. Lawrence

(Address)

Cottawood Idaho

15.

Filed

Oct 231913James E. Rains
Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH

October231913

(Month)

(Day)

(Year)

17. I HEREBY CERTIFY, That I attended deceased from investigation the death of deceased 1913, to 1913, that I last saw him alive on the 23rd Oct 1913, and that death occurred on the date stated above, at 8:55 A.M.

The CAUSE OF DEATH* was as follows:

Suicide by fire arms

(Duration)

yrs.

mos.

ds.

Contributory
(Secondary)

(Duration)

yrs.

mos.

ds.

(Signed)

Henry B. Blake

M. D.

Oct 23 1913

(Address)

Cottawood Idaho County

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place

of death

yrs.

mos.

days.

In the

State

yrs.

mos.

days.

Where was disease contracted if not at place of death?

Former or

usual residence.

19. PLACE OF BURIAL OR REMOVAL

Merced Cemetery, Merced, Calif.

DATE OF BURIAL

Oct 26 1913

20. UNDERTAKER

ADDRESS

Cottawood Idaho

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Form V. S. No. 5 20M.1-16-12

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics
File No. 6245

1. PLACE OF DEATH.

Registration District No. 2042

County of Idaho

Primary Registration District No. 2042

City of Green Creek Precinct (No. _____ St.)

Registered No. 174

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

George Francis Ruiner

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX

Male

4. COLOR OR RACE

White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED.

Single
(Write the word.)

6. DATE OF BIRTH

Oct

3

1913

(Month)

(Day)

(Year)

7. AGE

_____ yrs. _____ mos. 18 ds. 19

IF LESS than 1 day
how many _____ hrs. or
_____ mins.?

8. OCCUPATION

(a) Trade, profession or particular kind of work

none

(b) General nature of industry business, or establishment in which employed (or employer)

9. BIRTHPLACE

(State or Country)

Idaho

10. NAME OF FATHER

Joseph Ruiner

11. BIRTHPLACE OF FATHER

(State or Country)

Hungary

12. MAIDEN NAME OF MOTHER

Mary Tefless

13. BIRTHPLACE OF MOTHER

(State or Country)

Hungary

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

(Address)

Arthur Ruiner
Cottonwood RFD 403

15.

Filed Oct 23 1913

Jose E Ruiner
Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH

October

22nd

1913

(Month)

(Day)

(Year)

17. I HEREBY CERTIFY, That I attended deceased from

Oct 3

1913

to Oct 20

1913

that I last saw him alive on Oct 20 1913

and that death occurred on the date stated above, at 9 A.M.

The CAUSE OF DEATH* was as follows:

Deficient Assimilation
due to low vitality and
underdevelopment

(Duration)

yrs.

mos.

ds. 18

Contributory

(Secondary)

Fetal inanition in utero

(Duration)

yrs.

mos.

ds. 9

(Signed)

Wesley F. Orr M. D.

Oct 23 1913 (Address) Cottonwood Ida.

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place

of death

_____ yrs. _____ mos. _____ days.

In the

State

_____ yrs. _____ mos. _____ days.

Where was disease contracted if not at place of death?

Former or

usual residence

19. PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

Green Creek

Oct 24 1913

20. UNDERTAKER

ADDRESS

W. H. Ruiner

Cottonwood

Idaho

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Form V. S. No. 5 20M.1-16-12

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH.

Registration District No. 2045 10County of IdahoPrimary Registration District No. 2042City of Green Creek, Pocatello

(No. _____) St. _____

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Lena Reid HaarFile No. 6245Registered No. 173

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX

4. COLOR OR RACE

5. SINGLE, MARRIED, WIDOWED OR DIVORCED.

Female WhiteSingle
(Write the word.)

6. DATE OF BIRTH

March 10 1895
(Month) (Day) (Year)

7. AGE

18 yrs. 6 mos. 8 ds.

IF LESS than 1 day
how many hrs. or
..... mins.?

8. OCCUPATION

(a) Trade, profession or particular kind of work

None

(b) General nature of industry business, or establishment in which employed (or employer)

9. BIRTHPLACE

(State or Country)

Wis.

10. NAME OF FATHER

Jacob Reid Haar

11. BIRTHPLACE OF FATHER

(State or Country)

Switzerland

12. MAIDEN NAME OF MOTHER

Anna Young

13. BIRTHPLACE OF MOTHER

(State or Country)

Wis.

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

Theo. F. Schaeffer

(Address)

Cottonwood, Ida

15.

Filed Sept 17 1913Jesse L. Rains
Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH

Sept 18 1913
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from Sept 15 A.M. 1913, to Sept 18 P.M. 1913, that I last saw him alive on Sept 18 1913, and that death occurred on the date stated above, at 2:30 P.M.

The CAUSE OF DEATH* was as follows:

Malignant neoplasm
of spine, the duration of
which is unknown to me

(Duration) yrs. mos. ds.

Contributory
(Secondary)None

(Duration) yrs. mos. ds.

(Signed)

Malvin F. Orr M. D.Oct 2 1913 (Address) Cottonwood

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death yrs. mos. days. In the State yrs. mos. days.

Where was disease contracted if not at place of death?

Former or usual residence.

19. PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

Green Creek CemeterySept 21 1913

20. UNDERTAKER

ADDRESS

A. H. HaarCottonwood, Ida

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Form V. S. No. 5 20M.1-16-12

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics
File No. 624
Registered No. 172
If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

1. PLACE OF DEATH.

Registration District No. 2042 10

County of Idaho

Primary Registration District No. 2042

City of Cottonwood

(No. _____ St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Edward Frank Marlrich

PERSONAL AND STATISTICAL PARTICULARS

3. SEX

Male

4. COLOR OR RACE

White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED

Single

6. DATE OF BIRTH

Feb 21 1910
(Month) (Day) (Year)

7. AGE

3 yrs. 7 mos. 7 ds.

IF LESS than 1 day
how many hrs. or
..... mins.?

8. OCCUPATION

(a) Trade, profession or particular kind of work

(b) General nature of industry business, or establishment in which employed (or employer)

none

9. BIRTHPLACE

(State or Country)

Cottonwood

10. NAME OF FATHER

Edward Marlrich

11. BIRTHPLACE OF FATHER

(State or Country)

Ill.

12. MAIDEN NAME OF MOTHER

Magdalena Jorman

13. BIRTHPLACE OF MOTHER

(State or Country)

Ill.

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

Edward Marlrich

(Address)

Cottonwood Idaho

15.

Filed

Sept 29 1913

John E. Rains

Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH

Sept. 28 1913
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from

9-22-1913 to 9-27-1913

that I last saw him live on Sept 27th 1913

and that death occurred on the date stated above, at 12 M.

The CAUSE OF DEATH* was as follows:

Iles colitis

(Duration) yrs. mos. 6 ds.

Contributory
(Secondary)

(Duration) yrs. mos. ds.

(Signed)

9-29-1913 (Address) Cottonwood Idaho

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death yrs. mos. days. In the State yrs. mos. days.

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

Call Cem at Cottonwood Sept 30 1913

20. UNDERTAKER

ADDRESS

Cottonwood Idaho

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Form V. S. No. 5. 12½M. 7-24-11

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics
File No. 6245
Registered No. 32

1. PLACE OF DEATH. Registration District No. 24
County of Bear Lake Primary Registration District No. 2091
City of Bloomington, (No. , St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

Hina Ann Clayton Broomhead
If death occurred in a hospital, institution or camp give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX female 4. COLOR OR RACE white 5. SINGLE, MARRIED, WIDOWED OR DIVORCED. widowed
(Write the word.)

6. DATE OF BIRTH Jan 21 1835
(Month) (Day) (Year)

7. AGE 78 yrs. 5 mos. 14 ds. IF LESS than 1 day how many... hrs. or min?

8. OCCUPATION

(a) Trade, profession or particular kind of work
(b) General nature of industry business or establishment in which employed (or employer)

housewife

9. BIRTHPLACE

(State or Country)

England

10. NAME OF FATHER

Thomas Clayton

11. BIRTHPLACE OF FATHER

(State or Country)

England

12. MAIDEN NAME OF MOTHER

Ann Critchlow

13. BIRTHPLACE OF MOTHER

(State or Country)

England

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

Mar Broomhead

(Address)

Bloomington Idaho

15.

Filed June 6 1913

L. P. Cooley
Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH

June 4 1913
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from Mar 31 1913, to June 4 1913

that I last saw her alive on June 4 1913 and that death occurred on the date stated above, at 8:50 P. M.

The CAUSE OF DEATH* was as follows:

Apoplexy cerebral

(Duration) — yrs. — mos. 14 ds.
Contributory Arterio Sclerosis
(Secondary)

(Duration) 4 yrs. — mos. — ds.
(Signed) L. P. Cooley M. D.
June 5 1913 (Address) Bloomington, Idaho

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place In the
of death... yrs. ... mos. ... ds. State... yrs. ... mos. ... ds.
Where was disease contracted,
If not at place of death?
Former or
usual residence.

19. PLACE OF BURIAL OR REMOVAL DATE OF BURIAL

Panama Idaho June 7 1913
20. UNDERTAKER ADDRESS

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Form V. S. No. 5. 12½M.7-24-11

CERTIFICATE OF DEATH

1. PLACE OF DEATH.

County of Bear LakeCity of BloomingtonRegistration District No. 24Primary Registration District No. 2097

(No. _____, _____ St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

Margarette Peterson

State of Idaho

BOARD OF HEALTH
Bureau of Vital StatisticsFile No. 621Registered No. 30

If death occurred in a hospital, institution or camp give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX

female

4. COLOR OR RACE

white

5. SINGLE, MARRIED, WIDOWED OR DIVORCED.

married
(Write the word.)

6. DATE OF BIRTH

March 17
(Month) (Day)1848
(Year)

7. AGE

65 yrs. 3 mos. 4 ds.IF LESS than 1 day
how many hrs. or
..... min?

8. OCCUPATION

- (a) Trade, profession or particular kind of work.....
(b) General nature of industry business or establishment in which employed (or employer)

housewife

9. BIRTHPLACE

(State or Country)

Denmark

10. NAME OF FATHER

Christian Sorensen

11. BIRTHPLACE OF FATHER

(State or Country)

Denmark

12. MAIDEN NAME OF MOTHER

13. BIRTHPLACE OF MOTHER

(State or Country)

Denmark

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

Earl Peterson

(Address)

Montpelier

15.

Filed June 24 1913A. C. Cooley

Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH

June 21 1913
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from

March 1 1913, to June 20 1913that I last saw her alive on June 20 1913and that death occurred on the date stated above, at 3:45 A. M.

The CAUSE OF DEATH* was as follows:

Cancer of uterus and adnexia(Duration) 4 yrs. _____ mos. _____ ds.

Contributory

(Secondary)

septicaemia(Duration) _____ yrs. 4 mos. _____ ds.

(Signed)

L. A. Hottendorf M. D.June 21 1913 (Address) Bloomington, Idaho

State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place

In the

of death yrs. mos. ds. State yrs. mos. ds.

Where was disease contracted,

If not at place of death?

Former or

usual residence

19. PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

Bloomington June 22 1913

20. UNDERTAKER

ADDRESS

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Form V. S. No. 5. 10M. 6-20-11.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH.

Registration District No. 81County of BonnerPrimary Registration District No. 2158City of Prest River

(No. _____, St.)

File No. 6250

Registered No. _____

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

Raymond Preston Beardmore

If death occurred in a hospital, institution or camp give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX

Male

4. COLOR OR RACE

white

5. SINGLE, MARRIED, WIDOWED OR DIVORCED.

Single
(Write the word.)

6. DATE OF BIRTH

Jan
(Month)20
(Day)1913
(Year)

7. AGE

9 yrs. — mos. — ds.IF LESS than 1 day
how many... hrs. or
min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work

None

(b) General nature of industry business or establishment in which employed (or employer)

9. BIRTHPLACE

(State or Country)

Prest River Ida

10. NAME OF FATHER

Chas W. Beardmore

11. BIRTHPLACE OF FATHER

(State or Country)

Wis.

12. MAIDEN NAME OF MOTHER

Lucy E. Curmaer

13. BIRTHPLACE OF MOTHER

(State or Country)

Wis.

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

Chas W. Beardmore

(Address)

Prest River

15.

Filed

Oct. 21 1913E. Deaton McCarty
Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

Oct
(Month)20
(Day)1913
(Year)

17. I HEREBY CERTIFY, That I attended deceased from

Oct. 19 1913, to Oct. 20 1913that I last saw him alive on Oct. 20 1913and that death occurred on the date stated above, at 9 P M.

The CAUSE OF DEATH* was as follows:

Eastern Enter. Tis(Duration) — yrs. — mos. 4 ds.Contributory
(Secondary)(Duration) — yrs. — mos. — ds.(Signed) E. Deaton McCarty M. D.Oct. 21 1913 (Address) Prest River

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death... yrs... mos... ds. State... yrs... mos... ds.

Where was disease contracted.

If not at place of death?

Former or

usual residence

19. PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

Prest RiverOct 22 1913

20. UNDERTAKER

ADDRESS

Harold W. Harding
Harold W. Harding

STATE OF IDAHO,)
 : ss
County of Bonner.)

Lucy E. Beardmore being first duly sworn on oath deposes and says: That she is the mother of Raymond Preston Beardmore who died on October 21, 1913. That said Raymond Preston Beardmore's death certificate shows his name to be Raymond Preston Beardmore and his father's name is given as Charles W. Beardmore. That the correct spelling of the last name of said Raymond Preston and Charles W. is Beardmore and that said Raymond Preston and Charles W. Beardmore as recorded in said death certificate is an error in spelling.

Subscribed and sworn to be for me this 1st day of May, 1935

Lucy E. Beardmore
~~Notary Public for Idaho,~~
Residing at: Priest River, Idaho

Subscribed and Sworn to before me this 1st Day of May 1935.

Richa M. Lean
Notary public in and for Idaho,
Residing at Priest River,
My Comm. Expire May 15th. -39.

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Form V. S. No. 5 20M.1-16-12		CERTIFICATE OF DEATH		State of Idaho BOARD OF HEALTH Bureau of Vital Statistics	
1. PLACE OF DEATH.		Registration District No. <u>100</u>		File No. <u>6251</u>	
County of <u>Fremont</u>		Primary Registration District No. <u>2178</u>		Registered No. <u>31</u>	
City of <u>Replurg</u> (No. _____ St.)		2. FULL NAME <u>Anna Christy</u>		If death occurred in a hospital, institution or camp, give its NAME instead of street and number.	
If death occurs away from usual residence, give facts called for under special information.					
PERSONAL AND STATISTICAL PARTICULARS					
3. SEX <u>Female</u>		4. COLOR OR RACE <u>White</u>		5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.)	
6. DATE OF BIRTH <u>Nov. 30 1889</u> (Month) (Day) (Year)					
7. AGE <u>23 yrs. 10 mos. 9 ds.</u>				IF LESS than 1 day how many _____ hrs. or _____ mins.?	
8. OCCUPATION (a) Trade, profession or particular kind of work <u>Housewife</u> (b) General nature of industry, business, or establishment in which employed (or employer)					
9. BIRTHPLACE <u>Utah.</u> (State or Country)					
10. NAME OF FATHER <u>George Welsh</u>					
11. BIRTHPLACE OF FATHER <u>England</u> (State or Country)					
12. MAIDEN NAME OF MOTHER <u>Mary Gurbelson</u>					
13. BIRTHPLACE OF MOTHER <u>Denmark</u> (State or Country)					
14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE (Informant) <u>Charles E. Christy</u> (Address) <u>Ogden</u>					
15. <u>10-10</u> 191 <u>3</u> <u>L. G. Espe</u> Filed _____ Local Registrar					
MEDICAL CERTIFICATE OF DEATH					
16. DATE OF DEATH <u>10 8 1913</u> (Month) (Day) (Year)					
17. I HEREBY CERTIFY, That I attended deceased from <u>3 Pm. Oct 8 1913</u> , to <u>— 1913</u> , that I last saw him alive on <u>at 3 Pm. 1913</u> , and that death occurred on the date stated above, at <u>about 8 P.M.</u>					
The CAUSE OF DEATH* was as follows: <u>Unknown</u> <u>He was found dead at about 9 P.M.</u> <u>was suffering from Tonsillitis, a severe</u> <u>autopsy showed advanced stage of</u> <u>inflammation of heart muscle</u> (Duration) _____ yrs. _____ mos. <u>5 1/2</u> ds.					
Contributory (Secondary) _____ (Duration) _____ yrs. _____ mos. _____ ds.					
(Signed) <u>Joseph H. Carter M.D.</u> <u>10-10-1913</u> (Address) <u>Replurg, Idaho</u>					
*State the DISEASE CAUSING DEATH; or in deaths from violent causes, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.					
18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.) At place of death _____ yrs. _____ mos. _____ days. In the State _____ yrs. _____ mos. _____ days. Where was disease contracted if not at place of death? _____ Former or usual residence _____					
19. PLACE OF BURIAL OR REMOVAL <u>Ogden ut.</u>				DATE OF BURIAL <u>Oct. 11 1913</u>	
20. UNDERTAKER <u>John Phillips</u>				ADDRESS <u>Replurg</u>	

MARGIN RESERVED FOR BINDING
WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Form V. S. No. 5 20M.1-16-12

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH.

Registration District No. 100

County of Freemont

Primary Registration District No. 2178

City of Leton

(No. _____)

St.) _____

File No. 6252

Registered No. 32

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Deborah Stephens Mc Kinlay

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX

Female

4. COLOR OR RACE

White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED.

married.
(Write the word.)

6. DATE OF BIRTH

March.

10

1883

(Month)

(Day)

(Year)

7. AGE

30 yrs.

7 mos.

6 ds.

IF LESS than 1 day
how many _____ hrs. or
_____ mins.?

8. OCCUPATION

(a) Trade, profession or particular kind of work

House Wife

(b) General nature of industry business, or establishment in which employed (or employer)

9. BIRTHPLACE

(State or Country)

Utah.

10. NAME OF FATHER

Hyrum Smith Stephens.

11. BIRTHPLACE OF FATHER

(State or Country)

United States

12. MAIDEN NAME OF MOTHER

Hannah Elizabeth Wardell

13. BIRTHPLACE OF MOTHER

(State or Country)

England.

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

Geo A Mc Kinlay

(Address)

Leton.

15.

Filed 10-18

1913

L. L. Esch

Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH

Oct

16

1913

(Month)

(Day)

(Year)

17. I HEREBY CERTIFY, That I attended deceased from

Oct 4

1913

to Oct 16

1913

that I last saw her alive on Oct 15 1913

and that death occurred on the date stated above, at _____ M.

The CAUSE OF DEATH* was as follows:

Typhoid Fever.

(Duration) _____ yrs. _____ mos. 18 ds.

Contributory
(Secondary)

(Duration) _____ yrs. _____ mos. _____ ds.

(Signed)

J. R. Shupe M. D.

19

(Address)

Sugar City

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death _____ yrs. _____ mos. _____ days. In the State _____ yrs. _____ mos. _____ days.

Where was disease contracted if not at place of death?

Former or usual residence _____

19. PLACE OF BURIAL OR REMOVAL

Leton

DATE OF BURIAL

Oct 19 1913

20. UNDERTAKER

John Phillips

ADDRESS

Ree

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Form V. S. No. 5 20M.1-16-12

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH.

Registration District No. 100

County of Fremont

Primary Registration District No. 2178

File No. 6253

City of Rexburg

(No.) St.)

Registered No. 33

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

Harland

Laraine

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX

male

4. COLOR OR RACE

White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED.

(Write the word.)

6. DATE OF BIRTH

Oct.

3

1913

(Month)

(Day)

(Year)

7. AGE

yrs. mos. 25 ds.

IF LESS than 1 day
how many hrs. or
mins.?

8. OCCUPATION

(a) Trade, profession or
particular kind of work(b) General nature of industry
business, or establishment in
which employed (or employer)

9. BIRTHPLACE

(State or Country)

Rexburg

10. NAME OF
FATHER

Augustus M. Brown

11. BIRTHPLACE
OF FATHER

(State or Country)

Utah

12. MAIDEN NAME
OF MOTHER

Louise Virgin

13. BIRTHPLACE
OF MOTHER

(State or Country)

Idaho

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

Augustus M. Brown

(Address)

Rexburg

15.

Filed 10-27

1913

C. H. Epe

Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH

10

28

1913

(Month)

(Day)

(Year)

17. I HEREBY CERTIFY, That I attended deceased from

1913, to

1913,

that I last saw h alive on 1913,

and that death occurred on the date stated above, at M.

The CAUSE OF DEATH* was as follows:

Diphtheria

(Duration) yrs. mos. ds.

Contributory
(Secondary)

(Duration) yrs. mos. ds.

(Signed) J. H. Shupe M. D.

19 (Address) Sugar City

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death yrs. mos. days. In the State yrs. mos. days.

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

Rexburg

10/30 1913

20. UNDERTAKER

ADDRESS

John Phillips Rexburg

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICAL CLANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Form V. S. No. 5. 12-14-11

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics
File No. 6254
Registered No. 12

1. PLACE OF DEATH. Registration District No. 12
County of Boise Primary Registration District No. 2019
City of Idaho City (No. , St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Edward P. True

If death occurred in a hospital, institution or camp give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX male 4. COLOR OR RACE 5. SINGLE, MARRIED, WIDOWED OR DIVORCED. Widowed (Write the word.)

6. DATE OF BIRTH about 1851 (Month) (Day) (Year)

7. AGE about 62 yrs. mos. ds. IF LESS than 1 day how many hrs. or min?

8. OCCUPATION (a) Trade, profession or particular kind of work. Civil Engineer (b) General nature of industry business or establishment in which employed (or employer)

9. BIRTHPLACE (State or Country) Maine U.S.A.

10. NAME OF FATHER unknown

11. BIRTHPLACE OF FATHER (State or Country) unknown

12. MAIDEN NAME OF MOTHER unknown

13. BIRTHPLACE OF MOTHER (State or Country) unknown

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

(Address)

15.

Filed Nov 1919 May 1st Deputy Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH Nov 2 1919 (Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from Nov 2 1919, to Nov 2 1919

that I last saw him alive on Nov 2 1919 and that death occurred on the date stated above, at 8:30 AM.

The CAUSE OF DEATH* was as follows: Labor Pneumonia

(Duration) 18 hours yrs. mos. ds.

Contributory (Secondary)

(Duration) yrs. mos. ds.

(Signed) E. G. Lutz M. D. Nov 4 1919 (Address) Placerville Ida.

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death yrs. mos. ds. In the State yrs. mos. ds. Where was disease contracted, If not at place of death? Former or usual residence.

19. PLACE OF BURIAL OR REMOVAL DATE OF BURIAL Removal Nov 4 1919 Returned to Maine U.S.A.

20. UNDERTAKER ADDRESS Schrieber & Sidenfaden Boise Idaho

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Form V. S. No. 5. 12½ M. 7-24-11

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics
File No. 6255

1. PLACE OF DEATH.

Registration District No. 12

County of Boine

Primary Registration District No. 2019

City of Placerville

(No. , St.)

Registered No. 11

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

Mary Ann Blairchild

If death occurred in a hospital, institution or camp give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX

Female white

4. COLOR OR RACE

married
(Write the word.)

5. SINGLE, MARRIED, WIDOWED OR DIVORCED.

6. DATE OF BIRTH

Oct Mar 24 1893
(Month) (Day) (Year)

7. AGE

58 yrs. 6 mos. 17 ds.

IF LESS than 1 day
how many hrs. or min?

8. OCCUPATION

(a) Trade, profession or particular kind of work.
(b) General nature of industry business or establishment in which employed (or employer)

Housekeeper.

9. BIRTHPLACE

(State or Country)

Iowa

10. NAME OF FATHER

Barton.

11. BIRTHPLACE OF FATHER

(State or Country)

Ill.

12. MAIDEN NAME OF MOTHER

13. BIRTHPLACE OF MOTHER

(State or Country)

America

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

Mrs. R. Frazier

(Address)

Placerville, Cal.

15.

Filed Nov 1913

Mary L. Deputy
Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH

Oct 11 1913
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from

Feb 24 1912, to Oct 10 1913

that I last saw her alive on Oct 10 1913

and that death occurred on the date stated above, at 4 A. M.

The CAUSE OF DEATH* was as follows:

Chronic Nephritis

(Duration) unknown. yrs. mos. ds.

Contributory
(Secondary)

(Duration) yrs. mos. ds.

(Signed)

S. L. Frazier

M. D.

Nov 1913 (Address) Placerville Idaho

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place In the
of death yrs. mos. ds. State yrs. mos. ds.

Where was disease contracted,

If not at place of death?

Former or

usual residence.

19. PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

Placerville Cemetery, Oct 13 1913

20. UNDERTAKER

ADDRESS

Had none.

MARGIN RESERVED FOR BINDING

BE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
 of information should be carefully supplied. AGE should be stated EXACTLY.
 State CAUSE OF DEATH in plain terms, so that it may be properly classified. EXAC-
 TION is very important. See instructions on back of certificate.

County of <u>Kenosha</u>		Primary Registrar	District No. <u>2176</u>	BOARD OF HEALTH Bureau of Vital Statistics File No. <u>62</u>
City of <u>Kenosha</u>		(No., St.)	Registered No.	If death occurred in a institution or camp, give instead of street and
If death occurs away from usual residence, give facts called for under special information. 2. FULL NAME <u>Malcolm Jay Thompson</u>				
PERSONAL AND STATISTICAL PARTICULARS				
3. SEX <u>Male</u>	4. COLOR OR RACE <u>White</u>	5. SINGLE, MARRIED, DIVORCED, OR SEPARATED <u>Single</u>	16. DATE OF DEATH <u>Aug 29</u> (Month) (Day)	
6. DATE OF BIRTH <u>Dec. 14</u> (Month) (Day)		17. I HEREBY CERTIFY, That I attended death <u>Aug 28</u> 1913, to <u>Aug 29</u> that I last saw him alive on <u>Aug 28</u> and that death occurred on the date stated above, and		
7. AGE <u>2 yrs 9 mos 15 da.</u>		IF LESS than one year, state how many days		
8. OCCUPATION (a) Trade, profession or particular kind of work (b) General nature of industry, business, or establishment in which employed (or employer)				
9. BIRTHPLACE (State or Country) <u>Rigby Idaho.</u>				
10. NAME OF FATHER <u>James E. Thompson</u>				
11. BIRTHPLACE OF FATHER (State or Country) <u>Utah</u>				
12. MAIDEN NAME OF MOTHER <u>Julia A. Hanson</u>				
13. BIRTHPLACE OF MOTHER (State or Country) <u>Utah</u>				
14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE <u>James E. Thompson</u> <u>H. A. Crisler</u>				
The CAUSE OF DEATH* was as follows: <u>Supposed Diphtheria</u>				
..... (Duration) yrs. mos.				
Contributory (Secondary) (Duration) yrs. mos.				
(Signed) <u>Wm. D. Krich</u> <u>Aug 24 1913</u> (Address) <u>St. Higgins</u>				
*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSE, MEANS OF DEATH; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDE				
18. LENGTH OF RESIDENCE (For Hospitals, Ins Transients or Recent Residents.) At place of death yrs. mos. days. In the State yrs. mos.				
Where was disease contracted if not at place of death? Former or usual residence				
19. PLACE OF BURIAL OR REMOVAL <u>Glader</u>				DATE OF BURIAL <u>Aug 30</u>
20. UNDERTAKER <u>Ed. E. Ebert</u>				ADDRESS

Filed Oct 20 - 1913 m. P. Crisler
 Local Registrar

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH.

Registration District No. 35County of ElmorePrimary Registration District No. 2021City of King Hill

(No. _____ St.)

Registered No. _____

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

David Doughm

If death occurred in a hospital, institution or camp give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX

Male

4. COLOR OR RACE 5. SINGLE, MARRIED, WIDOWED OR DIVORCED.

WhiteWidower
(Write the word.)

6. DATE OF BIRTH

Oct.12th1913

(Month)

(Day)

(Year)

7. AGE

62

yrs.

mos.

ds.

IF LESS than 1 day
how many hrs. or
..... min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work

(b) General nature of industry business or establishment in which employed (or employer)

Rancher

9. BIRTHPLACE

(State or Country)

Armenia

10. NAME OF FATHER

Coratius Doughm

11. BIRTHPLACE OF FATHER

(State or Country)

London Canada

12. MAIDEN NAME OF MOTHER

Margaret Canoll

13. BIRTHPLACE OF MOTHER

(State or Country)

Canada

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

Miss Doughm

(Address)

Butte Montana

15.

Filed Oct. 13th 1913J. W. Davis

Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

Oct12th1913

(Month)

(Day)

(Year)

17. I HEREBY CERTIFY, That I attended deceased from

191

to

191

that I last saw h..... alive on..... 191

and that death occurred on the date stated above, at 1 A. M.

The CAUSE OF DEATH* was as follows:

apoplexy

(Duration)

yrs.

mos.

ds.

Contributory

(Secondary)

(Duration)

yrs.

mos.

ds.

(Signed)

J. W. Davis

M. D.

Oct. 13th 1913

(Address)

Glenn's Ferry Idaho

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and 2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place

In the

of death..... yrs..... mos..... ds.

State..... yrs..... mos..... ds.

Where was disease contracted.

If not at place of death?

Former or

usual residence.....

19. PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

Butte MontanaOct. 16th 1913

20. UNDERTAKER

ADDRESS

A. E. ThompsonGlenn's Ferry Idaho

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Form V. S. No. 5. 12½ M. 7-24-11

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics
File No. 6258
Registered No. _____

1. PLACE OF DEATH
County of Town Falls
City of Buhl

Registration District No. 34
Primary Registration District No. 2087
(No. _____, _____ St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Dorinda Cecil Boyd Blackwell

If death occurred in a hospital, institution or camp give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX 7 4. COLOR OR RACE W. 5. SINGLE, MARRIED, WIDOWED OR DIVORCED. Widowed
(Write the word.)

6. DATE OF BIRTH April 7 1877
(Month) (Day) (Year)

7. AGE 86 yrs. 6 mos. 24 ds. IF LESS than 1 day how many _____ hrs. or _____ min?

8. OCCUPATION
(a) Trade, profession or particular kind of work Housewife
(b) General nature of industry business or establishment in which employed (or employer)

9. BIRTHPLACE
(State or Country) Virginia

10. NAME OF FATHER Price

11. BIRTHPLACE OF FATHER
(State or Country) England

12. MAIDEN NAME OF MOTHER Not known

13. BIRTHPLACE OF MOTHER
(State or Country) England

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) _____
(Address) _____

15. Filed 10-31 1913 J. H. Murphy
Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH Oct 31 1913
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from affected with 1913
that I last saw h. alive on 1913
and that death occurred on the date stated above, at _____ M.
The CAUSE OF DEATH* was as follows:
old age

(Duration) _____ yrs. _____ mos. 7 ds.
Contributory (Secondary)

(Duration) _____ yrs. _____ mos. _____ ds.
(Signed) J. H. Murphy M. D.
10-31 1913 (Address) Buhl

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place _____ In the _____
of death _____ yrs. _____ mos. _____ ds. State _____ yrs. _____ mos. _____ ds.
Where was disease contracted,
If not at place of death? _____
Former or
usual residence _____

19. PLACE OF BURIAL OR REMOVAL DATE OF BURIAL
At Home 11-1 1913

20. UNDERTAKER ADDRESS
Home

STATE OF IDAHO,

COUNTY OF TWIN FALLS.

SS.

Frank⁹ Hartwell and Lula Hartwell, being first duly sworn, each for self and not one for the other, depose and say:- that they reside at Roseworth, County of Twin Falls, State of Idaho; have been acquainted with Dorinda Cecil Boyd Blackwell; that her sex was that of a woman; that she was white; a widow; that the date of her birth was April seventh, 1827; at the date of her death was eighty six years, six months and twenty four days; that her occupation was that of housework; that her birthplace was in the State of Virginia; that the date of her death was October 31, 1913; that I last saw her alive on the thirty first day of October, A. D. 1913; and that ~~she died~~ at eight o'clock on the said thirty first day of October, 1913; that the cause of her death was old age to the best knowledge and belief of the affiants; that she went to bed about the twenty fourth day of October, A. D. 1913 and has been continually sinking since that time, until the time of her death.

Frank D. Hartwell

Lula Hartwell

Subscribed and sworn to before me this thirty first day of October, A. D. 1913.

[Signature]
NOTARY PUBLIC.

My commission expires January 25, 1914.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Form V. S. No. 5 20M.1-16-12

CERTIFICATE OF DEATH

1. PLACE OF DEATH

Registration District No.

County of

Primary Registration District No.

City of

(No.

St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics
File No. 6259

Registered No.

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX

4. COLOR OR RACE

5. SINGLE, MARRIED, WIDOWED OR DIVORCED.

(Write the word.)

6. DATE OF BIRTH

7. AGE

IF LESS than 1 day
how many hrs. or
..... mins.?

8. OCCUPATION

- (a) Trade, profession or particular kind of work
(b) General nature of industry business, or establishment in which employed (or employer)

9. BIRTHPLACE

(State or Country)

10. NAME OF FATHER

11. BIRTHPLACE OF FATHER

(State or Country)

12. MAIDEN NAME OF MOTHER

13. BIRTHPLACE OF MOTHER

(State or Country)

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

(Address)

15.

Filed

1913

Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH

(Month)

(Day)

1913 (Year)

17. I HEREBY CERTIFY, That I attended deceased from
Sept 29 1913, to Oct 4 1913,
that I last saw him alive on Oct 3 1913,
and that death occurred on the date stated above, at 4 P. M.

The CAUSE OF DEATH* was as follows:

Myocarditis & Endocarditis with broken compensation

(Duration)

yrs. one mos.

ds.

Contributory

(Secondary) Anoxia

(Duration)

yrs. mos.

ds.

(Signed)

Oct 4 1913

(Address)

Buhl Ida

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL OR HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place

of death.....yrs.....mos.....days.

In the

State.....yrs.....mos.....days.

Where was disease contracted if not at place of death?

Former or usual residence.....

19. PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

Buhl

Oct 5th 1913

20. UNDERTAKER

ADDRESS

J. B. Evans

Buhl Ida

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Form V. S. No. 5 20M.1-16-12

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH

Registration District No.

County of

Primary Registration District No.

City of

(No.

St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

File No.

Registered No.

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX

4. COLOR OR RACE

5. SINGLE, MARRIED, WIDOWED OR DIVORCED.

(Write the word.)

6. DATE OF BIRTH

7. AGE

yrs. mos. ds.

IF LESS than 1 day
how many hrs. or
mins.?

8. OCCUPATION

- (a) Trade, profession or particular kind of work
(b) General nature of industry business, or establishment in which employed (or employer)

9. BIRTHPLACE

(State or Country)

10. NAME OF FATHER

11. BIRTHPLACE OF FATHER

(State or Country)

12. MAIDEN NAME OF MOTHER

13. BIRTHPLACE OF MOTHER

(State or Country)

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

(Address)

15.

Filed

1913

Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH

(Month)

(Day)

1913 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Sept 19 1913, to Oct 6 1913, that I last saw him alive on Oct 5 1913, and that death occurred on the date stated above, at 10 P.M.

The CAUSE OF DEATH* was as follows:

(Duration)

yrs.

mos.

ds.

Contributory
(Secondary)

(Duration)

yrs.

mos.

ds.

(Signed)

M. D.

Oct 7 1913 (Address) Burbl Ida

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death

yrs. mos. days.

In the State

yrs. mos. days.

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

20. UNDERTAKER

ADDRESS

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Form V. S. No. 5 20M.1-16-12

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH

Registration District No.

County of

Primary Registration District No.

City of

(No. _____, _____ St.)

File No.

Registered No.

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX

4. COLOR OR RACE

5. SINGLE, MARRIED, WIDOWED OR DIVORCED

(Write the word.)

6. DATE OF BIRTH

7. AGE

IF LESS than 1 day
how many _____ hrs. or
_____ mins.?

8. OCCUPATION

(a) Trade, profession or particular kind of work

(b) General nature of industry business, or establishment in which employed (or employer)

9. BIRTHPLACE

(State or Country)

10. NAME OF FATHER

11. BIRTHPLACE OF FATHER

(State or Country)

12. MAIDEN NAME OF MOTHER

13. BIRTHPLACE OF MOTHER

(State or Country)

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

(Address)

15.

Filed

1913

Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH

17. I HEREBY CERTIFY, That I attended deceased from

one week, at 12:30 PM, 12/13/13,

that I last saw him alive at 1 PM, 12/12/13,

and that death occurred on the date stated above, at 3 PM.

The CAUSE OF DEATH* was as follows:

Cerebral spinal Meningitis

(Duration) _____ yrs. _____ mos. 2 1/2 ds.

Contributory
(Secondary)

(Duration) _____ yrs. _____ mos. _____ ds.

(Signed) C. S. McCluskey M. D.

14/13 1913 (Address) Buhl Ida.

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death _____ yrs. _____ mos. _____ days. In the State _____ yrs. _____ mos. _____ days.

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

Buhl Ida.

10/13 1913

20. UNDERTAKER

ADDRESS

J. B. Evans

Buhl Ida

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics
File No. **6262**
Registered No. _____

1. PLACE OF DEATH _____ Registration District No. **39**
County of **Twin Falls** Primary Registration District No. **2087**
City of **Buhl** (No. _____, St.) _____

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

Lexie Catherine Lewis Low

If death occurred in a hospital, institution or camp give its NAME and street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX **F** 4. COLOR OR RACE **White** 5. SINGLE, MARRIED, WIDOWED OR DIVORCED. **Married**
(Write the word.)

6. DATE OF BIRTH **Sept 9 1874**
(Month) (Day) (Year)

7. AGE **49** yrs. **1** mos. **18** ds. IF LESS than 1 day how many hrs. or min?

8. OCCUPATION

(a) Trade, profession or particular kind of work. **Housewife**
(b) General nature of industry business or establishment in which employed (or employer)

9. BIRTHPLACE

(State or Country) **Kentucky**

10. NAME OF FATHER

11. BIRTHPLACE OF FATHER

(State or Country) **U.S.A.**

12. MAIDEN NAME OF MOTHER

13. BIRTHPLACE OF MOTHER

(State or Country) **U.S.A.**

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) **Arthur Low**

(Address) **Buhl Ida**

15.

Filed **10-29** 191**3**

J. Murphy
Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

Oct 27 1913
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from

Oct 22 1913, to **Oct 27 1913**.

that I last saw her alive on **Oct 26 1913**.

and that death occurred on the date stated above, at **7:30 PM**.

The CAUSE OF DEATH* was as follows:

Typhoid Fever

(Duration) _____ yrs. _____ mos. **10** ds.

Contributory (Secondary)

(Duration) _____ yrs. _____ mos. _____ ds.

(Signed) **D. J. McCluskey M.D.**

Oct 27 1913 (Address) **Buhl Ida**

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place _____ In the _____
of death _____ yrs. _____ mos. _____ ds. State _____ yrs. _____ mos. _____ ds.

Where was disease contracted,
If not at place of death?

Former or
usual residence.

19. PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

Buhl - Ida

10-29 1913

20. UNDERTAKER

ADDRESS

H. B. Fraw.

Buhl

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Form V. S. No. 5. 12½ M. 7-24-11

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH.

Registration District No. 50County of GevoraPrimary Registration District No. 2129City of Ilo

(No. _____, _____ St.)

File No. 6265Registered No. 5

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

OleviasBowenton

If death occurred in a hospital, institution or camp give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX

Male

4. COLOR OR RACE

white

5. SINGLE, MARRIED, WIDOWED OR DIVORCED.

Single
(Write the word.)

6. DATE OF BIRTH

Feb 131913

(Month)

(Day)

(Year)

7. AGE

1 yrs. 8 mos. 27 ds.

IF LESS than 1 day
how many _____ hrs. or
_____ min?

8. OCCUPATION

- (a) Trade, profession or particular kind of work.
(b) General nature of industry business or establishment in which employed (or employer)

Infant

9. BIRTHPLACE

(State or Country)

Lewis Co

10. NAME OF FATHER

Affred E. Bowenton

11. BIRTHPLACE OF FATHER

(State or Country)

Missouri-Sale

12. MAIDEN NAME OF MOTHER

Sarah Earty

13. BIRTHPLACE OF MOTHER

(State or Country)

Lincoln Co Kansas

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

A. E. Bowenton

(Address)

Ilo, Idaho.

15.

Filed Oct 9 19131913H. C. Parrish

Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH

Oct91913

(Month)

(Day)

(Year)

17. I HEREBY CERTIFY, That I attended deceased from

Sept 131913to Oct 91913that I last saw him alive on Oct 9 1913and that death occurred on the date stated above, at 10 A.M.

The CAUSE OF DEATH* was as follows:

Malnutrition

(Duration)

1 yrs.

mos.

ds.

Contributory (Secondary)

Cholera Infantum

(Duration)

1 yrs.

mos.

ds.

(Signed)

H. C. Parrish M. D.Oct 91913(Address) Ilo, Idaho.

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place

In the

of death _____ yrs. _____ mos. _____ ds. State _____ yrs. _____ mos. _____ ds.

Where was disease contracted,

If not at place of death?

Former or

usual residence.

19. PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

Ilo Cemetery10-10 1913

20. UNDERTAKER

ADDRESS

H. C. Bowenton & Inf CoIlo Idaho

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Form V. S. No. 5 20M.1-16-12

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics
File No. 6264
Registered No. 20

1. PLACE OF DEATH. Registration District No. 73
County of Bonneville Primary Registration District No. 2107
City of Grain (No., St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Lucy E. H. Cheney

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX F. 4. COLOR OR RACE W. 5. SINGLE, MARRIED, WIDOWED OR DIVORCED married
(Write the word.)

6. DATE OF BIRTH Feb. 24 1829
(Month) (Day) (Year)

7. AGE 84 yrs. 8 mos. 9 ds. IF LESS than 1 day how many hrs. or mins.?

8. OCCUPATION
(a) Trade, profession or particular kind of work Housewife
(b) General nature of industry, business, or establishment in which employed (or employer)

9. BIRTHPLACE Me.
(State or Country)

10. NAME OF FATHER J. Hardy

11. BIRTHPLACE OF FATHER Me.
(State or Country)

12. MAIDEN NAME OF MOTHER Eliza Hardy

13. BIRTHPLACE OF MOTHER Me.
(State or Country)

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) W. E. Cheney
(Address) Romney, 2.

15. Filed Nov 4 1913 Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH Nov 1 1913
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from 191, to 191, that I last saw him alive on 191, and that death occurred on the date stated above, at M.

The CAUSE OF DEATH* was as follows:

No physician
Died suddenly
probably myocarditis
(Duration) yrs. mos. ds.

Contributory (Secondary)

(Duration) yrs. mos. ds.

(Signed) Ray Fisher M. D.

Nov 5 1913 (Address) Rigley, Ida

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death... yrs. mos. days. In the State... yrs. mos. days.

Where was disease contracted if not at place of death?

Former or usual residence.

19. PLACE OF BURIAL OR REMOVAL DATE OF BURIAL

Shelton Nov 4 1913

20. UNDERTAKER ADDRESS

M. I. Peck & Sons Rigley

Form V. S. No. 5 20M.1-16-12

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH.

Registration District No. 72County of BonnevillePrimary Registration District No. 2117City of Idaho Falls(No. Stanche Williams St.)File No. 6265Registered No. 24

If death occurs away from usual residence, give facts called for under special information.

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME

PERSONAL AND STATISTICAL PARTICULARS.

3. SEX

Female

4. COLOR OR RACE

White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED.

(Write the word.)

6. DATE OF BIRTH

Aug
(Month)15
(Day)1909
(Year)

7. AGE

4 yrs. 2 mos. 18 ds.IF LESS than 1 day
how many hrs. or
..... mins.?

8. OCCUPATION

- (a) Trade, profession or particular kind of work
-
- (b) General nature of industry business, or establishment in which employed (or employer)

9. BIRTHPLACE

(State or Country)

Shelton Idaho

10. NAME OF FATHER

Thos. E. Williams

11. BIRTHPLACE OF FATHER

(State or Country)

Willing Utah

12. MAIDEN NAME OF MOTHER

Maria Hughes

13. BIRTHPLACE OF MOTHER

(State or Country)

Samara Idaho

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) T. E. Williams

(Address)

15.

Filed Nov 3 1913

Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH

Nov73

(Month)

(Day)

(Year)

17. I HEREBY CERTIFY, That I attended deceased from Disput arising between
1913, to 1913,that I last saw h. alive on 1913,and that death, occurred on the date stated above, at 9 P.M.

The CAUSE OF DEATH* was as follows:

Accidental poisoning
on a Sunday night
(Duration) yrs. mos. ds.Contributory
(Secondary)

(Duration) yrs. mos. ds.

(Signed)

Nov 3 1913 (Address) Idaho Falls, Ida.

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death yrs. mos. days. In the State yrs. mos. days.

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

Shelton Idaho11-3 1913

20. UNDERTAKER

ADDRESS

Amos & Co. 60Idaho Falls

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Form V. S. No. 5 20M.1-16-12

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH.

Registration District No. 7.3

County of Bonner

Primary Registration District No. 2117

City of Idaho Falls

(No. 7 St.)

File No. 6255

Registered No. 13

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

Infant Tanner Helena Tanner

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX

Female

4. COLOR OR RACE

White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED.

Single (Write the word.)

6. DATE OF BIRTH

Oct 27 1913
(Month) (Day) (Year)

7. AGE

.....yrs.mos.ds.

IF LESS than 1 day
how many hrs. or
38 mins.?

8. OCCUPATION

(a) Trade, profession or particular kind of work
(b) General nature of industry business, or establishment in which employed (or employer)

None

9. BIRTHPLACE

(State or Country)

Idaho

10. NAME OF FATHER

Thomas Tanner

11. BIRTHPLACE OF FATHER

(State or Country)

Utah

12. MAIDEN NAME OF MOTHER

Lusia Hathaway

13. BIRTHPLACE OF MOTHER

(State or Country)

Idaho

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

(Address)

Idaho Falls

15.

Filed

Oct 27 1913

Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH

Oct 27 1913
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from

Oct 27 1913, to Oct 27 1913,

that I last saw her alive on Oct 27 1913,

and that death occurred on the date stated above, at 3.00 M.

The CAUSE OF DEATH* was as follows:

Deficient oxygenation of blood probably due to failure of a certain heart valve to close properly.

(Duration)yrs.mos.ds.

Contributory
(Secondary)

(Duration)yrs.mos.ds.

(Signed) G. D. Pendleton M. D.

Oct 27 1913 (Address) Idaho Falls, Idaho

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of deathyrs.mos.days. In the Stateyrs.mos.days.

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

Rose Lawn 10/27 1913

20. UNDERTAKER

ADDRESS

G. H. Hunt Idaho Falls

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Form V. S. No. 5 20M.1-16-12

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH.

Registration District No. 73

County of Bonnyville

Primary Registration District No. 215-0

City of Idaho Falls

(No.) (St.)

File No. 6267

Registered No. 82

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Bertha Black Veach

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX

Female

4. COLOR OR RACE

White

5. SINGLE, MARRIED, WIDOWED, OR DIVORCED.

Child
(Write the word.)

6. DATE OF BIRTH

May 26 1913
(Month) (Day) (Year)

7. AGE

..... yrs. 6 mos. ds.

IF LESS than 1 day
how many hrs. or
..... mins.?

8. OCCUPATION

- (a) Trade, profession or particular kind of work
(b) General nature of industry, business, or establishment in which employed (or employer)

Child

9. BIRTHPLACE

(State or Country) Idaho Falls, Ida

10. NAME OF FATHER

Geo. Veach

11. BIRTHPLACE OF FATHER

(State or Country) Nottingham England

12. MAIDEN NAME OF MOTHER

Phoebe Foster

13. BIRTHPLACE OF MOTHER

(State or Country) Preston Ida

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Geo. Black

(Address) City

15.

Filed Oct 24 1913

Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH

Oct 26 1913
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from

Oct 8 1913, to Oct 26 1913

that I last saw her alive on Oct 26 1913

and that death occurred on the date stated above, at 10 A. M.

The CAUSE OF DEATH* was as follows:

Ho. Colitis

(Duration) yrs. mos. 18 da.

Contributory
(Secondary)

(Duration) yrs. mos. ds.

(Signed) W. D.

Oct 24 1913 (Address) Idaho Falls, Ida

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death.....yrs.....mos.....days. In the State.....yrs.....mos.....days.

Where was disease contracted if not at place of death?.....

Former or usual residence.....

19. PLACE OF BURIAL OR REMOVAL

Idaho Falls

DATE OF BURIAL

10/28 1913

20. UNDERTAKER

Greenwood

ADDRESS

Idaho Falls

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Form V. S. No. 5 20M.1-16-12

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH.

Registration District No. 72

County of Benewah

Primary Registration District No. 2100

City of Idaho Falls

(No. _____ St.)

File No. 6269

Registered No. F

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

Kenneth Davis

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX

Male

4. COLOR OR RACE

White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED.

Married
(Write the word.)

6. DATE OF BIRTH

Mar

7

1876

(Month)

(Day)

(Year)

7. AGE

37

yrs.

7

mos.

21

ds.

IF LESS than 1 day
how many _____ hrs. or
_____ mins.?

8. OCCUPATION

(a) Trade, profession or particular kind of work

(b) General nature of industry business, or establishment in which employed (or employer)

Housewife

9. BIRTHPLACE

(State or Country)

Utah

10. NAME OF FATHER

Marionia Fowler

11. BIRTHPLACE OF FATHER

(State or Country)

Unknown

12. MAIDEN NAME OF MOTHER

Sarah Hadden

13. BIRTHPLACE OF MOTHER

(State or Country)

Unknown

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

E. L. Davis

(Address)

Idaho Falls

15.

Filed

1913

E. L. Davis
Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH

Oct

26

1913

(Month)

(Day)

(Year)

17. I HEREBY CERTIFY, That I attended deceased from

Oct. 12

1913

to Oct. 26

1913

that I last saw her alive on Oct. 26 1913

and that death occurred on the date stated above, at 9:30 M.

The CAUSE OF DEATH* was as follows:

Chronic Paraneuritis
Nephritis

(Duration)

yrs.

mos.

ds.

Contributory

(Secondary)

(Duration)

yrs.

mos.

ds.

(Signed)

G. H. Gault M. D.

Oct. 19 1913

(Address) Idaho Falls, Id.

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place

of death

yrs.

mos.

days.

In the

State

yrs.

mos.

days.

Where was disease contracted if not at place of death?

Former or usual residence.

19. PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

Idaho

10-28

1913

20. UNDERTAKER

ADDRESS

G. H. Gault

Idaho Falls

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Form V. S. No. 5 20M.1-16-12

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics
File No. 6269

1. PLACE OF DEATH.

Registration District No. 73

County of Bonnerville

Primary Registration District No. 2150

City of Ucon

(No. , St.)

Registered No. 82

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

- Matsushita

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX

female

4. COLOR OR RACE

Japanese

5. SINGLE—MARRIED, WIDOWED OR DIVORCED.

(Write the word.)

6. DATE OF BIRTH

Oct
(Month)1
(Day)1943
(Year)

7. AGE

yrs. mos. 7 da.

IF LESS than 1 day
how many hrs. or
mins?

8. OCCUPATION

(a) Trade, profession or particular kind of work

(b) General nature of industry, business, or establishment in which employed (or employee)

9. BIRTHPLACE

(State or Country) Ucon Idaho.

10. NAME OF FATHER

K. Matsushita

11. BIRTHPLACE OF FATHER

(State or Country) Japan

12. MAIDEN NAME OF MOTHER

O. Sasaki

13. BIRTHPLACE OF MOTHER

(State or Country) Japan

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Sarah J. Simmons

(Address) Ucon Idaho

15.

Filed Oct 25 1913

Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

Oct
(Month)7
(Day)1913
(Year)

17. I HEREBY CERTIFY, That I attended deceased from

Oct 1

1913, to

Oct 6

1913,

that I last saw her alive on Oct 6 1913,

and that death occurred on the date stated above, at 10 AM.

The CAUSE OF DEATH* was as follows:

Premature

No medical attendance.

(Duration) yrs. mos. 7 da.

Contributory
(Secondary)

(Duration) yrs. mos. da.

(Signed) M. D.

10/25-1913 (Address) Ucon Idaho

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death yrs. mos. days. In the State yrs. mos. days.

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL

Ucon Ida

DATE OF BURIAL

Oct 1913

20. UNDERTAKER

ADDRESS

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Form V. S. No. 5 20M.1-16-12

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH.

Registration District No. 73

County of Bonneyville

Primary Registration District No. 2157

City of Ammon

(No. _____, St.)

File No. 6270

Registered No. 79

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Ruben E. Emery

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX

Male

4. COLOR OR RACE

White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED.

Single
(Write the word.)

6. DATE OF BIRTH

July 28

1910

(Month)

(Day)

(Year)

7. AGE

3 yrs. 7 mos. 22 ds.

IF LESS than 1 day
how many hrs. or
..... mins.?

8. OCCUPATION

(a) Trade, profession or particular kind of work

(b) General nature of industry, business, or establishment in which employed (or employer)

9. BIRTHPLACE

(State or Country)

Bonneyville Idaho

10. NAME OF FATHER

A. E. Emery

11. BIRTHPLACE OF FATHER

(State or Country)

Lehi Utah

12. MAIDEN NAME OF MOTHER

Olivia Mitchell

13. BIRTHPLACE OF MOTHER

(State or Country)

Escalante Utah

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

Dwight Henry

(Address)

Idaho Falls

15.

Filed

Oct 22

1913

Gay
Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH

Oct. 22

(Month)

(Day)

1913

(Year)

17. I HEREBY CERTIFY, That I attended deceased from

Sept. 5 1913, to Oct. 22, 1913,

that I last saw him alive on Oct. 21, 1913,

and that death occurred on the date stated above, at 1:30 PM

The CAUSE OF DEATH* was as follows:

Typhoid Fever

(Duration) yrs. 1 mos. 17 ds.

Contributory
(Secondary)

Nephritis

(Duration) yrs. _____ mos. 14 ds.

(Signed)

John G. Miller

M. D.

Oct 22 1913 (Address) Idaho Falls, Ida

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place

of death.....yrs.....mos.....days.

In the

State.....yrs.....mos.....days.

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

Ammon

Oct 23, 1913

20. UNDERTAKER

ADDRESS

C. E. Woodward Idaho Falls

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH

Registration District No. 73

County of Bonanza

Primary Registration District No. 2150

City of Payson

(No.)

(St.)

File No. 6272

Registered No. 77

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

Infant - Thomas

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX

Female

4. COLOR OR RACE

White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED.

Single
(Write the word.)

6. DATE OF BIRTH

Oct. 14 1913
(Month) (Day) (Year)

7. AGE

yrs. mos. ds.

IF LESS than 1 day
how many hrs. or
mins.?

8. OCCUPATION

(a) Trade, profession or particular kind of work

(b) General nature of industry business, or establishment in which employed (or employer)

none

9. BIRTHPLACE

(State or Country)

Idaho

10. NAME OF FATHER

William L. Thomas

11. BIRTHPLACE OF FATHER

(State or Country)

Utah

12. MAIDEN NAME OF MOTHER

Emelia Lewis

13. BIRTHPLACE OF MOTHER

(State or Country)

Utah

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

Wm. C. Thomas

(Address)

Idaho Falls

15.

Filed

Oct 10 1913

Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

Oct. 14 1913
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from

1913, to 1913,

that I last saw h. alive on 1913,

and that death occurred on the date stated above, at 6 P.M.

The CAUSE OF DEATH* was as follows:

No medical attendance -
(Duration) yrs. mos. ds.Contributory
(Secondary)

(Duration) yrs. mos. ds.

(Signed) M. D.

1913 (Address) Idaho Falls

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death yrs. mos. days. In the State yrs. mos. days.

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL DATE OF BURIAL

Payson Idaho Idaho Falls 1913

20. UNDERTAKER

G. H. Hunt

ADDRESS

Oct, 15

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Form V. S. No. 5 20M.1-16-12

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH.

Registration District No. 7.3

County of Bonner

Primary Registration District No. 211-0

City of Leads Ferry

(No. _____ St.)

File No. 6273

Registered No. 74

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Mamie Leggroan

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX

Female

4. COLOR OR RACE

Ethiopian

5. SINGLE, MARRIED, WIDOWED OR DIVORCED.

Child
(Write the word.)

6. DATE OF BIRTH

Aug 14 1906
(Month) (Day) (Year)

7. AGE

9 yrs. 2 mos. 2 ds.

IF LESS than 1 day
how many hrs. or
..... mins.?

8. OCCUPATION

(a) Trade, profession or particular kind of work
(b) General nature of industry, business, or establishment in which employed (or employer)

Child

9. BIRTHPLACE

(State or Country)

Idaho

10. NAME OF FATHER

Edward Leggroan

11. BIRTHPLACE OF FATHER

(State or Country)

Utah

12. MAIDEN NAME OF MOTHER

Blanche Flake

13. BIRTHPLACE OF MOTHER

(State or Country)

Utah

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Edmund Leggroan

(Address) Leads Ferry

15.

Filed Oct 17 1913

Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH

Oct 16 1913
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from

about Oct 1st 1913, to Oct 15 1913,

that I last saw her alive on Oct 15 1913,

and that death occurred on the date stated above, at 49 M.

The CAUSE OF DEATH* was as follows:

Abcess about the appendix

(Duration) 17 yrs. 17 mos. 17 ds.

Contributory (Secondary)

(Duration) 17 yrs. 17 mos. 17 ds.

(Signed) G. H. Pendleton M. D.

1913 (Address) Idaho Falls, Idaho

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death yrs. mos. days. In the State yrs. mos. days.

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL DATE OF BURIAL

Idaho Falls Oct. 19 1913

20. UNDERTAKER

ADDRESS

B. E. Hinwooley Idaho Falls

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Form V. S. No. 5. 10M. 6-20-11.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics
File No. 6215

1. PLACE OF DEATH
County of Bonneville
City of Lana

Registration District No. 73
Primary Registration District No. 2150
(No. _____, _____ St.)

Registered No. 74

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Eva Hansen

If death occurred in a hospital, institution or camp give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX girl 4. COLOR OR RACE white 5. SINGLE, MARRIED, WIDOWED OR DIVORCED.
(Write the word.)

6. DATE OF BIRTH Oct 2 1913
(Month) (Day) (Year)

7. AGE _____ yrs. _____ mos. _____ ds. IF LESS than 1 day how many _____ hrs. or _____ min.?

8. OCCUPATION

- (a) Trade, profession or particular kind of work
(b) General nature of industry business or establishment in which employed (or employer)

9. BIRTHPLACE Lana Bonneville Idaho
(State or Country)

10. NAME OF FATHER Charles W. Hansen

11. BIRTHPLACE OF FATHER Hyrum Utah
(State or Country)

12. MAIDEN NAME OF MOTHER Mary A. Lee

13. BIRTHPLACE OF MOTHER Poeble Utah
(State or Country)

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Sarah J. Rowberry
(Address) Lana Bonneville Idaho

15. Filed Oct 15 1913 C. J. Finn
Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH Oct 2 1913
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from _____ 191____, to _____ 191____

that I last saw h_____ alive on _____ 191____, and that death occurred on the date stated above, at _____ M.

The CAUSE OF DEATH* was as follows:

Premature

No medical attendance
(Duration) _____ yrs. _____ mos. _____ ds.

Contributory (Secondary) _____

(Signed) C. J. Finn M. D.
10/10-1913 (Address) Lana

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place _____ In the _____
of death _____ yrs. _____ mos. _____ ds. State _____ yrs. _____ mos. _____ ds.
Where was disease contracted.
If not at place of death?
Former or usual residence _____

19. PLACE OF BURIAL OR REMOVAL Lana DATE OF BURIAL Oct 2 1913

20. UNDERTAKER _____ ADDRESS _____

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Form V. S. No. 5. 10M. 6-20-11.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH.
County of Bonneville
City of Dona

Registration District No. 73
Primary Registration District No. 211-0

File No. 6276

Registered No. 73

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Eda Hansen

If death occurred in a hospital, institution or camp give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX girl 4. COLOR OR RACE white 5. SINGLE, MARRIED, WIDOWED OR DIVORCED.
(Write the word.)

6. DATE OF BIRTH Oct 2 1913
(Month) (Day) (Year)

7. AGE 20 yrs. 3 mos. 30 ds.
IF LESS than 1 day how many hrs. or min.?

8. OCCUPATION

- (a) Trade, profession or particular kind of work
(b) General nature of industry business or establishment in which employed (or employer)

9. BIRTHPLACE (State or Country) Dona Bonneville Idaho

10. NAME OF FATHER Charles W. Hansen

11. BIRTHPLACE OF FATHER (State or Country) Hoyman Utah

12. MAIDEN NAME OF MOTHER Mary A. Lee

13. BIRTHPLACE OF MOTHER (State or Country) Taovelle Utah

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Sarah J. Roush
(Address) Dona Bonneville Idaho

15. Filed Oct 15 1913 C. J. Quinn
Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH Oct 2 1913
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from 191 to 191

that I last saw h. alive on 191

and that death occurred on the date stated above, at M.

The CAUSE OF DEATH* was as follows:

Thrombosis
in middle of heart
(Duration) yrs. mos. ds.

Contributory (Secondary)

(Duration) yrs. mos. ds.
(Signed) C. J. Quinn M. D.
Oct 15 1913 (Address) Dona Bonneville Idaho

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death yrs. mos. ds. In the State yrs. mos. ds.
Where was disease contracted, If not at place of death?
Former or usual residence

19. PLACE OF BURIAL OR REMOVAL Dona DATE OF BURIAL Oct 2 1913

20. UNDERTAKER ADDRESS

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Form V. S. No. 5 20M.1-16-12

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics
File No. 6277

1. PLACE OF DEATH.

Registration District No. 72

County of Blaine

Primary Registration District No. 9

City of Idaho Falls

(No. St.)

Registered No. 72

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

Evah Robson

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX 4. COLOR OR RACE 5. SINGLE, MARRIED, WIDOWED OR DIVORCED.

Female White Child (Write the word.)

6. DATE OF BIRTH

Sept 22 1913 (Month) (Day) (Year)

7. AGE

x yrs. x mos. 18 ds.

IF LESS than 1 day how many hrs. or mins.?

8. OCCUPATION

(a) Trade, profession or particular kind of work
(b) General nature of industry, business, or establishment in which employed (or employer)

Child

9. BIRTHPLACE

(State or Country) Idaho

10. NAME OF FATHER

Clarence Robson

11. BIRTHPLACE OF FATHER

(State or Country) Utah

12. MAIDEN NAME OF MOTHER

Evah Robson Field

13. BIRTHPLACE OF MOTHER

(State or Country) Coltrane, Ida

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Clarence Robson

(Address)

15. Filed Oct 1 1913

Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

October 10 1913 (Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from

Oct 7 1913, to Oct 10 1913

that I last saw her alive on October 10 1913

and that death occurred on the date stated above, at 11 P.M.

The CAUSE OF DEATH* was as follows:

Broncho pneumonia

(Duration) yrs. mos. 6-7 ds.

Contributory (Secondary) Gastric infection

(Duration) yrs. mos. ds.

(Signed) M. D.

Oct 11 1913 (Address)

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death.....yrs.....mos.....days. In the State.....yrs.....mos.....days.

Where was disease contracted if not at place of death?.....

Former or usual residence.....

19. PLACE OF BURIAL OR REMOVAL DATE OF BURIAL

Idaho Falls 10/12/13

20. UNDERTAKER ADDRESS

B. E. Hinwood, Idaho Falls

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Form V. S. No. 5 20M.1-16-12

CERTIFICATE OF DEATH

 State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

 1. PLACE OF DEATH
County of Bonneville
City of Larkspur
Registration District No. 73
Primary Registration District No. 2150
(No. _____, _____ St.)

 File No. 6273
Registered No. 71

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME N.C. McFadden

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

 3. SEX Male 4. COLOR OR RACE White 5. SINGLE, MARRIED, WIDOWED OR DIVORCED. Single
(Write the word.)

 6. DATE OF BIRTH ?
(Month) (Day) (Year)

 7. AGE ? IF LESS than 1 day
how many _____ hrs. or _____ mins.?
_____ yrs. _____ mos. _____ ds.

8. OCCUPATION

 (a) Trade, profession or particular kind of work ?
(b) General nature of industry, business, or establishment in which employed (or employer)

 9. BIRTHPLACE ?
(State or Country)

 10. NAME OF FATHER ?

 11. BIRTHPLACE OF FATHER ?
(State or Country)

 12. MAIDEN NAME OF MOTHER ?

 13. BIRTHPLACE OF MOTHER ?
(State or Country)

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) W. J. McFadden(Address) Larkspur, Colo.

15.

Filed Sept. 29 1913

Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH

Sept. 18 1913
(Month) (Day) (Year)

 17. I HEREBY CERTIFY, That I attended deceased from Sept. 2 1913 to Sept. 18 1913

 that I last saw him alive on Sept. 18 1913

 and that death occurred on the date stated above, at 10 M.

The CAUSE OF DEATH* was as follows:

Chronic nephritis
 (Duration) Indefinite yrs. mos. ds.

 Contributory (Secondary) Stomach weakness

 (Duration) Indefinite yrs. mos. ds.

 (Signed) John W. Mellor M. D.

 9/29 1913 (Address) Idaho Falls

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death _____ yrs. _____ mos. _____ days. In the State _____ yrs. _____ mos. _____ days.

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL DATE OF BURIAL

Idaho Falls, Idaho. Sept. 29 1913

20. UNDERTAKER ADDRESS

G. H. Hunt Idaho Falls.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Form V. S. No. 5 20M.1-16-12

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH.

Registration District No. 1County of AdaPrimary Registration District No. 2003City of Meridian(No. near Meridian St.)File No. 6284

Registered No. _____

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

Freddie Lee Ulmar

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX

Male

4. COLOR OR RACE

White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED.

Single
(Write the word.)

6. DATE OF BIRTH

Feb. 22 1893
(Month) (Day) (Year)

7. AGE

20 yrs. 7 mos. 28 ds.

IF LESS than 1 day
how many hrs. or
..... mins.?

8. OCCUPATION

(a) Trade, profession or particular kind of work
(b) General nature of industry, business, or establishment in which employed (or employer)

Farmer

9. BIRTHPLACE

(State or Country)

Mo.

10. NAME OF FATHER

T. E. Ulmar

11. BIRTHPLACE OF FATHER

(State or Country)

Ind.

12. MAIDEN NAME OF MOTHER

Eora Robinson

13. BIRTHPLACE OF MOTHER

(State or Country)

Mo.

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

T. E. Ulmar

(Address)

Meridian Idaho

15.

Filed

Sept 21 1913
Sept 21 1913

C. L. Dutton
Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH

Sept 20 1913
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from

Sept 14 1913, to Sept 20 1913,
that I last saw him alive on Sept 20 1913,
and that death occurred on the date stated above, at 5:45 P.M.

The CAUSE OF DEATH* was as follows:

Typhoid fever with
valvular leak.

(Duration) yrs. mos. 7 ds.

Contributory
(Secondary)

Typhoid

(Duration) yrs. mos. ds.

(Signed)

H. F. Neal M. D.

19. (Address) Meridian Idaho

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death.....yrs.....mos.....days. In the State.....yrs.....mos.....days.

Where was disease contracted if not at place of death?.....

Former or usual residence.....

19. PLACE OF BURIAL OR REMOVAL DATE OF BURIAL

Meridian Cemetery Sept 21 1913

20. UNDERTAKER

ADDRESS

Schubert & Widener Boise

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. MARGIN RESERVED FOR BINDING. N. B.—Every item of information should be carefully supplied. AGE should be state EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Form V. S. No. 5. 10M. 6-20-11.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH.

Registration District No. 1

County of Ada

Primary Registration District No. 2003

City of Meridian

(No. , St.)

Registered No. 6281

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Edward Barber

If death occurred in a hospital, institution or camp give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX

4. COLOR OR RACE 5. SINGLE, MARRIED, WIDOWED OR DIVORCED.

male white single (Write the words)

6. DATE OF BIRTH

May - 23rd 1913 (Month) (Day) (Year)

7. AGE

3 yrs. 3 mos. ds. IF LESS than 1 day how many hrs. or min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work none
(b) General nature of industry business or establishment in which employed (or employer)

9. BIRTHPLACE

(State or Country) Ada Co. Idaho

10. NAME OF FATHER

John P Barber

11. BIRTHPLACE OF FATHER

(State or Country) Kan

12. MAIDEN NAME OF MOTHER

Edith M. Mascher

13. BIRTHPLACE OF MOTHER

(State or Country) Mo

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) H. F. Neal

(Address) Meridian Idaho

15.

Filed Oct 11th 1913 C. L. Dutton Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

Aug. 23 1913 (Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from

Aug 22 1913, to Aug 23 1913

that I last saw him alive on Aug 22 1913,

and that death occurred on the date stated above, at 10 A. M.

The CAUSE OF DEATH* was as follows:

Acute Gastro Enteric fever

(Duration) yrs. 2 mos. ds.

Contributory (Secondary) Two Previous acts

(Duration) yrs. mos. ds.

(Signed) H. F. Neal M. D.

Aug 23 1913 (Address) Meridian Idaho

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted.

If not at place of death?

Former or usual residence.

19. PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

O O F Cemetery Aug 25 1913

20. UNDERTAKER

ADDRESS

A. R. Staller

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Form V. S. No. 5. 10M. 6-20-11.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH. Registration District No. 1
County of Ada Primary Registration District No. 2003
City of Meridian (No. 1 St.)

File No. 6282

Registered No. _____

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

Virmona H. Knifed Stauch
If death occurred in a hospital, institution or nursing home, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX 4. COLOR OR RACE 5. SINGLE, MARRIED, WIDOWED OR DIVORCED.

Male White Single
(Write the word.)

6. DATE OF BIRTH

Jan 3 1904
(Month) (Day) (Year)

7. AGE

9 yrs. 10 mos. 3 ds. IF LESS than 1 day how many hrs. or min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work
(b) General nature of industry business or establishment in which employed (or employer)

9. BIRTHPLACE

(State or Country) Meridian, Ada Co., Id.

10. NAME OF FATHER

Royal A. Stanton

11. BIRTHPLACE OF FATHER

(State or Country) Idaho

12. MAIDEN NAME OF MOTHER

Dora Miller

13. BIRTHPLACE OF MOTHER

(State or Country) Iowa

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Royal A. Stanton

(Address) Meridian, Idaho

15.

Filed Nov. 6th 1913 R. L. Gutter
Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

Nov. 5 1913
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from

Oct. 25 1913, to Nov. 5 1913

that I last saw him alive on Nov. 5 1913

and that death occurred on the date stated above, at 6:45 A.M.

The CAUSE OF DEATH* was as follows:

Myocarditis

(Duration) yrs. mos. ds. 7
Contributory (Secondary) Rosaries & Rheumatism

(Duration) yrs. mos. ds. 10

(Signed) H. F. Neal M. D.
Nov. 5 1913 (Address) Meridian, Idaho

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death..... yrs..... mos..... ds. State..... yrs..... mos..... ds.

Where was disease contracted,
If not at place of death?.....
Former or usual residence.....

19. PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

Meridian Cemetery 1913

20. UNDERTAKER

ADDRESS

none

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Form V. S. No. 5 20M.1-16-12

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH.

Registration District No. 1County of AdairPrimary Registration District No. 2003File No. 6283City of Mora, Ida.

(No. _____, _____ St.)

Registered No. _____

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Anna McKinnick Fairchild
If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX

4. COLOR OR RACE

5. SINGLE, MARRIED, WID-
OWED OR DIVORCED.Female White Single
(Write the word.)

6. DATE OF BIRTH

March 17th 1911
(Month) (Day) (Year)

7. AGE

2 yrs. 6 mos. 28 ds.IF LESS than 1 day
how many _____ hrs. or
_____ mins.?

8. OCCUPATION

(a) Trade, profession or
particular kind of work(b) General nature of industry
business, or establishment in
which employed (or employer)none

9. BIRTHPLACE

(State or Country)

Boise Idaho.10. NAME OF
FATHERSherman D. Fairchild11. BIRTHPLACE
OF FATHER

(State or Country)

Idaho12. MAIDEN NAME
OF MOTHERGertrude Buchanan13. BIRTHPLACE
OF MOTHER

(State or Country)

Mason City, Ill.

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

Sherman D. Fairchild

(Address)

Mora Idaho

15.

Filed

Oct-10-1913C. L. Sutton

Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH

191
(Month) (Day) (Year)17. I HEREBY CERTIFY, That I attended deceased not at all191, to 191,that I last saw h alive on 191,and that death occurred on the date stated above, at M.

The CAUSE OF DEATH* was as follows:

Enterocolitis with subsequent depression

(Duration) _____ yrs. _____ mos. _____ ds.

Contributory
(Secondary)

(Duration) _____ yrs. _____ mos. _____ ds.

(Signed)

C. L. Sutton

M. D. -

10/15/1913, (Address)

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death _____ yrs. _____ mos. _____ days. In the State _____ yrs. _____ mos. _____ days.

Where was disease contracted
if not at place of death?Former or
usual residence

19. PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

Mora IdahoOct-15 1913

20. UNDERTAKER

ADDRESS

Sherman D. FairchildMoraAdair

MARGIN RESERVED FOR BINDING
WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Form V. S. No. 5 20M.1-16-12

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH.

Registration District No. 121

County of Bingham

Primary Registration District No. 1007

City of Blackfoot

(No. Hoofbeat & Hoarse St.)

File No. 6281

Registered No. 206

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Jessie B Warren

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX

4. COLOR OR RACE

5. SINGLE, MARRIED, WIDOWED OR DIVORCED.

Male

White

Married
(Write the word.)

6. DATE OF BIRTH

May
(Month)

28
(Day)

1883
(Year)

7. AGE

36 yrs. 4 mos. 7 ds.

IF LESS than 1 day
how many hrs. or
..... mins.

8. OCCUPATION

(a) Trade, profession or particular kind of work

Farmer

(b) General nature of industry business, or establishment in which employed (or employer)

9. BIRTHPLACE

(State or Country)

Mapleton Utah

10. NAME OF FATHER

Amos B Warren

11. BIRTHPLACE OF FATHER

(State or Country)

Springville Utah

12. MAIDEN NAME OF MOTHER

Leah Ann Johnson

13. BIRTHPLACE OF MOTHER

(State or Country)

Springville Utah

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

E. M. Snow

(Address)

Mapleton Utah

15.

Filed Oct 26 1913

W. E. Purdie
Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

Oct
(Month)

25
(Day)

1913
(Year)

17. I HEREBY CERTIFY, That I attended deceased from

Oct 20 1913 to Oct 25 1913

that I last saw him alive on Oct 25 1913.

and that death occurred on the date stated above, 25.

The CAUSE OF DEATH* was as follows:

Peritonitis

(Duration)

yrs.

mos.

ds.

Contributory
(Secondary)

Appendicitis

(Duration)

yrs.

mos.

ds.

(Signed)

F. W. Mitchell

M. D.

1475 1913 (Address) Blackfoot Idaho

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death

yrs.

mos.

days.

In the State

yrs.

mos.

days.

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

Mapleton Utah

101

20. UNDERTAKER

ADDRESS

E. J. Luck

Blackfoot

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Form V. S. No. 5 20M.1-16-12

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH.

Registration District No. 121

County of Bingham

Primary Registration District No. 1007

City of Blackfoot

(No. East Judicial St.)

File No. 6280

Registered No. 205

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Henry Duncan
If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX

Male

4. COLOR OR RACE

White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED.

Widowed
(Write the word.)

6. DATE OF BIRTH

July 17 1896
(Month) (Day) (Year)

7. AGE

87 yrs. 3 mos. 7 ds.

IF LESS than 1 day
how many hrs. or
..... mins.?

8. OCCUPATION

(a) Trade, profession or particular kind of work

Retired Farmer

(b) General nature of industry business, or establishment in which employed (or employer)

9. BIRTHPLACE

(State or Country)

Ind

10. NAME OF FATHER

William Duncan

11. BIRTHPLACE OF FATHER

(State or Country)

North Carolina

12. MAIDEN NAME OF MOTHER

Mary Emmett

13. BIRTHPLACE OF MOTHER

(State or Country)

Ind

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

James P. Duncan

(Address)

Aberdeen, Idaho

15.

Filed

Oct 24 1913 M. E. Pattee

Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH

Oct 24 1913
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from

Oct 1 1913, to Oct 24 1913.

that I last saw him alive on Oct 24 1913.

and that death occurred on the date stated above, at 2.0 M.

The CAUSE OF DEATH* was as follows:

myocardial degeneration of heart

(Duration) yrs. mos. ds.

Contributory chronic Bright's disease
(Secondary)

(Duration) yrs. mos. ds.

(Signed) H. J. Lumsden M. D.

10/24/1913 (Address) Blackfoot

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death yrs. mos. days. In the State yrs. mos. days.

Where was disease contracted if not at place of death?

Former or usual residence.....

19. PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

From City Cemetery

Oct 25 1913

20. UNDERTAKER

ADDRESS

E. J. Peck

Blackfoot

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Form V. S. No. 5 20M.1-16-12

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH.

Registration District No. 121

County of Bingham

Primary Registration District No. 2194

City of Rich

(No. _____, _____ St.)

File No. 6285

Registered No. 204

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Lawrence Ostberg

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX

male

4. COLOR OR RACE

white

5. SINGLE, MARRIED, WIDOWED OR DIVORCED.

(Write the word.)

6. DATE OF BIRTH

Oct 23 1913
(Month) (Day) (Year)

7. AGE

_____ yrs. _____ mos. _____ ds.

IF LESS than 1 day
how many _____ hrs. or
_____ mins.?

8. OCCUPATION

(a) Trade, profession or particular kind of work

none

(b) General nature of industry business, or establishment in which employed (or employer)

9. BIRTHPLACE

(State or Country)

Bingham Co Idaho

10. NAME OF FATHER

Lawrence Ostberg

11. BIRTHPLACE OF FATHER

(State or Country)

Idaho

12. MAIDEN NAME OF MOTHER

Gae McMurder

13. BIRTHPLACE OF MOTHER

(State or Country)

Idaho

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

Lawrence Ostberg

(Address)

Rich Idaho

15.

Filed

Oct 24 1913

M. E. Putrie

Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH

Oct 23 1913
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from

Oct 23 1913, to Oct 23 1913,

that I last saw him alive on 1913,

and that death occurred on the date stated above, at 2:30 M.

The CAUSE OF DEATH* was as follows:

Premature Birth

(Duration) _____ yrs. _____ mos. _____ ds.

Contributory Toxemia of mother
(Secondary)

(Duration) _____ yrs. _____ mos. _____ ds.

(Signed) H. D. Summers M. D.

10/23 1913 (Address) Blackfoot, Ida

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death _____ yrs. _____ mos. _____ days. In the State _____ yrs. _____ mos. _____ days.

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL DATE OF BURIAL

Grand Lash Thomas, Rich Oct 24 1913

20. UNDERTAKER

E. J. Park

ADDRESS

Blackfoot

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Form V. S. No. 5 20M.1-16-12

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH.

Registration District No. 121County of BinghamPrimary Registration District No. 1007City of Blackfoot(No. Blackfoot General Hospital)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Russ Margarette MorrillFile No. 6281Registered No. 203

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX

Female

4. COLOR OR RACE

White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED.

Single
(Write the word.)

6. DATE OF BIRTH

11

(Month)

13

(Day)

1892

(Year)

7. AGE

19 yrs. 11 mos. 10 ds.IF LESS than 1 day
how many hrs. or
..... mins.?

8. OCCUPATION

(a) Trade, profession or particular kind of work

School Girl

(b) General nature of industry business, or establishment in which employed (or employer)

9. BIRTHPLACE

(State or Country)

Blaine Co Idaho

10. NAME OF FATHER

Single Morrill

11. BIRTHPLACE OF FATHER

(State or Country)

Kansas

12. MAIDEN NAME OF MOTHER

Jennie Waring

13. BIRTHPLACE OF MOTHER

(State or Country)

Idaho

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

Gilbert H Waring

(Address)

Glenns Ferry Ida.

15.

Filed

Oct. 231912W. E. Paton

Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH

Oct

(Month)

23

(Day)

1913

(Year)

17. I HEREBY CERTIFY, That I attended deceased from

Sept. 15 1912 to Oct. 23 1913that I last saw him alive on Oct. 23 1913and that death occurred on the date stated above, at 11 A.M.

The CAUSE OF DEATH* was as follows:

Miliary Tuberculosis(Duration) yrs. 2 mos. ds.Contributory
(Secondary)

(Duration) yrs. mos. ds.

(Signed)

W. E. Paton

M. D.

(Address) Blackfoot Idaho

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death yrs. 1 mos. 7 days. In the State yrs. mos. days.Where was disease contracted if not at place of death? Fairfield IdahoFormer or usual residence Fairfield Idaho

19. PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

Fairfield Blaine Co IdaOct 1913

20. UNDERTAKER

ADDRESS

E. J. BeckBlackfoot Idaho

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Form V. S. No. 5 20M.1-16-12

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH Registration District No. 121
County of Bingham Primary Registration District No. 1007
City of Blackfoot (No. 192, E. Sonny St.)
If death occurs away from usual residence, give facts called for under special information.

File No. 6285

Registered No.

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Ruben Jermain Osborn

PERSONAL AND STATISTICAL PARTICULARS

MEDICAL CERTIFICATE OF DEATH.

3. SEX 4. COLOR OR RACE 5. SINGLE, MARRIED, WIDOWED OR DIVORCED.
Male White (Write the word.)

16. DATE OF DEATH

6. DATE OF BIRTH

10 31 1837
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from Sept. 30 1913, to Oct. 19 1913, that I last saw him alive on Oct. 19 1913, and that death occurred on the date stated above, at 10:30 A.M.

7. AGE

75 yrs. 11 mos. 18 ds.

IF LESS than 1 day
how many hrs. or
..... mins.?

The CAUSE OF DEATH* was as follows:
on Sept. 30, 1913 fell from short ladder causing severe shock with slight injuries, immediate cause Heart Failure.

8. OCCUPATION

(a) Trade, profession or particular kind of work
(b) General nature of industry business, or establishment in which employed (or employer)

Retired Rancher
Blackfoot

9. BIRTHPLACE

(State or Country)

Fairfield, Indiana

10. NAME OF FATHER

Thomas Osborn

11. BIRTHPLACE OF FATHER

(State or Country)

Virginia

12. MAIDEN NAME OF MOTHER

Jedman

13. BIRTHPLACE OF MOTHER

(State or Country)

Don't Know

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

R. J. Osborn

(Address)

Salt Lake City, Utah

15.

Filed

Oct. 20 1913

W. E. Putney
Local Registrar

(Duration) yrs. mos. ds.
Contributory General Arterial Sclerosis
(Secondary)
(Duration) 30 yrs. mos. ds.
(Signed) Dr. J. H. Brown M. D.
10/20/1913 (Address) Blackfoot, Ida.

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death yrs. mos. days. In the State yrs. mos. days.

Where was disease contracted if not at place of death?
Former or usual residence.....

19. PLACE OF BURIAL OR REMOVAL DATE OF BURIAL
Gr. Home city cemetery Oct. 31 1913

20. UNDERTAKER ADDRESS
E. J. Link Blackfoot

Form V. S. No. 5 20M.1-16-12

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH.

Registration District No. 121County of BinghamPrimary Registration District No. 2194City of Blackfoot(No. Idaho Avenue Blackfoot St.)File No. 6289Registered No. 101

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

Marlin L Davis

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX

Male

4. COLOR OR RACE

White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED.

Married
(Write the word.)

6. DATE OF BIRTH

1848

(Month)

(Day)

(Year)

7. AGE

65 yrs.

mos.

ds.

IF LESS than 1 day
how many hrs. or
mins.?

8. OCCUPATION

(a) Trade, profession or particular kind of work

Farmer

(b) General nature of industry business, or establishment in which employed (or employer)

9. BIRTHPLACE

(State or Country)

Saline Co. Mo.

10. NAME OF FATHER

11. BIRTHPLACE OF FATHER

(State or Country)

12. MAIDEN NAME OF MOTHER

13. BIRTHPLACE OF MOTHER

(State or Country)

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

Geo. E. Rye

(Address)

Blackfoot, Idaho

15.

Filed

Oct 18 19131913M. C. Rye
Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH

October171913

(Month)

(Day)

(Year)

17. I HEREBY CERTIFY, That I attended deceased from

July 12 1913, to Oct 16 1913,
that I last saw him alive on Oct 16 1913and that death occurred on the date stated above, at 3-12A.M.

The CAUSE OF DEATH* was as follows:

apoplexy (Cerebral)(Duration) 5 yrs. 5 mos. — ds.Contributory
(Secondary)Arterial Sclerosis
Don't know(Duration) — yrs. — mos. — ds.

(Signed)

Geo. E. Rye

M. D.

Oct 18 1913(Address) Blackfoot

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death 5 yrs. 7 mos. 7 days. In the State 18 yrs. — mos. — days.Where was disease contracted if not at place of death? at Mountain Home, IdahoFormer or usual residence Mountain Home, Idaho

19. PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

Mountain Home191—

20. UNDERTAKER

ADDRESS

E. J. RyeBlackfoot

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Form V. S. No. 5 20M.1-16-12

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH.

Registration District No. 34

County of Elmore

Primary Registration District No. 2120

City of Mtn Home

(No. _____, St.)

File No. 6291

Registered No. 25

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

Josephine La Haie

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX

F

4. COLOR OR RACE

W

5. SINGLE, MARRIED, WIDOWED OR DIVORCED.

Single
(Write the word)

6. DATE OF BIRTH

Sep
(Month)

14
(Day)

1911
(Year)

7. AGE

2 yrs. 20 mos. 20 ds.

IF LESS than 1 day
how many _____ hrs. or
_____ mins.?

8. OCCUPATION

(a) Trade, profession or particular kind of work

(b) General nature of industry business, or establishment in which employed (or employer)

X

9. BIRTHPLACE

(State or Country) Elmore Co., Ida.

10. NAME OF FATHER

Albert La Haie

11. BIRTHPLACE OF FATHER

(State or Country) Province Quebec

12. MAIDEN NAME OF MOTHER

Clara Roshlan

13. BIRTHPLACE OF MOTHER

(State or Country) Wisconsin

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Albert La Haie

(Address) Mtn. Home, Ida.

15.

Filed Oct 4th 1913

B. W. Martin
Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

Oct

3rd

1913

(Month)

(Day)

(Year)

17. I HEREBY CERTIFY, That I attended deceased from

Oct 2 1913 to Oct 3 1913

that I last saw him alive on Oct 3 1913

and that death occurred on the date stated above, at 5 P. M.

The CAUSE OF DEATH* was as follows:

2nd degree burn of
one half surface of body

(Duration) 0 yrs. 0 mos. 0 ds.

Contributory
(Secondary)

(Duration) _____ yrs. _____ mos. _____ ds.

(Signed)

F. S. Hawley

M. D.

Oct 4, 1913 (Address) Mtn Home

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death _____ yrs. _____ mos. _____ days. In the State _____ yrs. _____ mos. _____ days.

Where was disease contracted if not at place of death?

Former or usual residence.

19. PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

Mtn Home Idaho Oct 4, 1913

20. UNDERTAKER

ADDRESS

J. M. Cowan

Mtn Home

Form V. S. No. 5. 10M. 6-20-11.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH.

Registration District No. 34County of EdmorePrimary Registration District No. 2020City of Int. Home

(No. _____, _____ St.)

File No. 6291Registered No. 24

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

Harriett E. Brantfield

If death occurred in a hospital, institution or camp give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX

F

4. COLOR OR RACE

W

5. SINGLE, MARRIED, WIDOWED OR DIVORCED.

(W) Married

6. DATE OF BIRTH

Feb.
(Month)19
(Day)1871
(Year)

7. AGE

42711

IF LESS than 1 day

how many _____ hrs. or

min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work

at home &

(b) General nature of industry business or establishment in which employed (or employer)

children

9. BIRTHPLACE

(State or Country)

Clark County, Ill.

10. NAME OF FATHER

Johnathan Brantfield

11. BIRTHPLACE OF FATHER

(State or Country)

Clark County, Ill.

12. MAIDEN NAME OF MOTHER

Rachel Morgan

13. BIRTHPLACE OF MOTHER

(State or Country)

Clark County, Ill.

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

(Address)

15.

Filed

Oct. 1st1913B. W. Walker

Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

Oct
(Month)1
(Day)1913
(Year)

17. I HEREBY CERTIFY, That I attended deceased from

July 8 1913, to Oct 1 1913that I last saw her alive on Oct 1 1913,and that death occurred on the date stated above, at 6:30 A.M.

The CAUSE OF DEATH* was as follows:

Valvular heart lesion -
(Mitral Stenosis) insufficiency(Duration) 13 yrs. _____ mos. _____ ds.Contributory (Secondary) Oedema, Suppression of
urine

(Duration) _____ yrs. _____ mos. _____ ds.

(Signed) W. P. Frazier M. D.Oct 1 1913 (Address) Int. Home

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL OR HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place

In the

of death _____ yrs. _____ mos. _____ ds. State _____ yrs. _____ mos. _____ ds.

Where was disease contracted.

If not at place of death?

Former or

usual residence

19. PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

Int. Home, Ida.Oct 2 1913

20. UNDERTAKER

ADDRESS

H. S. WilburInt. Home

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Form V. S. No. 5 20M.1-16-12		CERTIFICATE OF DEATH		State of Idaho BOARD OF HEALTH Bureau of Vital Statistics	
1. PLACE OF DEATH County of <u>Elmore</u> City of <u>Mountain View</u>		Registration District No. <u>34</u> Primary Registration District No. <u>2020</u> (No. _____ St.)		File No. <u>6292</u> Registered No. <u>26</u>	
If death occurs away from usual residence, give facts called for under special information.		2. FULL NAME <u>Ronald Cooper</u>		If death occurred in a hospital, institution or camp, give its NAME instead of street and number.	
PERSONAL AND STATISTICAL PARTICULARS					
3. SEX <u>Male</u>		4. COLOR OR RACE <u>White</u>		5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.)	
6. DATE OF BIRTH <u>May</u> <u>30</u> <u>1911</u> (Month) (Day) (Year)					
7. AGE <u>2</u> yrs. <u>4</u> mos. — ds. IF LESS than 1 day how many _____ hrs. or _____ mins.?					
8. OCCUPATION (a) Trade, profession or particular kind of work (b) General nature of industry, business, or establishment in which employed (or employer)					
9. BIRTHPLACE <u>Montana</u> (State or Country)					
10. NAME OF FATHER <u>A. N. Cooper</u>					
11. BIRTHPLACE OF FATHER <u>Ontario Canada</u> (State or Country)					
12. MAIDEN NAME OF MOTHER <u>Flora Tripp</u>					
13. BIRTHPLACE OF MOTHER <u>Maine</u> (State or Country)					
14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE (Informant) <u>A. N. Cooper</u> (Address) <u>Mountain View</u>					
15. Filed <u>Oct. 8th</u> <u>1913</u> <u>Burkhalter</u> Local Registrar					
MEDICAL CERTIFICATE OF DEATH					
16. DATE OF DEATH <u>Oct</u> <u>7</u> <u>1913</u> (Month) (Day) (Year)					
17. I HEREBY CERTIFY, That I attended deceased from <u>Oct 1</u> <u>1913</u> , to <u>Oct 7</u> <u>1913</u> , that I last saw him alive on <u>Oct 7</u> <u>1913</u> , and that death occurred on the date stated above, at <u>3 P.M.</u> The CAUSE OF DEATH* was as follows: <u>Acute Enteritis</u>					
(Duration) _____ yrs. _____ mos. <u>7</u> ds. Contributory <u>Pneumonia (broncho)</u> (Secondary) (Duration) _____ yrs. _____ mos. <u>2</u> ds. (Signed) <u>W. L. Frazer</u> M. D. <u>Oct 8 1913</u> (Address) <u>mt. home</u>					
*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.					
18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.) At place of death _____ yrs. _____ mos. _____ days. In the State _____ yrs. _____ mos. _____ days. Where was disease contracted if not at place of death? Former or usual residence _____					
19. PLACE OF BURIAL OR REMOVAL <u>Mountain View</u> DATE OF BURIAL <u>Oct 9</u> <u>1913</u>					
20. UNDERTAKER <u>J. M. Owens</u> ADDRESS <u>Mountain View</u>					

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Form V. S. No. 5 20M.1-16-12

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH.

Registration District No. 69County of BinghamPrimary Registration District No. 2147City of Woodville

(No. _____, _____ St.)

Registered No. _____

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME William Oran Mangrum

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX

M.

4. COLOR OR RACE

W.

5. SINGLE, MARRIED, WIDOWED OR DIVORCED.

(Write the word)

6. DATE OF BIRTH

July 22 - 1913
(Month) (Day) (Year)

7. AGE

1 yrs. 1 mos. 12 ds.IF LESS than 1 day
how many hrs. or
..... mins.?

8. OCCUPATION

(a) Trade, profession or particular kind of work
(b) General nature of industry, business, or establishment in which employed (or employer)St. Roman

9. BIRTHPLACE

(State or Country) Woodville Idaho.

10. NAME OF FATHER

Mr. Oran Mangrum

11. BIRTHPLACE OF FATHER

(State or Country) Utah.

12. MAIDEN NAME OF MOTHER

Lavina Thurston.

13. BIRTHPLACE OF MOTHER

(State or Country) Utah.

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) William Oran Mangrum.(Address) R#4 Idaho Falls.

15.

Filed 9-4- 1913 Edwin Crites
Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH

Sept 3 1913
(Month) (Day) (Year)17. I HEREBY CERTIFY, That I attended deceased from Sept 3 1913, to Sept 3 1913that I last saw him alive on Sept 3 1913and that death occurred on the date stated above, at 9:00 M.

The CAUSE OF DEATH* was as follows:

Cholera Infantum

(Duration) yrs. mos. ds.

Contributory
(Secondary)

(Duration) yrs. mos. ds.

(Signed) W. E. Roberts M. D.Sept 19 1913 (Address) Shelley Idaho

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death yrs. mos. days. In the State yrs. mos. days.

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL

Woodville Sept - 9. 1913

20. UNDERTAKER

Dr. Roberts

ADDRESS

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Form V. S. No. 5 20M.1-16-12

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH. Registration District No. 69
County of Bingham Primary Registration District No. 2147
City of Shelley (No. _____ St.)

File No. 6295

Registered No. _____

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Charles Khol

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX M. 4. COLOR OR RACE Wh. 5. SINGLE, MARRIED, WID-
OWED OR DIVORCED Married
(Write the word.)

6. DATE OF BIRTH

Nov. 17 1
(Month) (Day) (Year)

7. AGE

50 yrs. 10 mos. 17 ds.

IF LESS than 1 day
how many hrs. or
..... mins.?

8. OCCUPATION

(a) Trade, profession or
particular kind of work
(b) General nature of industry
business, or establishment in
which employed (or employer)

Farmer

9. BIRTHPLACE

(State or Country)

Ohio

10. NAME OF FATHER

John Jacob Holm

11. BIRTHPLACE OF FATHER

(State or Country)

Germany

12. MAIDEN NAME OF MOTHER

Patricia

13. BIRTHPLACE OF MOTHER

(State or Country)

Germany

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

J. W. Bequith

(Address)

Shelley

15.

Filed 9-27 1913

Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH

9 — 28 1913
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from

..... 191....., to 191.....,
that I last saw h. alive on 191.....,

and that death occurred on the date stated above, at M.

The CAUSE OF DEATH* was as follows:

Cause of death not reported

..... (Duration) yrs. mos. ds.

Contributory
(Secondary)

..... (Duration) yrs. mos. ds.

(Signed) M. D.

19. (Address)

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death yrs. mos. days. In the State yrs. mos. days.

Where was disease contracted
if not at place of death?

Former or
usual residence

19. PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

Idaho Falls Ida. 9-29 1913

20. UNDERTAKER

ADDRESS

C. E. Dinwoodie Ida. Falls, Ida.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Form V. S. No. 5 20M.1-16-12

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics
6295

1. PLACE OF DEATH
County of Bingham
City of Taylor
Registration District No. 69
Primary Registration District No. 2147
(No. _____, St.)

File No. _____ Registered No. _____

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Died with out name

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX F 4. COLOR OR RACE W. 5. SINGLE, MARRIED, WIDOWED OR DIVORCED Infant
(Write the word.)

6. DATE OF BIRTH

10 — 14 1913
(Month) (Day) (Year)

7. AGE

_____ yrs. _____ mos. 1 ds.

IF LESS than 1 day
how many _____ hrs. or
_____ mins.?

8. OCCUPATION

(a) Trade, profession or particular kind of work _____

(b) General nature of industry business, or establishment in which employed (or employer) _____

9. BIRTHPLACE

(State or Country) Taylor10. NAME OF FATHER H. C. Thomas

11. BIRTHPLACE OF FATHER

(State or Country) Utah12. MAIDEN NAME OF MOTHER Amelia Lewis

13. BIRTHPLACE OF MOTHER

(State or Country) Utah

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) H. M. O. Thomas(Address) Shelley R. D # 1

15.

Filed 10-16 1915Edwin Miller

Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

10 — 15 1915
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from

1915, to 1915,that I last saw h. alive on 1915,and that death occurred on the date stated above, at M.

The CAUSE OF DEATH was as follows:

Int. Anemia

(Duration) _____ yrs. _____ mos. _____ ds.

Contributory
(Secondary)

(Duration) _____ yrs. _____ mos. _____ ds.

(Signed) W. M. O. Thomas M. D.

19. (Address) _____

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death. _____ yrs. _____ mos. _____ days. In the State. _____ yrs. _____ mos. _____ days.

Where was disease contracted if not at place of death?

Former or usual residence _____

19. PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

Taylor10-16 1915

20. UNDERTAKER

ADDRESS

Dr. Miller

Form V. S. No. 5 20M.1-16-12

CERTIFICATE OF DEATH

 State of Idaho
 BOARD OF HEALTH
 Bureau of Vital Statistics

1. PLACE OF DEATH.

Registration District No. 47County of LewisPrimary Registration District No. 2124City of Keyperce

(No. _____, _____ St.)

File No. 6298Registered No. 6

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Alga Clarice Ranney

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX

F

4. COLOR OR RACE

W

5. SINGLE, MARRIED, WIDOWED OR DIVORCED.

Single
(Write the word.)

6. DATE OF BIRTH

3 (Month) 4 (Day) 1913 (Year)

7. AGE

13 yrs. 7 mos. 10 ds.
 IF LESS than 1 day
 how many _____ hrs. or
 _____ mins.?

8. OCCUPATION

(a) Trade, profession or particular kind of work

none

(b) General nature of industry business, or establishment in which employed (or employer)

9. BIRTHPLACE

(State or Country)

Russell Ida

10. NAME OF FATHER

W J Ranney

11. BIRTHPLACE OF FATHER

(State or Country)

Idaho

12. MAIDEN NAME OF MOTHER

Bertha Whitney

13. BIRTHPLACE OF MOTHER

(State or Country)

Oregon

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

W J Ranney

(Address)

Keyperce Ida

15.

Filed

Oct 15 1913D W James

Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH

10 (Month) 14 (Day) 1913 (Year)

17. I HEREBY CERTIFY, That I attended deceased from

Jenny 1913, to Oct 1913
 that I last saw her alive on Oct 10 1913
and that death occurred on the date stated above, at 6 AM.

The CAUSE OF DEATH* was as follows:

Stroke - right
brain
about one year
 (Duration) _____ yrs. _____ mos. _____ ds.
Contributory
(Secondary)

(Duration) _____ yrs. _____ mos. _____ ds.

(Signed) D W James - M. D.10-14-1913 (Address) Keyperce

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death _____ yrs. _____ mos. _____ days. In the State _____ yrs. _____ mos. _____ days.

Where was disease contracted if not at place of death? _____

Former or usual residence. _____

19. PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

KeyperceOct 15 1913

20. UNDERTAKER

ADDRESS

P. S. MillerKeyperce

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Form V. S. No. 5. 12½ M. 7-24-11

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH.
County of Benewah
City of Wendover

Registration District No. 47
Primary Registration District No. 2174
(No. _____, St.)

File No. 6299
Registered No. 5

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Theodore Riggins

If death occurred in a hospital, institution or camp give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX Male 4. COLOR OR RACE White 5. SINGLE, MARRIED, WIDOWED OR DIVORCED. Single
(Write the word.)

6. DATE OF BIRTH Oct 13th 1910
(Month) (Day) (Year)

7. AGE 2 yrs. 9 mos. 24 ds. IF LESS than 1 day how many _____ hrs. or _____ min?

8. OCCUPATION

(a) Trade, profession or particular kind of work. none
(b) General nature of industry business or establishment in which employed (or employer)

9. BIRTHPLACE

(State or Country) Texas to Idaho

10. NAME OF FATHER

Fred Riggins

11. BIRTHPLACE OF FATHER

(State or Country) Germany

12. MAIDEN NAME OF MOTHER

Erlene Koepf

13. BIRTHPLACE OF MOTHER

(State or Country) Germany

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Fred Riggers
(Address) Nezperce

15.

Filed Nov 7 1913 H. H. Jones
Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH

August 7 1913
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from _____ 191____, to _____ 191____

that I last saw h_____ alive on _____ 191____

and that death occurred on the date stated above, at 10 P.M.

The CAUSE OF DEATH* was as follows:

Injury - from skull
knocked by horse in back
of head
(Duration) _____ yrs. _____ mos. _____ ds.

Contributory
(Secondary)

(Duration) _____ yrs. _____ mos. _____ ds.
(Signed) P. E. Miller M. D.
19 _____ (Address) Nezperce

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place _____ In the _____
of death _____ yrs. _____ mos. _____ ds. State _____ yrs. _____ mos. _____ ds.
Where was disease contracted,
If not at place of death? _____
Former or
usual residence _____

19. PLACE OF BURIAL OR REMOVAL DATE OF BURIAL

Nezperce Aug 9 1913

20. UNDERTAKER ADDRESS

P. E. Miller Nezperce

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Form V. S. No. 5 20M.1-16-12

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH.

Registration District No. 18

County of MinidokaPrimary Registration District No. 2102City of Eden

(No. _____ St.)

File No. 639Registered No. 4

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

James H. Nichols

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX

4. COLOR OR RACE

5. SINGLE, MARRIED, WIDOWED OR DIVORCED.

Male whiteSingle (Widowed word.)

6. DATE OF BIRTH

(Month) _____ (Day) _____ (Year) _____

7. AGE

28 yrs. _____ mos. _____ ds.IF LESS than 1 day
how many _____ hrs. or
_____ mins.?

8. OCCUPATION

(a) Trade, profession or particular kind of work

(b) General nature of industry business, or establishment in which employed (or employer)

farmer

9. BIRTHPLACE

(State or Country)

Michigan

10. NAME OF FATHER

George Nichols

11. BIRTHPLACE OF FATHER

(State or Country)

12. MAIDEN NAME OF MOTHER

13. BIRTHPLACE OF MOTHER

(State or Country)

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

(Address)

Lee T. Loya
Eden, Idaho

15.

Filed

Aug 181913John H. Nichols
John H. Nichols
Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH

Aug.151913

(Month)

(Day)

(Year)

17. I HEREBY CERTIFY, That I attended deceased from

after death to 1913that I last saw him alive on 1913and that death occurred on the date stated above, at M.

The CAUSE OF DEATH* was as follows:

Gunshot Wounds

(Duration) _____ yrs. _____ mos. _____ ds.

Contributory
(Secondary)

(Duration) _____ yrs. _____ mos. _____ ds.

(Signed) B. O. Barnes M. D.19 _____ (Address) Justice of Peace

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death _____ yrs. _____ mos. _____ days. In the State _____ yrs. _____ mos. _____ days.

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL DATE OF BURIAL

Branscity Michigan 1913

20. UNDERTAKER

ADDRESS

J. J. Groome Idaho Falls

CERTIFICATE OF DEATH

State of Idaho

BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH.

Registration District No.

County of Idaho

Primary Registration District No.

City of Boise

(No., St.)

File No. 6301

Registered No.

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Robert Alexander Grant

If death occurred in a hospital, institution or camp give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX

Male

4. COLOR OR RACE

White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED.

Married
(Write the word.)

6. DATE OF BIRTH

June 21 1864
(Month) (Day) (Year)

7. AGE

49 yrs. 9 mos. ds.IF LESS than 1 day
how many hrs. or
..... min?

8. OCCUPATION

(a) Trade, profession or particular kind of work.

(b) General nature of industry business or establishment in which employed (or employer)

Theatrical Manager

9. BIRTHPLACE

(State or Country)

Virginia

10. NAME OF FATHER

James P. Grant

11. BIRTHPLACE OF FATHER

(State or Country)

Penn.

12. MAIDEN NAME OF MOTHER

Virginia Sloan

13. BIRTHPLACE OF MOTHER

(State or Country)

Richmond Virginia

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

Ethel A. Grant(Address) Burley 2da.

15.

Filed 191V. A. Killen
Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH

March 23 1913
(Month) (Day) (Year)17. I HEREBY CERTIFY, That I attended deceased from February 1911, to March 23 1913that I last saw him alive on March 23 1913
and that death occurred on the date stated above, at 11:25 P.

The CAUSE OF DEATH* was as follows:

Cerebral hemorrhage(Duration) 2 yrs. 19 mos. 19 ds.Contributory
(Secondary)(Duration) 2 yrs. 19 mos. 19 ds.

(Signed)

John M. Minter M. D.
Feb 25 1913 (Address) Burley 2da.

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place In the
of death yrs. mos. ds. State yrs. mos. ds.Where was disease contracted,
If not at place of death?Former or
usual residence.

19. PLACE OF BURIAL OR REMOVAL DATE OF BURIAL

Burley 2da March 1913

20. UNDERTAKER

ADDRESS

L. B. Talbot Burley 2da

WHITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. CLAIMS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. If
CLANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact state-
ment of OCCUPATION is very important. See instructions on back of certificate.

Form V. S. No. 5. 10M. 6-20-11.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH

Registration District No. 34

County of Elmore

Primary Registration District No. 2020

City of Mountain Home

(No. Painck Bommer St.)

File No. 6302

Registered No. 19

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

Painck Bommer

If death occurred in a hospital, institution or camp give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX

Male

4. COLOR OR RACE

White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED.

Single
(Write the word)

6. DATE OF BIRTH

Unknown
(Month) (Day) (Year)

7. AGE

65 yrs. — mos. — ds.

IF LESS than 1 day
how many . . . hrs. or
. . . min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work
(b) General nature of industry business or establishment in which employed (or employer)

Miner

9. BIRTHPLACE

(State or Country)

Pennsylvania

10. NAME OF FATHER

Not known

11. BIRTHPLACE OF FATHER

(State or Country)

" "

12. MAIDEN NAME OF MOTHER

" "

13. BIRTHPLACE OF MOTHER

(State or Country)

" "

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

(Address)

John B. Calawell
Mountain Home

15.

Filed July 28th 1913

Burkhalter
Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

July 28 1913
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from

July 20 1913, to July 28 1913

that I last saw him alive on July 27 1913,
and that death occurred on the date stated above, at 4 a M.

The CAUSE OF DEATH* was as follows:

Pneumonia (Toxoid)

(Duration) . . . yrs. . . mos. 14 ds.

Contributory
(Secondary)

(Duration) . . . yrs. . . mos. . . ds.

(Signed) W. H. Frazer M. D.

July 28 1913 (Address) Mountain Home

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place . . . yrs. . . mos. . . ds. In the
of death . . . yrs. . . mos. . . ds. State . . . yrs. . . mos. . . ds.

Where was disease contracted,
If not at place of death?

Former or
usual residence.

19. PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

Mountain Home July 29 1913

20. UNDERTAKER

ADDRESS

J. M. Conner Mountain Home

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Form V. S. No. 5 20M.1-16-12

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics
File No. 6303
Registered No. _____
If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

1. PLACE OF DEATH. Registration District No. ~~97~~ 97.
County of Lapwai Primary Registration District No. 2174
City of Heyburn (No. _____ St.)
If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Ruby Grace Hook

PERSONAL AND STATISTICAL PARTICULARS

3. SEX F 4. COLOR OR RACE W 5. SINGLE, MARRIED, WIDOWED OR DIVORCED. Widowed
(Write the word.)

6. DATE OF BIRTH 6 1890
(Month) (Day) (Year)

7. AGE 23 yrs. 0 mos. 0 ds. IF LESS than 1 day how many hrs. or mins.?

8. OCCUPATION (a) Trade, profession or particular kind of work House wife
(b) General nature of industry, business, or establishment in which employed (or employer)

9. BIRTHPLACE Idaho
(State or Country)

10. NAME OF FATHER Geo W Jenkins

11. BIRTHPLACE OF FATHER Idaho
(State or Country)

12. MAIDEN NAME OF MOTHER Ella Juncos

13. BIRTHPLACE OF MOTHER Idaho
(State or Country)

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Geo W Jenkins
(Address) Lapwai, Ida

15. Filed July 26 1913 John H. Allen
Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH 7 25 1913
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from Feb 12 1913 to July 1913
that I last saw him alive on _____ 1913
and that death occurred on the date stated above, at 2 P.M.

The CAUSE OF DEATH* was as follows:
Pulmonary Tuberculosis

6 (Duration) 6 yrs. 6 mos. 0 ds.
Contributory (Secondary) _____
(Duration) yrs. mos. ds.
(Signed) John H. Allen M. D.
19 (Address) _____

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL OR HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death _____ yrs. _____ mos. _____ days. In the State _____ yrs. _____ mos. _____ days.
Where was disease contracted if not at place of death? _____
Former or usual residence _____

19. PLACE OF BURIAL OR REMOVAL Reverton DATE OF BURIAL July 26 1913

20. UNDERTAKER Wasson ADDRESS Reverton

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Form V. S. No. 5 20M.1-16-12

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH.

Registration District No.

County of

Primary Registration District No.

City of

(No.

St.)

File No.

Registered No.

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX

4. COLOR OR RACE

5. SINGLE, MARRIED, WIDOWED OR DIVORCED.

6. DATE OF BIRTH

7. AGE

IF LESS than 1 day
how many hrs. or mins.?

8. OCCUPATION

(a) Trade, profession or particular kind of work

(b) General nature of industry business, or establishment in which employed (or employer)

9. BIRTHPLACE

(State or Country)

10. NAME OF FATHER

11. BIRTHPLACE OF FATHER

(State or Country)

12. MAIDEN NAME OF MOTHER

13. BIRTHPLACE OF MOTHER

(State or Country)

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

(Address)

15.

Filed

6 — 23

1913

M. S. Donker

Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH

17. I HEREBY CERTIFY, That I attended deceased from

June 17, 1913, to June 21, 1913

that I last saw him alive on June 21, 1913

and that death occurred on the date stated above, at 8 P. M.

The CAUSE OF DEATH* was as follows:

Meningitis

(Duration) yrs. mos. ds.

Contributory (Secondary)

(Duration) yrs. mos. ds.

(Signed)

(Address)

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents)

At place of death yrs. mos. days. In the State yrs. mos. days.

Where was disease contracted if not at place of death? Boise, Idaho

Former or usual residence Boise, Idaho

19. PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

St. Johns Cemetery June 25, 1913

20. UNDERTAKER

ADDRESS

Schreiber & Sidenfaden Boise

Dr. Smith

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Form V, S. No. 5. 12½ M. 7-24-11

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics
File No. 46748
Registered No. 318

1. PLACE OF DEATH. Registration District No. 12
County of Kootenai Primary Registration District No. 2063
City of Post Falls, Rural (No. _____, St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME H. N. Goss

If death occurred in a hospital, institution or camp give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX M. 4. COLOR OR RACE W. 5. SINGLE, MARRIED, WIDOWED OR DIVORCED. M
(Write the word.)

6. DATE OF BIRTH 1866
(Month) (Day) (Year)

7. AGE 4 yrs. 1 mos. 1 ds. IF LESS than 1 day how many _____ hrs. or _____ min?

8. OCCUPATION
(a) Trade, profession or particular kind of work. Rancher
(b) General nature of industry business or establishment in which employed (or employer)

9. BIRTHPLACE
(State or Country) Honville, Maine.

10. NAME OF FATHER

11. BIRTHPLACE OF FATHER
(State or Country)

12. MAIDEN NAME OF MOTHER

13. BIRTHPLACE OF MOTHER
(State or Country)

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) B. F. Campbell M. D.
(Address) Post Falls.

15. Filed 8/10 1913 S. S. Shuman
Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH July 15-1913 - 12³⁰ M. 1913
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from July 15-11 A. M. 1913, to July 15-12³⁰ M. 1913 that I last saw him alive on July 15-12³⁰ M. 1913, and that death occurred on the date stated above, at 12³⁰ M.

The CAUSE OF DEATH* was as follows:
due to fall with apparent internal injury
had been a sufferer from advanced Myocarditis
and Nephritis, death due to heart failure

(Duration) 5 yrs. mos. 5 ds.
Contributory Chronic Myocarditis and Nephritis
(Secondary) Number of years.
(Duration) 5 yrs. 5 mos. 5 ds.

(Signed) B. F. Campbell M. D.
July 15 1913 (Address) Post Falls Idaho

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place _____ In the _____
of death _____ yrs. _____ mos. _____ ds. State _____ yrs. _____ mos. _____ ds.
Where was disease contracted, _____
If not at place of death? _____
Former or _____
usual residence _____

19. PLACE OF BURIAL OR REMOVAL Washington DATE OF BURIAL July 15 1913

20. UNDERTAKER Smith & Co. Spokane Wash. ADDRESS 1133-24 Riverside.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Form V. S. No. 5 20M.1-16-12

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH

Registration District No.

County *Ada*

Primary Registration District No.

City of *Boise*(No. *Boise City Nat Bank Bldg*)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

*John Porter*File No. *500630*Registered No. *277*

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX

Male

4. COLOR OR RACE

white American

5. SINGLE, MARRIED, WIDOWED OR DIVORCED.

widower
(Write the word.)

6. DATE OF BIRTH

not obtainable

(Month)

(Day)

(Year)

7. AGE

86 yrs. — mos. — ds.

IF LESS than 1 day
how many hrs. or
..... mins.

8. OCCUPATION

(a) Trade, profession or particular kind of work
(b) General nature of industry business, or establishment in which employed (or employer)

Lawyer

9. BIRTHPLACE

(State or Country)

Pa.

10. NAME OF FATHER

not obtainable

11. BIRTHPLACE OF FATHER

(State or Country)

12. MAIDEN NAME OF MOTHER

13. BIRTHPLACE OF MOTHER

(State or Country)

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

W. S. Porter

(Address)

Boise

15.

Filed *9-26* 191*3*

M. S. Parker
Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH

*Sept**25**1913*

(Month)

(Day)

(Year)

17. I HEREBY CERTIFY, That I attended deceased from

Sept 24 1913, to *Sept 25* 1913that I last saw him alive on *Sept 25* 1913and that death occurred on the date stated above, at *8:30 AM*

The CAUSE OF DEATH* was as follows:

Apoplexy & old age(Duration) yrs. mos. *1* ds.

Contributory (Secondary)

Old age

(Duration) yrs. mos. ds.

(Signed)

J. E. Brown M.D.
9-26 1913 (Address) *Boise, Idaho*

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death yrs. mos. days. In the State yrs. mos. days.

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

*Eldora Iowa**Sept 26 1913*

20. UNDERTAKER

ADDRESS

*Fry & Summers Co**Boise*

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Form V. S. No. 5. 10M. 6-20-11.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH.

Registration District No. 8 (4)County of LanyonPrimary Registration District No. 1008City of Prattville

(No. _____, _____ St.)

File No. 6307Registered No. 100

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME none

If death occurred in a hospital, institution or camp give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX

4. COLOR OR RACE 5. SINGLE, MARRIED, WIDOWED OR DIVORCED.

female white

(Write the word.)

6. DATE OF BIRTH

Sept 22 1913
(Month) (Day) (Year)

7. AGE

3 hours
yrs. mos. ds.

IF LESS than 1 day
how many hrs. or
min.

8. OCCUPATION

- (a) Trade, profession, or particular kind of work
(b) General nature of industry business, or establishment in which employed (or employer)

9. BIRTHPLACE

(State or Country) Lanyon

10. NAME OF FATHER

Adam Blind

11. BIRTHPLACE OF FATHER

(State or Country) Russia

12. MAIDEN NAME OF MOTHER

Shama Gresham

13. BIRTHPLACE OF MOTHER

(State or Country) Russia

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Adam Blind(Address) Prattville

15.

Filed Oct 4 19133J. C. Woodward
Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

Sept 22 1913
(Month) (Day) (Year)17. I HEREBY CERTIFY, That I attended deceased from Sept 22 1913 to Sept 22 1913that I last saw him alive on Sept 22 1913, and that death occurred on the date stated above, at 6 P M.

The CAUSE OF DEATH* was as follows:

prolonged labor(Duration) _____ yrs. _____ mos. 3 hours ds.

Contributory (Secondary)

(Duration) _____ yrs. _____ mos. _____ ds.

(Signed) E. J. Barton M. D.Sept 23 1913 (Address) Prattville

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place _____ In the _____

of death _____ yrs. _____ mos. _____ ds. State _____ yrs. _____ mos. _____ ds.

Where was disease contracted,

If not at place of death?

Former or

usual residence.

19. PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

1913

20. UNDERTAKER

ADDRESS

none

Form V. S. No. 5. 10M. 6-20-11.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics
File No. **6308**
Registered No. _____

1. PLACE OF DEATH.

Registration District No. _____

County of Boise

Primary Registration District No. _____

City of Arrowrock

(No. _____, _____ St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

Louis Eddy Hicks

If death occurred in a hospital, institution or camp give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX

M.

4. COLOR OR RACE

W.

5. SINGLE, MARRIED, WIDOWED OR DIVORCED.

Married.
(Write the word.)

6. DATE OF BIRTH

August 18 1862
(Month) (Day) (Year)

7. AGE

51 yrs.2 mos.3 ds.IF LESS than 1 day
how many hrs. or
..... min.

8. OCCUPATION

- (a) Trade, profession or particular kind of work
-
- (b) General nature of industry business or establishment in which employed (or employer)

Printer

9. BIRTHPLACE

(State or Country)

Ohio.

10. NAME OF FATHER

L. E. Hicks

11. BIRTHPLACE OF FATHER

(State or Country)

Ohio.

12. MAIDEN NAME OF MOTHER

Not obtainable

13. BIRTHPLACE OF MOTHER

(State or Country)

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

Joseph H. Shaw

(Address)

Arrowrock, Idaho

15.

Filed _____ 191__

J. H. Shaw
Py Jms
Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

October

(Month)

21

(Day)

1913

(Year)

17. I HEREBY CERTIFY, That I attended deceased from October 18, 1913, to October 21, 1913that I last saw him alive on October 21, 1913, and that death occurred on the date stated above, at 3 A. M.

The CAUSE OF DEATH* was as follows:

Nephritis
[Chronic Parenchymatous](Duration) 1 yrs. 1 mos. 1 ds.

Contributory (Secondary)

Pulmonary Tuberculosis(Duration) 2 yrs. 2 mos. 2 ds.

(Signed)

Joseph H. Shaw M. D.(Address) Arrowrock, Ida.

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place

of death yrs. mos. ds. State yrs. mos. ds.

Where was disease contracted,

If not at place of death?

Former or usual residence.

19. PLACE OF BURIAL OR REMOVAL

Boise Idaho

DATE OF BURIAL

Oct. 22, 1913

20. UNDERTAKER

Schreibler & Hidenfoden

ADDRESS

Boise

MARGIN RESERVED FOR BINDING
WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Form V. S. No. 5. 12½M. 7-24-11

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics
File No. 631
Registered No. 111

1. PLACE OF DEATH. Registration District No. 61
County of Salok Primary Registration District No. 1011
City of Moscow (No. , St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

John Knight

If death occurred in a hospital, institution or camp give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX Male 4. COLOR OR RACE White 5. SINGLE, MARRIED, WIDOWED OR DIVORCED. Married
(Write the word.)

6. DATE OF BIRTH Dec 14 1894
(Month) (Day) (Year)

7. AGE 71 yrs. 9 mos. 24 ds.
IF LESS than 1 day how many..... hrs. or min?

8. OCCUPATION Farmer
(a) Trade, profession or particular kind of work.
(b) General nature of industry business or establishment in which employed (or employer)

9. BIRTHPLACE Oh
(State or Country)

10. NAME OF FATHER Backenr Knight

11. BIRTHPLACE OF FATHER Oh
(State or Country)

12. MAIDEN NAME OF MOTHER Don't Know

13. BIRTHPLACE OF MOTHER Pan
(State or Country)

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Anna Worthington
(Address) Cavendish

15. Oct 7 1913 J F R Ld
Filed Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH 10 7 1913
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from Oct 6 - 1913, to Oct 7 - 1913
that I last saw h. a. alive on Oct 7 - 1913
and that death occurred on the date stated above, at 5:40 P.M.

The CAUSE OF DEATH* was as follows:

Prostatectomy

(Duration) 10 yrs. mos. ds.

Contributory (Secondary)

(Duration) yrs. mos. ds.

(Signed) Chas L. Britman M. D.

1078 - 1913 (Address) Moscow, Idaho

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place In the
of death..... yrs..... mos..... ds. State..... yrs..... mos..... ds.
Where was disease contracted,
If not at place of death?.....

former or residence.

19. PLACE OF BURIAL OR REMOVAL Beck DATE OF BURIAL Oct 7 1913

20. UNDERTAKER Geo. Stetly ADDRESS Moscow

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Form V. S. No. 5 20M.1-16-12

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH.

Registration District No. 61County of IdahoPrimary Registration District No. 1011City of Moscow

(No. _____, St.)

File No. 6311Registered No. 112

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Wadell Byrnes

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX

F

4. COLOR OR RACE

W

5. SINGLE, MARRIED, WIDOWED OR DIVORCED.

Single
(Write the word.)

6. DATE OF BIRTH

Feb. 12 1899
(Month) (Day) (Year)

7. AGE

14 yrs. 8 mos. 24 ds.

IF LESS than 1 day
how many hrs. or
..... mins.?

8. OCCUPATION

(a) Trade, profession or particular kind of work

None

(b) General nature of industry business, or establishment in which employed (or employer)

None

9. BIRTHPLACE

(State or Country)

Iowa

10. NAME OF FATHER

Frank Byrnes

11. BIRTHPLACE OF FATHER

(State or Country)

I. C.

12. MAIDEN NAME OF MOTHER

Lloyd

13. BIRTHPLACE OF MOTHER

(State or Country)

Canada

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

Frank Byrnes

(Address)

Moscow Idaho

15.

Filed

Oct 9 1913 J. F. Rae
Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH

Oct 6 1913
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from Sept 26 1913, to Oct 6 1913

that I last saw her alive on Oct 6 1913

and that death occurred on the date stated above, at 1558 1/2

The CAUSE OF DEATH* was as follows:

Typhoid fever(Duration) yrs. mos. 17 ds.

Contributory

(Secondary)

(Duration) yrs. mos. ds.

(Signed) Joseph Aspray M. D.Oct 8 1913 (Address) Moscow Idaho

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL OR HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death yrs. mos. days. In the State yrs. mos. days.

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL

Moscow

DATE OF BURIAL

Oct 10 1913

20. UNDERTAKER

Geo. Hitt

ADDRESS

Moscow

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Form V. S. No. 5 20M:1-16-12

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH.

Registration District No. 61County of LatahPrimary Registration District No. 1011City of Moscow

(No. _____ St.)

File No. 6312Registered No. 113

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

John S. Johnson

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX

4. COLOR OR RACE

5. SINGLE, MARRIED, WIDOWED OR DIVORCED.

Male Whitemarried
(Write the word.)

6. DATE OF BIRTH

Feb 6 1847
(Month) (Day) (Year)

7. AGE

66 yrs. 7 mos. 1 ds.

IF LESS than 1 day
how many hrs. or
..... mins.?

8. OCCUPATION

(a) Trade, profession or particular kind of work
(b) General nature of industry business, or establishment in which employed (or employer)

Farmer

9. BIRTHPLACE

(State or Country)

Sweden

10. NAME OF FATHER

John Johnson

11. BIRTHPLACE OF FATHER

(State or Country)

Sweden

12. MAIDEN NAME OF MOTHER

Don't know

13. BIRTHPLACE OF MOTHER

(State or Country)

Sweden

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

August Johnson

(Address)

Moscow

15.

Filed

Oct 8191357 Rae

Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH

Oct 6 1913
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from

June 17 1913 to Oct 6 1913
that I last saw him alive on Oct 4 1913

and that death occurred on the date stated above, at _____ M.

The CAUSE OF DEATH* was as follows:

Sarcophagus
(Fascia)(Duration) 2 yrs. _____ mos. _____ ds.Contributory
(Secondary)

(Duration) _____ yrs. _____ mos. _____ ds.

(Signed)

H. E. Wick M. D.19..... (Address) Moscow Idaho

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death yrs. mos. days. In the State yrs. mos. days.

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

MoscowOct 9 1913

20. UNDERTAKER

ADDRESS

Geo. StutzMoscow

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Form V. S. No. 5 20M.1-16-12

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH.

Registration District No. 61County of LatahPrimary Registration District No. 1011City of Moscow

(No. _____, St.)

File No. 6313Registered No. 114

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

Elvira Slanby

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX

Female

4. COLOR OR RACE

White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED.

Widow
(Write the word.)

6. DATE OF BIRTH

September 20 1832
(Month) (Day) (Year)

7. AGE

81 yrs. 1 mos. 6 ds.IF LESS than 1 day
how many hrs. or
..... mins.?

8. OCCUPATION

(a) Trade, profession or particular kind of work

Farmer

(b) General nature of industry, business, or establishment in which employed (or employer)

9. BIRTHPLACE

(State or Country)

New York

10. NAME OF FATHER

Joseph Howard

11. BIRTHPLACE OF FATHER

(State or Country)

Don't no

12. MAIDEN NAME OF MOTHER

Pearl Franklin

13. BIRTHPLACE OF MOTHER

(State or Country)

Don't no

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

A. A. Lyman

(Address)

Moscow Idaho

15.

Filed

Oct 29 1913D. F. Rau

Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH

Oct. 27th
(Month) (Day) (Year)17. I HEREBY CERTIFY, That I attended deceased from Oct. 17 1913, to Oct. 27 1913,that I last saw her alive on Oct 26 1913, and that death occurred on the date stated above, at 5³⁰ AM.

The CAUSE OF DEATH was as follows:

apoplexy

(Duration) yrs. mos. ds.

Contributory
(Secondary)

(Duration) yrs. mos. ds.

(Signed)

Wm. C. Field, D.O.

19 (Address)

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death yrs. mos. days. In the State yrs. mos. days.

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL

Moscow

DATE OF BURIAL

Oct 29 1913

20. UNDERTAKER

Geo. Slitz

ADDRESS

Moscow

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Form V. S. No. 5 20M.1-16-12

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH.

Registration District No. 61County of LatahPrimary Registration District No. 1011City of Moscow

(No. _____, St.)

File No. 6311Registered No. 113

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

Lee M. Humphreys

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX

M

4. COLOR OR RACE

White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED.

Married
(Write the word.)

6. DATE OF BIRTH

March
(Month)27
(Day)1864
(Year)

7. AGE

49 yrs. 0 mos. 0 ds.IF LESS than 1 day
how many hrs. or
..... mins.?

8. OCCUPATION

(a) Trade, profession or particular kind of work

Farmer

(b) General nature of industry, business, or establishment in which employed (or employer)

9. BIRTHPLACE

(State or Country)

Colorado

10. NAME OF FATHER

Thomas Humphreys

11. BIRTHPLACE OF FATHER

(State or Country)

Idaho

12. MAIDEN NAME OF MOTHER

Matilda Jackson

13. BIRTHPLACE OF MOTHER

(State or Country)

Can.

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

Sarah E. Humphreys

(Address)

Moscow R. F. D. no 5

15.

Filed

Oct 29

191

D. F. Rae

Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH

Oct.28

1913

(Month)

(Day)

(Year)

17. I HEREBY CERTIFY, That I attended deceased from

Jan 1 1912, to Oct. 28 1913,that I last saw him alive on Oct. 27 1913,and that death occurred on the date stated above, at 4:45 P.M.

The CAUSE OF DEATH* was as follows:

Exhaustion following repeated hemorrhages from duodenal ulcer(Duration) 2 yrs. 0 mos. 0 ds.Contributory
(Secondary)(Duration) 0 yrs. 0 mos. 0 ds.

(Signed)

W. F. Carruthers

M. D.

Oct 29 1913 (Address) Moscow, Id.

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death X yrs. 1 1/2 mos. 0 days. In the State Idaho yrs. 0 mos. 0 days.

Where was disease contracted if not at place of death?

Idaho

Former or usual residence

near Moscow.

19. PLACE OF BURIAL OR REMOVAL

Moscow Cem.

DATE OF BURIAL

Oct 30 1913

20. UNDERTAKER

Geo. Stettin

ADDRESS

Moscow, Id.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Form V. S. No. 5 20M.1-16-12

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH.

Registration District No. 61County of KalahPrimary Registration District No. 1011City of Moscow

(No. _____ St.)

File No. 6315Registered No. 116

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

Lesley Edward Pearce

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX

Male

4. COLOR OR RACE

White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED.

Single
(Write the word.)

6. DATE OF BIRTH

Aug 28 1913
(Month) (Day) (Year)

7. AGE

3 yrs. 2 mos. 22 ds.IF LESS than 1 day
how many hrs. or
..... mins.?

8. OCCUPATION

(a) Trade, profession or particular kind of work
(b) General nature of industry business, or establishment in which employed (or employer)

9. BIRTHPLACE

(State or Country)

Near Moscow

10. NAME OF FATHER

Daniel Grey Pierce

11. BIRTHPLACE OF FATHER

(State or Country)

Idaho

12. MAIDEN NAME OF MOTHER

Kellipane Hunt

13. BIRTHPLACE OF MOTHER

(State or Country)

Catch Co Idaho

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

D. G. Pearce

(Address)

15.

Filed

Oct 311913D. F. Rae

Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH

Oct 30 1913
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from

Oct. 27 1913, to Oct. 30 1913,that I last saw him alive on Oct. 29 1913,and that death occurred on the date stated above, at 304

The CAUSE OF DEATH* was as follows:

Heoscolitis(Duration) yrs. 2 mos. 4 ds.Contributory
(Secondary)

(Duration) yrs. mos. ds.

(Signed)

J. N. Clarke M. D.Oct 31 1913 (Address) Moscow

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death yrs. mos. days. In the State yrs. mos. days.

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL

Moscow

DATE OF BURIAL

Nov 1 1913

20. UNDERTAKER

Geo. H. Heth

ADDRESS

Moscow

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Form V. S. No. 5 20M.1-16-12

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH

Registration District No.

County of Lewiston

Primary Registration District No.

City of Reg. Prec.

(No. 1009 St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

Gladys Mattison

File No.

6318

Registered No.

41

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX

F

4. COLOR OR RACE

W.

5. SINGLE, MARRIED, WIDOWED OR DIVORCED.

married
(Write the word.)

6. DATE OF BIRTH

June 29 187
(Month) (Day) (Year)

7. AGE

26 yrs. 4 mos. 13 ds.

IF LESS than 1 day
how many hrs. or mins.?

8. OCCUPATION

(a) Trade, profession or particular kind of work

Housewife

(b) General nature of industry business, or establishment in which employed (or employer)

9. BIRTHPLACE

(State or Country)

Minnesota

10. NAME OF FATHER

Dr. Harrington

11. BIRTHPLACE OF FATHER

(State or Country)

N.Y.

12. MAIDEN NAME OF MOTHER

L. Lycks

13. BIRTHPLACE OF MOTHER

(State or Country)

Ohio

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

J. J. Vassar

(Address)

Lewiston

15.

Filed

Dec. 10

1918

L. J. Perkins

Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH

Nov 12

(Month)

(Day)

1913

(Year)

17. I HEREBY CERTIFY, That I attended deceased from

Oct 75 1911, to Nov 12 1913,

that I last saw him alive on Nov 12 1913,

and that death occurred on the date stated above, at 12:45 M.

The CAUSE OF DEATH* was as follows:

Erysitis

(Duration)

yrs.

mos.

10 ds.

Contributory

(Secondary)

(Duration)

yrs.

mos.

ds.

(Signed)

C. W. Saaff M. D.

1913

(Address)

Lewiston

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place

of death.....yrs.....mos.....days.

In the

State.....yrs.....mos.....days.

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

Lewiston

Nov 14 1913

20. UNDERTAKER

ADDRESS

C. J. Vassar

Lewiston

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Form V. S. No. 5 20M.1-16-12

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH. Registration District No. 34
County of Elmore Primary Registration District No. 2020
City of Mountain Home (No. _____ St.)

File No. 6317
Registered No. _____

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Franklin Velie

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX Male 4. COLOR OR RACE White 5. SINGLE, MARRIED, WIDOWED OR DIVORCED. Married
(Write the word.)

6. DATE OF BIRTH Sept - 5 - 1838
(Month) (Day) (Year)

7. AGE 75 yrs. 2 mos. 7 ds. IF LESS than 1 day how many _____ hrs. or _____ mins.?

8. OCCUPATION
(a) Trade, profession or particular kind of work Former
(b) General nature of industry business, or establishment in which employed (or employer)

9. BIRTHPLACE New York
(State or Country)

10. NAME OF FATHER Jacob Velie

11. BIRTHPLACE OF FATHER New York
(State or Country)

12. MAIDEN NAME OF MOTHER Mary Miller

13. BIRTHPLACE OF MOTHER New York
(State or Country)

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) E. J. Wheeler
(Address) Mountain Home Idaho

15. Filed Nov. 13th 1913 Bev. Walker
Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH Nov 12 1913
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from Nov 9 1913, to Nov 12 1913, that I last saw him alive on Nov 12 1913, and that death occurred on the date stated above, at 12 M.

The CAUSE OF DEATH* was as follows:

Bright's Disease

(Duration) _____ yrs. _____ mos. 3 ds.
Contributory Diabetic Coma
(Secondary)

(Duration) _____ yrs. _____ mos. _____ ds.

(Signed) W. F. Frasier M. D.
Nov. 12, 1913 (Address) Mountain Home

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death _____ yrs. _____ mos. _____ days. In the State _____ yrs. _____ mos. _____ days.

Where was disease contracted if not at place of death?

Former or usual residence.

19. PLACE OF BURIAL OR REMOVAL Campbell, N. Y. DATE OF BURIAL _____ 1913

20. UNDERTAKER J. M. Cowen ADDRESS Mountain Home Idaho

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Form V. S. No. 5. 12½ M. 7-24-11

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics
File No. 631
Registered No. 354

1. PLACE OF DEATH. Registration District No. 2118
County of Butte Primary Registration District No. 2118
City of Drum Mission (No. _____, _____ St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Joseph M. Caruana

If death occurred in a hospital, institution or camp give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX 4. COLOR OR RACE 5. SINGLE, MARRIED, WIDOWED OR DIVORCED.

Male White Single (Write the word.)

6. DATE OF BIRTH

Aug 24 1836
(Month) (Day) (Year)

7. AGE

77 yrs. 2 mos. 5 ds.

IF LESS than 1 day
how many hrs. or
..... min?

8. OCCUPATION

(a) Trade, profession or particular kind of work.
(b) General nature of industry business or establishment in which employed (or employer).

Priest

9. BIRTHPLACE

(State or Country)

Valletta, Malta

10. NAME OF FATHER

Caruana

11. BIRTHPLACE OF FATHER

(State or Country)

Not known

12. MAIDEN NAME OF MOTHER

Not known

13. BIRTHPLACE OF MOTHER

(State or Country)

Not known

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Father, Hugler

(Address) Drumst, Ida

15.

Filed 20 30 1913

J. D. Hugler
Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH

Oct 29 1913
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from

Nov 1 1913, to Oct 29 1913

that I last saw him alive on Oct 28 1913

and that death occurred on the date stated above, at 8:15 A.M.

The CAUSE OF DEATH* was as follows:

Heart Failure from
Bright's Disease

(Duration) 3 8 hours
yrs. — mos. — ds.

Contributory (Secondary) Bright's Disease

(Duration) 3 yrs. — mos. — ds.

(Signed) J. R. Gallard M. D.

19 (Address) Drumst, Ida

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place In the
of death yrs. mos. ds. State yrs. mos. ds.

Where was disease contracted,

If not at place of death?

Former or

usual residence.

19. PLACE OF BURIAL OR REMOVAL DATE OF BURIAL

As per Oct 31 1913

20. UNDERTAKER

ADDRESS

None

RESERVED FOR BINDING
WITH UNFADING INK—THIS IS A PERMANENT RECORD.
AGE should be stated EXACTLY. PHYSI-
ON should be carefully supplied. AGE should be properly classified. Exact state-
CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact state-
ION is very important. See instructions on back of certificate.

Form V. S. No. 5. 12½M.7-24-11

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics
File No. 6319

1. PLACE OF DEATH.
County of Latah
City of Idaho

Registration District No. 38
Primary Registration District No. 2086
(No. _____, _____ St.)

Registered No. _____

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

Edward Lloyd Malone

If death occurred in a hospital, institution or camp give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX M. 4. COLOR OR RACE W. 5. SINGLE, MARRIED, WIDOWED OR DIVORCED.
(Write the word.)

6. DATE OF BIRTH Nov. 17 1913
(Month) (Day) (Year)

7. AGE _____ yrs. _____ mos. 2 ds.
IF LESS than 1 day
how many _____ hrs. or _____ min?

8. OCCUPATION

- (a) Trade, profession or particular kind of work
(b) General nature of industry business or establishment in which employed (or employer)

9. BIRTHPLACE Idaho
(State or Country)

10. NAME OF FATHER Herschel Malone

11. BIRTHPLACE OF FATHER Idaho
(State or Country)

12. MAIDEN NAME OF MOTHER L. Peck

13. BIRTHPLACE OF MOTHER Idaho
(State or Country)

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

Informant) A. A. Newberry
(Address) Idaho

191

Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH Nov. 18 1913
(Month) (Day) (Year)

17. I HEREBY CERTIFY That I attended deceased from Nov. 17 1913 to Nov 18 1913
that I last saw him alive on Nov. 17 1913
and that death occurred on the date stated above, at 12 M.
The CAUSE OF DEATH* was as follows:

Not known

(Duration) _____ yrs. _____ mos. _____ ds.

Contributory (Secondary)

(Duration) _____ yrs. _____ mos. _____ ds.
(Signed) A. A. Newberry M. D.
19 _____ (Address) Idaho

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place _____ In the _____
of death _____ yrs. _____ mos. _____ ds. State _____ yrs. _____ mos. _____ ds.
Where was disease contracted,
If not at place of death?
Former or
usual residence.

19. PLACE OF BURIAL OR REMOVAL Idaho DATE OF BURIAL 11/18 1913

20. UNDERTAKER None ADDRESS

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Form V. S. No. 5. 12½ M. 7-24-11

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics
File No. 6320

1. PLACE OF DEATH. Registration District No. 38
County of Twin Falls Primary Registration District No. 2086
City of Filer (No. _____ St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

Mrs. Jane Brown

Registered No. _____

If death occurred in a hospital, institution or camp give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX F 4. COLOR OR RACE W 5. SINGLE, MARRIED, WIDOWED OR DIVORCED. Widowed
(Write the word.)

6. DATE OF BIRTH Apr 17 1881
(Month) (Day) (Year)

7. AGE 82 yrs. 6 mos. ds. IF LESS than 1 day how many hrs. or min?

8. OCCUPATION

- (a) Trade, profession or particular kind of work.
(b) General nature of industry business or establishment in which employed (or employer)

Housewife

9. BIRTHPLACE

(State or Country)

Illinois

10. NAME OF FATHER

David Huggins

11. BIRTHPLACE OF FATHER

(State or Country)

Ill.

12. MAIDEN NAME OF MOTHER

✓

13. BIRTHPLACE OF MOTHER

(State or Country)

✓

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

Mrs. E. Foster

(Address)

Filer, Ida

15.

Filed

10/18 1913

1913

Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH Oct 18 1913
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from Sept 30 1912, to Oct 18 1913 that I last saw h. alive on Oct 16 1913 and that death occurred on the date stated above, at 4:30 A.M.

The CAUSE OF DEATH* was as follows:

Heart Disease & Senility

(Duration) yrs. mos. ds.

Contributory (Secondary)

(Duration) yrs. mos. ds.
(Signed) A. A. Newberry M. D.
19 (Address)

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place In the
of death. yrs. mos. ds. State. yrs. mos. ds.
Where was disease contracted,
If not at place of death?
Former or usual residence.

19. PLACE OF BURIAL OR REMOVAL DATE OF BURIAL
Filer Cemetery 10/19 1913

20. UNDERTAKER ADDRESS
J. J. Grossman Twin Falls, Ida

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Form V. S. No. 5. 10M. 6-20-11.

CERTIFICATE OF DEATH

 State of Idaho
 BOARD OF HEALTH
 Bureau of Vital Statistics

1. PLACE OF DEATH.

Registration District No. 81County of BonnerPrimary Registration District No. 2158

City of _____

(No. _____, _____ St.)

File No. 3 6321Registered No. 3

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

Giuseppena Elda Mauro

If death occurred in a hospital, institution or camp give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX

F

4. COLOR OR RACE

W

5. SINGLE, MARRIED, WIDOWED OR DIVORCED.

Single
 (Write the word.)

6. DATE OF BIRTH

November 18 1913
 (Month) (Day) (Year)

7. AGE

15 yrs. 3 mos. 15 ds.

 IF LESS than 1 day
 how many _____ hrs. or
 _____ min.

8. OCCUPATION

(a) Trade, profession or particular kind of work

None

(b) General nature of industry business or establishment in which employed (or employer)

9. BIRTHPLACE

(State or Country)

Idaho

10. NAME OF FATHER

Frank S Mauro

11. BIRTHPLACE OF FATHER

(State or Country)

Italy

12. MAIDEN NAME OF MOTHER

Luisa Mayo

13. BIRTHPLACE OF MOTHER

(State or Country)

Italy

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

Frank S Mauro

(Address)

Trust River Idg

15.

Filed

Nov 21 1913Ed McCarty

Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

November 18 1913
 (Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from

Nov 18 1913, to Nov 18 1913
that I last saw him alive on Nov 18 1913,and that death occurred on the date stated above, at 5:20 P. M.

The CAUSE OF DEATH* was as follows:

Acute Nephritis(Duration) _____ yrs. _____ mos. 4 ds.Contributory
(Secondary)

(Duration) _____ yrs. _____ mos. _____ ds.

(Signed) E. McCarty M. D.1/21 1913 (Address) Trust River

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death _____ yrs. _____ mos. _____ ds. State _____ yrs. _____ mos. _____ ds.

Where was disease contracted.

If not at place of death?

Former or

usual residence.

19. PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

Trust River Idg_____ 1913

20. UNDERTAKER

ADDRESS

S. R. K. HoffPrattstown

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Form V. S. No. 5 20M.1-16-12

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH.

Registration District No.

County of Jerome

Primary Registration District No.

City of Stanthony

(No., St.)

File No. 6322

Registered No.

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Samuel H. Winters

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX

4. COLOR OR RACE

5. SINGLE, MARRIED, WID-
OWED OR DIVORCEDMaleWhiteMarried
(Write the word.)

6. DATE OF BIRTH

March 28 1882
(Month) (Day) (Year)

7. AGE

31 yrs. 7 mos. 21 ds.

IF LESS than 1 day
how many hrs. or
..... mins.?

8. OCCUPATION

(a) Trade, profession or
particular kind of workFarmer(b) General nature of industry
business, or establishment in
which employed (or employer)

9. BIRTHPLACE

(State or Country)

Utah

10. NAME OF

FATHER

A. D. Winters

11. BIRTHPLACE

OF FATHER

Utah

(State or Country)

12. MAIDEN NAME

OF MOTHER

Melissa Allen

13. BIRTHPLACE

OF MOTHER

Utah

(State or Country)

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

A. D. Winters

(Address)

Chester Rd

15.

Filed

Dec 5 1914 W. W. Winters

Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH

Nov 19 1913
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from

Nov 14 1913, to Nov 19 1913,that I last saw him alive on Nov 19 1913,and that death occurred on the date stated above, at 7 A. M.

The CAUSE OF DEATH* was as follows:

Puritonitis(Duration) yrs. mos. 2 ds.Contributory
(Secondary)appendicitis(Duration) yrs. mos. 6 ds.

(Signed)

W. W. Winters

M. D.

19.

(Address)

St Anthony

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place

of death yrs. mos. days.

In the

State yrs. mos. days.

Where was disease contracted
if not at place of death?Former or
usual residence

19. PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

Willson 1 IdaNov 21 1913

20. UNDERTAKER

ADDRESS

none

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Form V. S. No. 5. 10M. 6-20-11.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

File No. 6323

Registered No.

If death occurred in a hospital, institution or camp give its NAME instead of street and number.

1. PLACE OF DEATH
County of *Idaho*
City of *St Anthony*

Registration District No. *99*
Primary Registration District No. *2177*
(No., St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME *Orrin J Jackson*

PERSONAL AND STATISTICAL PARTICULARS

3. SEX *male* 4. COLOR OR RACE *white* 5. SINGLE, MARRIED, WIDOWED OR DIVORCED.
(Write the word.)

6. DATE OF BIRTH *Dec 22 1887*
(Month) (Day) (Year)

7. AGE *85* yrs. *11* mos. *ds.*
IF LESS than 1 day how many hrs. or min.?

8. OCCUPATION
(a) Trade, profession, or particular kind of work *nurseryman*
(b) General nature of industry business, or establishment in which employed (or employer)

9. BIRTHPLACE
(State or Country) *Maine*

10. NAME OF FATHER *Don't know*

11. BIRTHPLACE OF FATHER
(State or Country) *Don't know*

12. MAIDEN NAME OF MOTHER *Don't know*

13. BIRTHPLACE OF MOTHER
(State or Country) *Don't know*

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) *W. S. Wenz*
(Address) *St Anthony*

15. Filed *Dec 5 1913* *W. S. Wenz*
Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH *Nov 22 1913*
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from *Nov 5 1913*, to *Nov 22 1913*
that I last saw him alive on *Nov 21 1913*
and that death occurred on the date stated above, at M.

The CAUSE OF DEATH* was as follows:

Senil Probity

(Duration) yrs. mos. ds.

Contributory (Secondary)

(Duration) yrs. mos. ds.

(Signed) *W. S. Wenz* M. D.

19 (Address)

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL,

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place In the
of death yrs. mos. ds. State yrs. mos. ds.

Where was Disease contracted,
If not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL *St Anthony Ida* DATE OF BURIAL *Nov 1913*

20. UNDERTAKER *W. S. Wenz* ADDRESS

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Form V. S. No. 5. 10M. 6-20-11.

CERTIFICATE OF DEATH

State of Idaho.
BOARD OF HEALTH
Bureau of Vital Statistics
File No. **6324**

1. PLACE OF DEATH
County of Idaho
City of Epine

Registration District No. 99
Primary Registration District No. 2177
(No. _____ St.)

Registered No. _____

If death occurred in a hospital, institution or camp give its NAME instead of street and number.

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

Lucy Rawson

PERSONAL AND STATISTICAL PARTICULARS

3. SEX Female 4. COLOR OR RACE White 5. SINGLE, MARRIED, WIDOWED OR DIVORCED. Married
(Write the word.)

6. DATE OF BIRTH Aug 1 1845
(Month) (Day) (Year)

7. AGE 68 yrs. 3 mos. 5 ds. IF LESS than 1 day how many _____ hrs. or _____ min.?

8. OCCUPATION

(a) Trade, profession, or particular kind of work
(b) General nature of industry business, or establishment in which employed (or employer)

Housewife

9. BIRTHPLACE

(State or Country)

England

10. NAME OF FATHER

Henry Camp

11. BIRTHPLACE OF FATHER

(State or Country)

England

12. MAIDEN NAME OF MOTHER

Don't know

13. BIRTHPLACE OF MOTHER

(State or Country)

England

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

W. B. Sweet

(Address)

15.

Aug 6 1913

W. B. Sweet

Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

Dec 1st 1913
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from

Aug 1 1910, to Nov 30 1913
that I last saw him alive on Nov 28 1913,
and that death occurred on the date stated above, at 2 9 M.

The CAUSE OF DEATH* was as follows:

Gastric Ulcer

(Duration) _____ yrs. _____ mos. _____ ds.

Contributory
(Secondary)

Housewife

(Duration) _____ yrs. _____ mos. _____ ds.

(Signed) _____ M. D.

19 _____ (Address) St. Anthony

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place _____ In the _____
of death _____ yrs. _____ mos. _____ ds. State _____ yrs. _____ mos. _____ ds.

Where was Disease contracted,

If not at place of death?

Former or

usual residence.

19. PLACE OF BURIAL OR REMOVAL

Epine

DATE OF BURIAL

Dec 8 1913

20. UNDERTAKER

none

ADDRESS

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

File No. 6325

1. PLACE OF DEATH.

Registration District No. 91

County of Shoshone

Primary Registration District No. 2171

City of St Anthony

(No. , St.)

Registered No.

If death occurred in a hospital, institution or camp give its NAME instead of street and number.

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

Samuel Rice

PERSONAL AND STATISTICAL PARTICULARS

3. SEX

male

4. COLOR OR RACE

white

5. SINGLE, MARRIED, WIDOWED OR DIVORCED.

married
(Write the word.)

6. DATE OF BIRTH

November

30

1885

(Month)

(Day)

(Year)

7. AGE

58

yrs. no

mos.

1

ds.

IF LESS than 1 day
how many hrs. or
min.?

8. OCCUPATION

- (a) Trade, profession, or particular kind of work
(b) General nature of industry, business, or establishment in which employed (or employer)

Farmer & Sheepman

9. BIRTHPLACE

(State or Country)

Utah

10. NAME OF FATHER

Edward Rice

11. BIRTHPLACE OF FATHER

(State or Country)

12. MAIDEN NAME OF MOTHER

Lizzie Bixby

13. BIRTHPLACE OF MOTHER

(State or Country)

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

Edwin Rice

(Address)

15.

Filed

Dec 5 1913

W. H. W. Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

Dec 18

(Month)

(Day)

1913 (Year)

17. I HEREBY CERTIFY, That I attended deceased from

Nov 17

1913

to Dec 18

1913

that I last saw him alive on Nov 30 1913

and that death occurred on the date stated above, at 3 P. M.

The CAUSE OF DEATH* was as follows:

S. S. S.

(Duration) yrs. mos. 14 ds.

Contributory (Secondary)

Mental irregularities

(Duration) yrs. mos. ds.

(Signed)

W. H. W. M. D.

19 (Address) St Anthony Del

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place In the

of death yrs mos ds State yrs mos ds.

Where was Disease contracted,

If not at place of death?

Former or

usual residence

19. PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

Buried in Ida

Dec 3rd 1913

20. UNDERTAKER

none

ADDRESS

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Form V. S. No. 5 20M.1-16-12

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH

Registration District No. 99

County of Fremont

Primary Registration District No. 3177

City of St Anthony

(No. St.)

File No. 6326

Registered No.

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

Chas O Anderson

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX

male

4. COLOR OR RACE

white

5. SINGLE, MARRIED, WIDOWED OR DIVORCED.

married
(Write the word.)

6. DATE OF BIRTH

July 18 1873
(Month) (Day) (Year)

7. AGE

40 yrs. 5 mos. 9 ds.

IF LESS than 1 day
how many hrs. or mins.?

8. OCCUPATION

(a) Trade, profession or particular kind of work
(b) General nature of industry business, or establishment in which employed (or employer)

Farmer

9. BIRTHPLACE

(State or Country)

Ill.

10. NAME OF FATHER

Mr Anderson

11. BIRTHPLACE OF FATHER

(State or Country)

Illinois

12. MAIDEN NAME OF MOTHER

Jessie Brady

13. BIRTHPLACE OF MOTHER

(State or Country)

Not known

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Mr C. P. Anderson

(Address) 741 St Anthony

15.

Filed Dec 5 1913 W. S. West
Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

Nov 13 1913
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from

1913, to 1913,

that I last saw him alive on 1913,

and that death occurred on the date stated above, at M.

The CAUSE OF DEATH* was as follows:

Suicide by hanging

(Duration) yrs. mos. ds.

Contributory
(Secondary)

(Duration) yrs. mos. ds.

(Signed) J. B. West M. D.

19 (Address)

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death. yrs. mos. days. In the State. yrs. mos. days.

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL DATE OF BURIAL

Ourer Nov 15 1913

20. UNDERTAKER

ADDRESS

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Form V. S. No. 5 20M.1-16-12

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics
File No. 6325
Registered No. 8

1. PLACE OF DEATH

Registration District No. 47

County of Fewell

Primary Registration District No. 2124

City of X X

(No. _____ St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

Henry Duck

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX

4. COLOR OR RACE

5. SINGLE, MARRIED, WIDOWED OR DIVORCED.

Male

White

Married
(Write the word.)

6. DATE OF BIRTH

1
(Month)

26
(Day)

1869
(Year)

7. AGE

44 yrs. 9 mos. 24 ds.

IF LESS than 1 day
how many hrs. or
..... min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work
(b) General nature of industry, business, or establishment in which employed (or employer)

Farmer

9. BIRTHPLACE

(State or Country)

Schleswig Holstein Germany

10. NAME OF FATHER

Henry F. Duck

11. BIRTHPLACE OF FATHER

(State or Country)

Schleswig Holstein Germany

12. MAIDEN NAME OF MOTHER

Anna Bahr

13. BIRTHPLACE OF MOTHER

(State or Country)

Schleswig Holstein Germany

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

W. Bryant

(Address)

Idaho

15.

Filed 11-20- 1913

21 Malone

Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH

11
(Month)

19
(Day)

1913
(Year)

17. I HEREBY CERTIFY, That I attended deceased from

11-13

1913, to

11-19

1913

that I last saw him alive on 11-19 1913

and that death occurred on the date stated above, at 5-30 AM.

The CAUSE OF DEATH* was as follows:

Tuberc. Pneumonia

(Duration) yrs. mos. 8 ds.

Contributory (Secondary)

(Duration) yrs. mos. ds.

(Signed) O. A. Gaffney M. D.

11-10-1913 (Address) Idaho

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death yrs. mos. days. In the State yrs. mos. days.

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

Wegener Cemetery

Nov-22-1913

20. UNDERTAKER

ADDRESS

Idaho

Idaho

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Form V. S. No. 5. 12½ M. 7-24-11

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH.

Registration District No. 47

County of Lewis

Primary Registration District No. 2124

City of Hazelton

(No. 1, St.)

File No. 6329

Registered No. 7

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

Eva Lois Gentry

If death occurred in a hospital, institution or camp give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX

F

4. COLOR OR RACE

W

5. SINGLE, MARRIED, WIDOWED OR DIVORCED.

Married
(Write the word.)

6. DATE OF BIRTH

Aug 25 1878
(Month) (Day) (Year)

7. AGE

35 yrs. 2 mos. 29 ds.

IF LESS than 1 day
how many hrs. or
..... min?

8. OCCUPATION

(a) Trade, profession or particular kind of work.

Housewife

(b) General nature of industry business or establishment in which employed (or employer)

9. BIRTHPLACE

(State or Country)

Wisconsin

10. NAME OF FATHER

H. C. Pierce

11. BIRTHPLACE OF FATHER

(State or Country)

Wisconsin

12. MAIDEN NAME OF MOTHER

Angie M. Telect

13. BIRTHPLACE OF MOTHER

(State or Country)

Wisconsin

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

Angie M. Pierce

(Address)

Waffle Lake

15.

Filed

11 24

1913

H. Jones

Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH

Nov 23 1913
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from 11/16 1913, to 11/21 1913

that I last saw him alive on 11/21 1913 and that death occurred on the date stated above, at 3:00 A.M.

The CAUSE OF DEATH* was as follows:

Pericution vomiting of pregnancy

(Duration) yrs. mos. 14 ds.

Contributory (Secondary)

Abortion

(Duration) yrs. mos. ds.

(Signed)

D. A. Jefferys

M. D.

11/24 1913 (Address) Hazelton

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; (2) whether ACCIDENTAL, SUICIDAL OR HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place

In the

of death yrs. mos. ds. State yrs. mos. ds.

Where was disease contracted.

If not at place of death?

Former or

usual residence.

19. PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

Hazelton

11/24 1913

20. FUNERAL TAKER

H. C. Miller

ADDRESS

Hazelton

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Form V. S. No. 5 20M.1-16-12

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics
File No. 633
Registered No. 258

1. PLACE OF DEATH.

Registration District No. 12County of BoisePrimary Registration District No. 2051City of Boise

(No. _____, _____ St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

Neal Smith

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX

4. COLOR OR RACE

5. SINGLE, MARRIED, WIDOWED OR DIVORCED.

MWS.

(Write the word.)

6. DATE OF BIRTH

(Month) _____ (Day) _____ (Year) _____

7. AGE

25 yrs. _____ mos. _____ ds.IF LESS than 1 day
how many _____ hrs. or
_____ mins.?

8. OCCUPATION

(a) Trade, profession or particular kind of work

(b) General nature of industry business, or establishment in which employed (or employer)

Proprietor

9. BIRTHPLACE

(State or Country)

Boise, Idaho

10. NAME OF FATHER

11. BIRTHPLACE OF FATHER

(State or Country)

12. MAIDEN NAME OF MOTHER

13. BIRTHPLACE OF MOTHER

(State or Country)

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

(Address)

Boise, Idaho

15.

Filed

12/101913J. D. Skumel

Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH

Nov. 10 - 1913
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from

Sept. 1 1913, to Nov. 10 1913that I last saw him alive on 9 1913and that death occurred on the date stated above, at 8 M.

The CAUSE OF DEATH* was as follows:

Consolidated Lung & Spleen
Vascular Heart Disease

(Duration) _____ yrs. _____ mos. _____ ds.

Contributory

(Secondary)

(Duration) _____ yrs. _____ mos. _____ ds.

(Signed) J. D. Skumel M. D.11/10 1913 (Address) Boise

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death _____ yrs. _____ mos. _____ days. In the State _____ yrs. _____ mos. _____ days.

Where was disease contracted if not at place of death?

Former or usual residence _____

19. PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

Boise11/11 1913

20. UNDERTAKER

ADDRESS

BoiseBoise

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Form V. S. No. 5 20M.1-16-12

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH.

Registration District No.

County of Kootenai

Primary Registration District No. 2051

City of Near Grange

(No. St.)

File No. 6331

Registered No. 359

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

Harold Henry Johnson

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX

M

4. COLOR OR RACE

W

5. SINGLE, MARRIED, WIDOWED OR DIVORCED.

S (Write the word.)

6. DATE OF BIRTH

7/10 (Month) 7 (Day) 1913 (Year)

7. AGE

..... yrs. mos. 4 ds.

IF LESS than 1 day
how many hrs. or
..... mins.?

8. OCCUPATION

- (a) Trade, profession or particular kind of work
(b) General nature of industry business, or establishment in which employed (or employer)

9. BIRTHPLACE

(State or Country) Near Grange Idaho

10. NAME OF FATHER

Henry Johnson

11. BIRTHPLACE OF FATHER

(State or Country) American Wis.

12. MAIDEN NAME OF MOTHER

Porter

13. BIRTHPLACE OF MOTHER

(State or Country) Mo.

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Henry Johnson

(Address) Grange

15.

Filed 12/10

1913

J. D. Johnson
Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH

Nov (Month) 11 (Day) 1913 (Year)

17. I HEREBY CERTIFY, That I attended deceased from

..... 191....., to 191.....,

that I last saw him alive on 191.....,

and that death occurred on the date stated above, at M.

The CAUSE OF DEATH* was as follows:

Was there when he was
Harold Henry Johnson

..... (Duration) yrs. mos. ds.

Contributory
(Secondary)

..... (Duration) yrs. mos. ds.

(Signed) J. D. Johnson M. D.

19..... (Address)

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death yrs. mos. days. In the State yrs. mos. days.

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

Grange

191.....

20. UNDERTAKER

ADDRESS

Klapp

Grange

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Form V. S. No. 5 20M.1-16-12

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH.

Registration District No. 12County of KootenaiPrimary Registration District No. 2057File No. 6332City of Hamden

(No. _____, _____ St.)

Registered No. 360

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Regis

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX m4. COLOR OR RACE W5. SINGLE, MARRIED, WIDOWED OR DIVORCED. A

(Write the word.)

6. DATE OF BIRTH

(Month)

(Day)

(Year)

7. AGE

3 yrs. 4 mos. 9 ds.

IF LESS than 1 day
how many hrs. or
..... mins.?

8. OCCUPATION

(a) Trade, profession or particular kind of work Child

(b) General nature of industry business, or establishment in which employed (or employer)

9. BIRTHPLACE

(State or Country) Oklahoma10. NAME OF FATHER Renford Rogers11. BIRTHPLACE OF FATHER Michigan

(State or Country)

12. MAIDEN NAME OF MOTHER May Taylor13. BIRTHPLACE OF MOTHER Missouri

(State or Country)

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Regis(Address) Hamden

15.

Filed 12/101913

Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH

(Month)

(Day)

1913
(Year)

17. I HEREBY CERTIFY, That I attended deceased from

1913, to1913,that I last saw h. alive on 1913,and that death occurred on the date stated above, at M.

The CAUSE OF DEATH* was as follows:

Whooping CoughHad no Doctor

(Duration)

yrs.

mos.

ds.

Contributory

(Secondary)

(Duration)

yrs.

mos.

ds.

(Signed) J. S. Druman

M. D.

11/25/13 (Address)

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place

of death. yrs. mos. days.

In the

State. yrs. mos. days.

Where was disease contracted
if not at place of death?

Former or
usual residence.

19. PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

Buried11/25 191320. UNDERTAKER KloperADDRESS OP

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. PHYSICIANS—Every item of information should be carefully supplied. AGE should be stated EXACTLY. Exact statement of CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Form V. S. No. 5. 12½ M. 7-24-11

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics
File No. 6333
Registered No. 356

1. PLACE OF DEATH. Registration District No. 12
County of Kootenai Primary Registration District No. 2051
City of Post Falls (No. _____, _____ St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

Mary Ann Russell

If death occurred in a hospital, institution or camp give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX 4. COLOR OR RACE 5. SINGLE, MARRIED, WIDOWED OR DIVORCED.

Female White Widowed
(Write the word.)

6. DATE OF BIRTH

July 17 1840
(Month) (Day) (Year)

7. AGE

73 yrs. 3 mos. 14 ds.

IF LESS than 1 day
how many.....hrs. or
.....min?

8. OCCUPATION

(a) Trade, profession or particular kind of work.
(b) General nature of industry business or establishment in which employed (or employer)

Housewife

9. BIRTHPLACE

(State or Country)

Osteo Co. N.J.

10. NAME OF FATHER

Henry Schirder

11. BIRTHPLACE OF FATHER

(State or Country)

Germany

12. MAIDEN NAME OF MOTHER

Hellie Evans

13. BIRTHPLACE OF MOTHER

(State or Country)

Pennsylvania

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

(Address)

Thos J Russell
Post Falls

15.

Filed.....191.....

M. A. Dordant
Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH

October 31 1913
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from
Oct 19 1913, to Oct 31 1913

that I last saw h. u alive on Oct 19 1913

and that death occurred on the date stated above, at 1 P.M.

The CAUSE OF DEATH* was as follows:

Senility

(Duration)yrs.mos.ds.

Contributory (Secondary)

Paralysis

(Duration) 7 yrs.mos.ds.

(Signed)

Nov 2 1913 (Address) Count Allen Idaho

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At placeyrs.mos.ds. In the
of death.....yrs.mos.ds. State.....yrs.mos.ds.

Where was disease contracted,

If not at place of death?

Former or

usual residence.....

19. PLACE OF BURIAL OR REMOVAL DATE OF BURIAL

Post Falls 11/2 1913

20. UNDERTAKER

ADDRESS

Kloph Rothrum

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Form V. S. No. 5. 12½ M. 7-24-11

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics
File No. 6334
Registered No. 245

1. PLACE OF DEATH. Registration District No. 244 12
County of Butte Primary Registration District No. 2051
City of Butte (No. _____, _____ St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Antoine Cherrapsin

If death occurred in a hospital, institution or camp give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX 4. COLOR OR RACE 5. SINGLE, MARRIED, WIDOWED OR DIVORCED.

Male Indian

Single
(Write the word.)

6. DATE OF BIRTH

Feb 1902
(Month) (Day) (Year)

7. AGE

10 yrs. 6 mos. — ds.

IF LESS than 1 day
how many.....hrs. or
.....min?

8. OCCUPATION

(a) Trade, profession or particular kind of work.....
(b) General nature of industry business or establishment in which employed (or employer)

none

9. BIRTHPLACE

(State or Country)

Kootenai Co., Ida

10. NAME OF FATHER

Chas. Cherrapsin

11. BIRTHPLACE OF FATHER

(State or Country)

Kootenai Co., Ida

12. MAIDEN NAME OF MOTHER

13. BIRTHPLACE OF MOTHER

(State or Country)

Id. Spokane

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Chas. Cherrapsin

(Address) Ormsd., Ida

15.

Filed July 10 1913

Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH

Aug 1 1913
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from

Jan 1912, to Aug 1 1913

that I last saw him alive on July 31 1913

and that death occurred on the date stated above, at 2 PM

The CAUSE OF DEATH* was as follows:

Intestinal tuberculosis

(Duration) yrs. 8 mos. ds.

Contributory (Secondary)

None

(Duration) yrs. mos. ds.

(Signed)

Jno. R. Cessard, M. D.

Aug 1 1913 (Address) Ormsd., Ida

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place In the
of death..... yrs. mos. ds. State..... yrs. mos. ds.

Where was disease contracted,

If not at place of death?

Former or

usual residence.....

19. PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

Aug 2 1913

20. UNDERTAKER

ADDRESS

22 map

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Form V. S. No. 5 20M.1-16-12

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics
File No. 6335

1. PLACE OF DEATH.

Registration District No. 17

County of *Boonemai*

Primary Registration District No. 1003

City of *Coeur d'Alene*

(No. _____ St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

Charley R. Zigler

Registered No. 346

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX

Male

4. COLOR OR RACE

White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED.

Single
(Write the word.)

6. DATE OF BIRTH

*June**1**1888*

(Month)

(Day)

(Year)

7. AGE

25 yrs. *5* mos. *17* ds.IF LESS than 1 day
how many _____ hrs. or
_____ mins.?

8. OCCUPATION

(a) Trade, profession or particular kind of work

Laborer

(b) General nature of industry business, or establishment in which employed (or employer)

9. BIRTHPLACE

(State or Country)

Chicago Ill

10. NAME OF FATHER

Morgan E. Zigler

11. BIRTHPLACE OF FATHER

(State or Country)

Missouri

12. MAIDEN NAME OF MOTHER

Abbie E. Gardner

13. BIRTHPLACE OF MOTHER

(State or Country)

Illinois

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

Abbie E. Zigler

(Address)

Coeur d'Alene

15.

Filed

*11/10*191*0**J. D. Shuman*
Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH

*October**17*191*2*

(Month)

(Day)

(Year)

17. I HEREBY CERTIFY, That I attended deceased from

*Oct. 8*191*3*to *Oct. 17*191*3*that I last saw him alive on *Oct. 16* 191*3*and that death occurred on the date stated above, at *6.4* M.

The CAUSE OF DEATH* was as follows:

Phlebitis

(Duration)

yrs.

mos.

ds.

Contributory
(Secondary)*Suppurative lymphadenitis*

(Duration)

yrs.

mos.

ds.

(Signed)

John Wood M. D.
Oct. 17, 1913 (Address) *Coeur d'Alene Ida.*

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place

of death _____ yrs. _____ mos. _____ days.

In the

State _____ yrs. _____ mos. _____ days.

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL

Forest Com.

DATE OF BURIAL

Oct. 19 191*3*

20. UNDERTAKER

Cassedy & Nelson

ADDRESS

Coeur d'Alene

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Form V. S. No. 5 20M.1-16-12

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics
File No. 6335

Registered No. 347

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

1. PLACE OF DEATH

Registration District No. 14

County of

Primary Registration District No. 1003

City of

(No.)

St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

Charles Ewing Pickard

PERSONAL AND STATISTICAL PARTICULARS

3. SEX

4. COLOR OR RACE

5. SINGLE, MARRIED, WIDOWED OR DIVORCED.

Male

White

Widower
(Write the word.)

6. DATE OF BIRTH

Oct

6

1836

(Month)

(Day)

(Year)

7. AGE

77

yrs.

mos.

13

ds.

IF LESS than 1 day
how many hrs. or
..... mins.?

8. OCCUPATION

(a) Trade, profession or particular kind of work

(b) General nature of industry business, or establishment in which employed (or employer)

Retired

9. BIRTHPLACE

(State or Country)

Tennessee

10. NAME OF FATHER

Pickard

11. BIRTHPLACE OF FATHER

(State or Country)

12. MAIDEN NAME OF MOTHER

13. BIRTHPLACE OF MOTHER

(State or Country)

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

Chas W. Nolan

(Address)

15.

Filed

11/10

1913

Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH

Oct

19th

1913

(Month)

(Day)

(Year)

17. I HEREBY CERTIFY, That I attended deceased from

Oct 12th

1913,

to

Oct 19th

1913,

that I last saw him alive on Oct 12 1913,

and that death occurred on the date stated above, at 11 A.M.

The CAUSE OF DEATH* was as follows:

Cerebral Hemorrhage

(Duration)

yrs.

mos.

7 ds.

Contributory
(Secondary)

yrs.

mos.

7

ds.

(Duration)

yrs.

mos.

7 ds.

(Signed)

Jno. B. B. B.

M. D.

Oct 20 1913

(Address)

Boonville, Pa.

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place

of death

yrs.

mos.

days

In the

State

yrs.

mos.

days

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

Forest Cemetery

Oct 21 1913

20. UNDERTAKER

ADDRESS

Cassidy & Spahn

Boonville, Pa.

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Form V. S. No. 5 20M.1-16-12

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH.

Registration District No. 12

County of Kootenai

Primary Registration District No. 1008

City of Coeur

(No. _____, St.)

File No. 633

Registered No. 248

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Mary A Brown

PERSONAL AND STATISTICAL PARTICULARS

3. SEX

4. COLOR OR RACE

5. SINGLE, MARRIED, WIDOWED OR DIVORCED.

Female white

(Write the word.)

6. DATE OF BIRTH

(Month) (Day) (Year)

7. AGE

71 yrs. 0 mos. 0 ds.

IF LESS than 1 day
how many hrs. or mins.?

8. OCCUPATION

(a) Trade, profession or particular kind of work

(b) General nature of industry business, or establishment in which employed (or employer)

9. BIRTHPLACE

(State or Country)

10. NAME OF FATHER

11. BIRTHPLACE OF FATHER

(State or Country)

12. MAIDEN NAME OF MOTHER

13. BIRTHPLACE OF MOTHER

(State or Country)

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) E. Van Vleet

(Address) Coeur d'Alene 7th St

15.

Filed 11/10 1913

Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH

Oct. 21 st 1913
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from

Oct. 20th 1913, to Oct. 21st 1913,

that I last saw him alive on Oct. 20th 1913,

and that death occurred on the date stated above, at 7 P. M.

The CAUSE OF DEATH* was as follows:

Old age

(Duration) about 1 yrs. 0 mos. 0 ds.

Contributory none known
(Secondary)

(Duration) 0 yrs. 0 mos. 0 ds.

(Signed) E. Van Vleet M. D.

19. (Address) 507 Foster

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death... yrs. ... mos. ... days. In the State... yrs. ... mos. ... days.

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

Forest Cem

Oct. 24 1913

20. UNDERTAKER

ADDRESS

E. Van Vleet

Coeur

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
 N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Form V. S. No. 5 20M.1-16-12

CERTIFICATE OF DEATH

 State of Idaho
 BOARD OF HEALTH
 Bureau of Vital Statistics

1. PLACE OF DEATH.

Registration District No. 12County of IdahoPrimary Registration District No. 10052057City of Conrad

(No. _____, St.)

File No. 633Registered No. 349

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

And Christ

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX

male

4. COLOR OR RACE

white

5. SINGLE, MARRIED, WIDOWED OR DIVORCED.

single
(Write the word.)

6. DATE OF BIRTH

 (Month) (Day) (Year)

7. AGE

36 yrs. _____ mos. _____ ds.
 IF LESS than 1 day
 how many _____ hrs. or
 _____ mins.?

8. OCCUPATION

 (a) Trade, profession or particular kind of work
 (b) General nature of industry, business, or establishment in which employed (or employer)
farmer

9. BIRTHPLACE

(State or Country)

10. NAME OF FATHER

11. BIRTHPLACE OF FATHER

(State or Country)

12. MAIDEN NAME OF MOTHER

13. BIRTHPLACE OF MOTHER

(State or Country)

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Mr Stanley(Address) Spokane Bridge

15.

Filed 11/101913
S. S. Greenman
 Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH

10 22 1913
 (Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from

1913, to 1913,that I last saw him alive on 1913,and that death occurred on the date stated above, at M.

The CAUSE OF DEATH* was as follows:

Auto delatation of heart

(Duration) _____ yrs. _____ mos. _____ ds.

Contributory

(Secondary)

(Duration) _____ yrs. _____ mos. _____ ds.

(Signed) John Hunt Shepherd

M. D.

19. (Address) Conrad, Kootenai County

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death _____ yrs. _____ mos. _____ days. In the State _____ yrs. _____ mos. _____ days.

Where was disease contracted if not at place of death?

Former or usual residence.

19. PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

Mountain View1913

20. UNDERTAKER

ADDRESS

SpokaneC. W. A.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Form V. S. No. 5. 12½M.7-24-11

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics
File No. 6339
Registered No. 2350

1. PLACE OF DEATH. Registration District No. 2118 17
County of Boonville Primary Registration District No. 2118
City of Boonville (No. _____, _____ St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Meodemus Vincent

If death occurred in a hospital, institution or camp give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX 4. COLOR OR RACE 5. SINGLE, MARRIED, WIDOWED OR DIVORCED.

male Indian Single
(Write the word.)

6. DATE OF BIRTH

Feb 9 1904
(Month) (Day) (Year)

7. AGE

9 yrs. 8 mos. 15 ds.

IF LESS than 1 day
how many.....hrs. or
.....min?

8. OCCUPATION

(a) Trade, profession or particular kind of work.....
(b) General nature of industry business or establishment in which employed (or employer)

None

9. BIRTHPLACE

(State or Country)

Reservation

10. NAME OF FATHER

Peter Vincent

11. BIRTHPLACE OF FATHER

(State or Country)

Reservation

12. MAIDEN NAME OF MOTHER

Jessie Halse

13. BIRTHPLACE OF MOTHER

(State or Country)

Reservation

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

Peter Vincent

(Address)

Boonville, Ida

15.

Filed Oct 26 1913 W. D. L. Langer
Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH

Oct 24 1913
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from

Jan 1912, to Oct 24 1913
that I last saw him alive on Oct 10 1913

and that death occurred on the date stated above, at 3 P.M.

The CAUSE OF DEATH* was as follows:

Pulmonary Tuberculosis

(Duration) 1 yrs. 0 mos. 0 ds.

Contributory (Secondary)

(Duration) 0 yrs. 0 mos. 0 ds.

(Signed)

J. R. Leppard M. D.

Oct 26 1913 (Address) Boonville, Ida

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place

In the

of death.....yrs.....mos.....ds. State.....yrs.....mos.....ds.

Where was disease contracted,

If not at place of death?

Former or

usual residence.....

19. PLACE OF BURIAL OR REMOVAL DATE OF BURIAL

Boonville

Oct 26 1913

20. UNDERTAKER

ADDRESS

None

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Form V. S. No. 5. 12½ M. 7-24-11

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH. Registration District No. 2118
County of Bozeman Primary Registration District No. 2118
City of Bozeman (No. _____, _____ St.)

File No. 6349
Registered No. 351

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Charles Abraham

If death occurred in a hospital, institution or camp give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX _____ 4. COLOR OR RACE Malay Indian 5. SINGLE, MARRIED, WIDOWED, OR DIVORCED. Single
(Write the word.)

6. DATE OF BIRTH

June (Month) 1905 (Year)
(Day) _____

7. AGE

8 yrs. 9 mos. _____ ds.
IF LESS than 1 day how many _____ hrs. or _____ min?

8. OCCUPATION

(a) Trade, profession or particular kind of work. None
(b) General nature of industry business or establishment in which employed (or employer)

9. BIRTHPLACE

(State or Country) Reservation

10. NAME OF FATHER

Leo Abraham

11. BIRTHPLACE OF FATHER

(State or Country) Reservation

12. MAIDEN NAME OF MOTHER

Mary

13. BIRTHPLACE OF MOTHER

(State or Country) Reservation

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Leo Abraham
(Address) Bozeman, Idaho

15.

Filed Oct. 29 1913 Geo D. Longley
Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH

Oct (Month) 26 (Day) 1913 (Year)

17. I HEREBY CERTIFY, That I attended deceased from _____ 191____, to _____ 191____

that I last saw him _____ alive on _____ 191____

and that death occurred on the date stated above, at _____ M.

The CAUSE OF DEATH* was as follows:

From description of case
likely Tuberculosis

_____ (Duration) _____ yrs. _____ mos. _____ ds.

Contributory
(Secondary)

_____ (Duration) _____ yrs. _____ mos. _____ ds.

(Signed) _____ M. D.

_____ 19____ (Address)

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place _____ In the _____
of death _____ yrs. _____ mos. _____ ds. State _____ yrs. _____ mos. _____ ds.

Where was disease contracted, _____
If not at place of death? _____

Former or _____
usual residence _____

19. PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

Bozeman Oct 29 1913

20. UNDERTAKER

ADDRESS

None

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Form V. S. No. 5 20M.1-16-12

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH. Registration District No. 12
County of Berlin Primary Registration District No. 2051
City of Spokane Bridge (No. _____ St.)

File No. 6341
Registered No. 352

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Philip Giles

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX Male 4. COLOR OR RACE White 5. SINGLE, MARRIED, WIDOWED OR DIVORCED. Widower
(Write the word.)

6. DATE OF BIRTH 1840
(Month) (Day) (Year)

7. AGE 73 yrs. mos. ds.
IF LESS than 1 year, how long

8. OCCUPATION
(a) Trade, profession or particular kind of work Farmer
(b) General nature of industry, business, or establishment in which employed (or employer)

9. BIRTHPLACE Tenn.
(State or Country)

10. NAME OF FATHER Dont know.

11. BIRTHPLACE OF FATHER Dont know
(State or Country)

12. MAIDEN NAME OF MOTHER

13. BIRTHPLACE OF MOTHER
(State or Country)

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) W. F. Plonsek
(Address) Spokane Bridge, Wn

15. Filed 11/10 1913 W. F. Plonsek
Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH Oct. 26 1913
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from Oct. 22 1913, to Oct. 26 1913, that I last saw him alive on Oct. 25 1913, and that death occurred on the date stated above, at 6:30 P.M.

CAUSE OF DEATH* was as follows:
Pneumo-pneumonia.

(Duration) yrs. mos. 4 ds.
Contributory (Secondary) Influenza.

(Duration) yrs. mos. 7 ds.
(Signed) John O'Leary, M. D.
Oct. 27, 1913 (Address) Pleasant View, Idaho.

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death yrs. mos. days. In the State yrs. mos. days.

Where was disease contracted if not at place of death?

Former or usual residence.

19. PLACE OF BURIAL OR REMOVAL Pleasant View DATE OF BURIAL Oct. 27 1913

20. UNDERTAKER Cassidy & Nelson ADDRESS 209-2nd E. De.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Form V. S. No. 5 20M.1-16-12

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH.

Registration District No. 12County of BoonePrimary Registration District No. 1003City of Corn & Alene

(No. _____ St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

Viola Ximena ColbyFile No. 6342Registered No. 353

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX

4. COLOR OR RACE

5. SINGLE, MARRIED, WID-
OWED OR DIVORCED.FemalewhiteMarried

6. DATE OF BIRTH

June271883

(Month)

(Day)

(Year)

7. AGE

303mos.29ds.IF LESS than 1 day
how many hrs. or
..... mins.

8. OCCUPATION

(a) Trade, profession or
particular kind of workHousewife(b) General nature of industry
business, or establishment in
which employed (or employer)

9. BIRTHPLACE

(State or Country)

Illinois10. NAME OF
FATHERAlbert J. Atwood11. BIRTHPLACE
OF FATHER

(State or Country)

Illinois12. MAIDEN NAME
OF MOTHERCaroline Bierer13. BIRTHPLACE
OF MOTHER

(State or Country)

Illinois

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

C. Colby

(Address)

Corn & Alene, Ida

15.

Filed

11/101913M. Brown

Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH

October28th1913

(Month)

(Day)

(Year)

17. I HEREBY CERTIFY, That I attended deceased from

Oct 21st1913

to

Oct 26th1913that I last saw her alive on Oct 26th 1913and that death occurred on the date stated above, at M.

The CAUSE OF DEATH* was as follows:

Acute
Bright's Disease

(Duration)

8ds.Contributory acute indigestion
(Secondary)

(Duration)

3ds.

(Signed)

A. Hunter M. D.19

(Address)

502 Foster

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions,
Transients or Recent Residents.)At place
of death8mos.In the
State8mos.8days.Where was disease contracted
if not at place of death?Former or
usual residence

19. PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

Forest CmnNov 2 1913

20. UNDERTAKER

ADDRESS

Cassidy & Nelson Corn & Alene

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Form V. S. No. 5 20M.1-16-12

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH.

Registration District No. 12County of KootenaiPrimary Registration District No. 1003City of Paris D. Allen

(No. _____, St.)

File No. 6343Registered No. 355

If death occurs after usual residence, give facts called for under special information.

2. FULL NAME Susan Ring

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX

Female

4. COLOR OR RACE

white

5. SINGLE, MARRIED, WIDOWED OR DIVORCED.

single
(Write the word.)

6. DATE OF BIRTH

(Month)

(Day)

(Year)

7. AGE

55 yrs. 5 mos. 5 ds.IF LESS than 1 day
how many hrs. or mins.

8. OCCUPATION

(a) Trade, profession or particular kind of work

(b) General nature of industry business, or establishment in which employed (or employer)

9. BIRTHPLACE

(State or Country)

Ireland

10. NAME OF FATHER

John Ring

11. BIRTHPLACE OF FATHER

(State or Country)

Mary Powell

12. MAIDEN NAME OF MOTHER

Ireland

13. BIRTHPLACE OF MOTHER

(State or Country)

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Mr. Lomant(Address) 704 Union St. C. W. A.

15.

Filed 11/10 1913 State Registrar

Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH

Oct.29th1913

(Month)

(Day)

(Year)

17. I HEREBY CERTIFY, That I attended deceased from

Aug.1913, toOct 29th1913,that I last saw her alive on Oct 25th 1913,and that death occurred on the date stated above, at 4 P. M.

The CAUSE OF DEATH* was as follows:

Cancer of the Rectum(Duration) 2 yrs. — mos. — ds.

Contributory

(Secondary)

(Duration) — yrs. — mos. — ds.

(Signed)

Geo. B. B. M. D.Oct 1913 (Address) Paris D. Allen City

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death — yrs. — mos. — days. In the State — yrs. — mos. — days.

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

St. ThomasOct 31 1913

20. UNDERTAKER

ADDRESS

St. ThomasC. W. A.

CERTIFICATE OF DEATH.

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH.

County of Blaine
City of Parma

Registration District No.

Primary Registration District No.

(No. St.)

File No. 6344

Registered No.

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME George Robert Watson

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX

Male

4. COLOR OR RACE

White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED.

Child
(Write the word.)

6. DATE OF BIRTH.

December
22 1908
(Month) (Day) (Year)

7. AGE

4 Yrs. 10 Mos. 20 ds.IF LESS than 1 day
how many X hrs. or
..... min.

8. OCCUPATION

(a) Trade, profession or particular kind of work....
(b) General nature of industry, business, or establishment in which employed (or employer)....at Home

9. BIRTHPLACE

(State or Country)

Sheldon Iowa

10. NAME OF FATHER

James B Watson

11. BIRTHPLACE OF FATHER

(State or Country)

Pennsylvania

12. MAIDEN NAME OF MOTHER

Emma B. Tillotson

13. BIRTHPLACE OF MOTHER

(State or Country)

New York

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant)

(Address)

J. B. WatsonParma, Ind.

15.

Filed

Nov 13 1913

Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

Nov - 12 1913
(Month) (Day) (Year)17. I HEREBY CERTIFY, That I attended deceased from Oct 21 1913, to Nov 12 1913,
that I last saw him alive on Nov 12 1913
and that death occurred on the date stated above, at 9 A. M.

The CAUSE OF DEATH* was as follows:

Laryngitis complicated with meningitis probably tubercular.
(Duration) Yrs. mos. 27 ds.Contributory
(Secondary)

(Signed)

11/12 1913 (Address) Parma

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death.....yrs.....mos.....days In the State.....yrs.....mos.....days

Where was disease contracted if not at place of death?.....

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

Parma11/13 1913

20. UNDERTAKER

ADDRESS

Platt & SonsParma

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

FORM V. S. No. 5-25 M. 1-16-13

CERTIFICATE OF DEATH.

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH.

County of Cassia
City of Pampa

Registration District No.
Primary Registration District No.
(No. St.)

File No. **6345**
Registered No.

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

Mary A. Holloway

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX

F

4. COLOR OR RACE

W

5. SINGLE, MARRIED, WIDOWED OR DIVORCED.

(Write the word.)

6. DATE OF BIRTH.

May

?

1829

(Month)

(Day)

(Year)

7. AGE

84

Yrs.

7

Mos.

?

ds.

IF LESS than 1 day
how many hrs. or
..... min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work...
(b) General nature of industry, business, or establishment in which employed (or employer).....

At Home

9. BIRTHPLACE

(State or Country)

Tennessee

10. NAME OF FATHER

Tucker

11. BIRTHPLACE OF FATHER

(State or Country)

12. MAIDEN NAME OF MOTHER

13. BIRTHPLACE OF MOTHER

(State or Country)

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant)

(Address)

J. H. Holloway
Pampa, Ida. P. R. 3

15.

Filed

11/24

193

Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

11

(Month)

23

(Day)

1913

(Year)

17. I HEREBY CERTIFY, That I attended deceased from Nov. 23 1913, to same 1913, that I last saw him alive on Nov. 23 1913, and that death occurred on the date stated above, at 9 P. M.

The CAUSE OF DEATH* was as follows:

Lobar Pneumonia

(Duration) Yrs. mos. a few ds.

Contributory
(Secondary)

(Duration) yrs. mos. ds.

(Signed) Chas. B. Allen M. D.

11-24-1913 (Address) Pampa, Ida.

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death.....yrs.....mos.....days In the State.....yrs.....mos.....days

Where was disease contracted if not at place of death?.....

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

Pampa

11/24 1913

20. UNDERTAKER

ADDRESS

Platt & Graham Pampa

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be state EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Form V. S. No. 5. 10M. 6-20-11.

CERTIFICATE OF DEATH

 State of Idaho
 BOARD OF HEALTH
 Bureau of Vital Statistics

1. PLACE OF DEATH

Registration District No. 35

County of Elmore

Primary Registration District No. 3021

City of Tipton

(No. , St.)

Registered No.

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

Edward C. Regner

If death occurred in a hospital, institution or camp give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX

Male

4. COLOR OR RACE

White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED.

Married
(Write the word.)

6. DATE OF BIRTH

May

9²

1876

(Month)

(Day)

(Year)

7. AGE

36

yrs.

6

mos.

ds.

 IF LESS than 1 day
 how many hrs. or
 10 min.

8. OCCUPATION

Rancher

(a) Trade, profession or particular kind of work

(b) General nature of industry business or establishment in which employed (or employer)

9. BIRTHPLACE

(State or Country)

Idaho

10. NAME OF FATHER

Not obtainable

11. BIRTHPLACE OF FATHER

(State or Country)

Idaho

12. MAIDEN NAME OF MOTHER

Not obtainable

13. BIRTHPLACE OF MOTHER

(State or Country)

Idaho

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

J. W. Davis

(Address)

Elmer's Ferry Idaho

15.

Filed Nov 20² 1913J. W. Davis
Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

Nov.

19²

1913

(Month)

(Day)

(Year)

17. I HEREBY CERTIFY, That I attended deceased from

Nov. 16²

1913

to Nov. 19²

1913

that I last saw him alive on Nov. 18² 1913

and that death occurred on the date stated above, at 11:45 A.M.

The CAUSE OF DEATH* was as follows:

Pneumonia double lobe

(Duration) yrs. mos. 5 ds.

Contributory
(Secondary)

(Duration) yrs. mos. ds.

(Signed)

J. W. Davis

M. D.

Nov. 20² 1913

(Address) Elmer's Ferry

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death yrs. mos. ds. State yrs. mos. ds.

Where was disease contracted.

If not at place of death?

Former or

usual residence.

19. PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

Chicago Cook Co. Jail

1913

20. UNDERTAKER

ADDRESS

A. E. Thompson

Elmer's Ferry Idaho

Form V. S. No. 5. 12½M.7-24-11

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics
File No. 6341
Registered No. 5

1. PLACE OF DEATH. Registration District No. 109
County of Custer Primary Registration District No. 2187
City of Mackay (No. , St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Tom McGuire

If death occurred in a hospital, institution or camp give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX male 4. COLOR OR RACE white 5. SINGLE, MARRIED, WIDOWED OR DIVORCED. Single.
(Write the word.)

6. DATE OF BIRTH Oct 21 1913
(Month) (Day) (Year)

7. AGE about 60 yrs. IF LESS than 1 day how many hrs. or min?

8. OCCUPATION (a) Trade, profession or particular kind of work. Miner (b) General nature of industry business or establishment in which employed (or employer) Copper Mining

9. BIRTHPLACE (State or Country) Dont know

10. NAME OF FATHER Dont know

11. BIRTHPLACE OF FATHER Dont know
(State or Country)

12. MAIDEN NAME OF MOTHER Dont know

13. BIRTHPLACE OF MOTHER Dont know
(State or Country)

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE (Informant) H. B. Garlitz (Address) Mackay Ida

15. Filed Dec 1st 1913 J. P. Richards Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH Oct 21st 1913
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from 191 to 191 that I last saw h alive on 191 and that death occurred on the date stated above, at 10A.M.

The CAUSE OF DEATH* was as follows:
Probable cause a poplexy or heart disease

(Duration) yrs. mos. ds. Contributory (Secondary) Dont know (Duration) yrs. mos. ds. (Signed) R. E. Mason M. D. 10/22 1913 (Address) Mackay Ida

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place In the of death yrs. mos. ds. State yrs. mos. ds. Where was disease contracted, If not at place of death? Former or usual residence.

19. PLACE OF BURIAL OR REMOVAL DATE OF BURIAL Mackay Idaho 10/22 1913

20. UNDERTAKER ADDRESS Mr Baxter Mackay

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. N. B.—Every item of information should be carefully supplied. AGE should be state EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Form V. S. No. 5. 10M. 6-20-11.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH.

Registration District No.

County of Ada

Primary Registration District No.

City of Meridian

(No. St.)

File No. 6348

Registered No.

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

Eva Stanton

If death occurred in a hospital, institution or camp give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX

4. COLOR OR RACE

5. SINGLE, MARRIED, WIDOWED OR DIVORCED.

Female white

(Write the word.)

6. DATE OF BIRTH

Febr. 8 1916
(Month) (Day) (Year)

7. AGE

36 yrs. 9 mos. 9 ds.

IF LESS than 1 day
how many hrs. or
..... min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work
(b) General nature of industry business or establishment in which employed (or employer)

none

9. BIRTHPLACE

(State or Country)

Idaho

10. NAME OF FATHER

11. BIRTHPLACE OF FATHER

(State or Country)

12. MAIDEN NAME OF MOTHER

13. BIRTHPLACE OF MOTHER

(State or Country)

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

(Address)

15.

Filed

Nov 18 1916

Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

Nov. 17 1916
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from

Nov. 17 1916 to Nov. 17 1916that I last saw her alive on Nov. 17 1916and that death occurred on the date stated above, at 6:10 AM

The CAUSE OF DEATH* was as follows:

Don't know probably

(Duration) yrs. mos. ds.

Contributory (Secondary) Probably injured with

(Duration) yrs. mos. ds.

(Signed) J. H. Neal M. D.Nov. 17 1916 (Address) Meridian

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted.

If not at place of death?

Former or

usual residence.

19. PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

Meridian IdaNov 18 1916

20. UNDERTAKER

ADDRESS

Dr. Retacher Septon

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Form V. S. No. 5. 12½ M. 7-24-11

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH. Registration District No.
County of Boise Primary Registration District No. 3019
City of Idaho City (No. St.)

File No. 6349
Registered No. 13

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

John Delbert Koski

If death occurred in a hospital, institution or camp give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX 4. COLOR OR RACE 5. SINGLE, MARRIED, WIDOWED OR DIVORCED.

male white Single
(Write the word.)

6. DATE OF BIRTH 7 31 1912
(Month) (Day) (Year)

7. AGE IF LESS than 1 day
1 yrs. 3 mos. 19 ds. how many hrs. or min?

8. OCCUPATION

(a) Trade, profession or particular kind of work. Had none
(b) General nature of industry business or establishment in which employed (or employer)

9. BIRTHPLACE

(State or Country) Idaho

10. NAME OF FATHER John Koski

11. BIRTHPLACE OF FATHER Michigan
(State or Country)

12. MAIDEN NAME OF MOTHER Ethel Cora Warkies

13. BIRTHPLACE OF MOTHER Illinois
(State or Country)

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)
(Address)

15. Filed 191 May 1st Deputy Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH

Nov 19 1913
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from never attended him
191....., to 191.....

that I last saw him alive on 191.....

and that death occurred on the date stated above, at M.

The CAUSE OF DEATH* was as follows:

unknown

12 hrs (Duration) yrs. mos. ds.

Contributory (Secondary)

(Duration) yrs. mos. ds.

(Signed) E. G. Fitz M. P.
1913 (Address) Placerville Idaho

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place In the
of death yrs. mos. ds. State yrs. mos. ds.

Where was disease contracted,
If not at place of death?

Former or
usual residence

19. PLACE OF BURIAL OR REMOVAL DATE OF BURIAL

Idaho City Nov 21 1913

20. UNDERTAKER ADDRESS

Had none.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Form V, S. No. 5. 12½ M. 7-24-11

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics
File No. 6350
Registered No. 14

1. PLACE OF DEATH. Registration District No. 12
County of Boise Primary Registration District No. 2019
City of Idaho City (No. St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

Arthur Addison Hall

If death occurred in a hospital, institution or camp give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX male 4. COLOR OR RACE white 5. SINGLE, MARRIED, WIDOWED OR DIVORCED. married
(Write the word.)

6. DATE OF BIRTH

1873
(Month) (Day) (Year)

7. AGE

40 yrs. mos. ds.

IF LESS than 1 day
how many hrs. or min?

8. OCCUPATION

(a) Trade, profession or particular kind of work.
(b) General nature of industry business or establishment in which employed (or employer)

Clerical work

9. BIRTHPLACE

(State or Country)

Alabama

10. NAME OF FATHER

unknown

11. BIRTHPLACE OF FATHER

(State or Country)

unknown

12. MAIDEN NAME OF MOTHER

unknown

13. BIRTHPLACE OF MOTHER

(State or Country)

unknown

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

(Address)

15.

Filed Dec 8 1913

May L. Deputy
Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH

Nov 28 1913
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from

Nov 19 1913, to Nov 28 1913

that I last saw him alive on Nov 19 1913

and that death occurred on the date stated above, at 1 A.M.

The CAUSE OF DEATH* was as follows:

Bronchial Pneumonia

(Duration) yrs. mos. 9 ds.

Contributory
(Secondary)

(Duration) yrs. mos. ds.

(Signed) G. G. Fitz M. D.

Dec 8 1913 (Address) Plummerville

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place In the
of death yrs. mos. ds. State yrs. mos. ds.

Where was disease contracted,

If not at place of death?

Former or

usual residence.

19. PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

Idaho City.

Nov 30 1913

20. UNDERTAKER

ADDRESS

Had none

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Form V. S. No. 5 20M.1-16-12

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics
File No. 7 6351
Registered No. 2

1. PLACE OF DEATH.

Registration District No. 170County of CassiaPrimary Registration District No. 2199City of Marion

(No. _____)

St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

Margaret Padlock

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX

Female

4. COLOR OR RACE

White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED.

Widowed
(Write the word.)

6. DATE OF BIRTH

Jan. 26 1830
(Month) (Day) (Year)

7. AGE

83 yrs. 9 mos. 26 ds.

IF LESS than 1 day
how many hrs. or
..... mins.?

8. OCCUPATION

- (a) Trade, profession or particular kind of work
(b) General nature of industry, business, or establishment in which employed (or employer)

Home work

9. BIRTHPLACE

(State or Country)

Tennessee

10. NAME OF FATHER

James Deshanies

11. BIRTHPLACE OF FATHER

(State or Country)

Unknown

12. MAIDEN NAME OF MOTHER

13. BIRTHPLACE OF MOTHER

(State or Country)

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

O. L. Padlock

(Address)

Oakley Idaho

15.

Filed

Nov. 23 1913 E. Pollokham

Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH

Nov. 22 1913
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from

1911, to Oct. 26 1913that I last saw her alive on Oct. 24 1913and that death occurred on the date stated above, at 7 P. M.

The CAUSE OF DEATH* was as follows:

Hypostatic Pneumonia.(Duration) yrs. mos. 1 ds.Contributory Partial paralysis
(Secondary) accident Aug.

(Duration) yrs. mos. ds.

(Signed) E. Pollokham M. D.Nov. 23 1913 (Address) Oakley Idaho

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death yrs. mos. days. In the State yrs. mos. days.

Where was disease contracted if not at place of death?

Former or usual residence.

19. PLACE OF BURIAL OR REMOVAL

Marion

DATE OF BURIAL

Nov. 25 1913

20. UNDERTAKER

H. Sessions

ADDRESS

Marion, Ida

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Form V. S. No. 5 20M.1-16-12

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics
File No. **F 6352**
Registered No. **2**

1. PLACE OF DEATH.

County of **Cassia**City of **Burley**Registration District No. **170**Primary Registration District No. **2199**

(No. , St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME **Frank L. Clark**

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX

Male

4. COLOR OR RACE

White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED.

Married.
(Write the word.)

6. DATE OF BIRTH

July 22 191**3**
(Month) (Day) (Year)

7. AGE

36 yrs. **5** mos. **2** ds.

IF LESS than 1 day
how many hrs. or
..... mins.?

8. OCCUPATION

- (a) Trade, profession or particular kind of work
(b) General nature of industry business, or establishment in which employed (or employer)

Farmer**Merchant last 2 years**

9. BIRTHPLACE

(State or Country)

Utah

10. NAME OF FATHER

Thomas H. Clark

11. BIRTHPLACE OF FATHER

(State or Country)

Utah

12. MAIDEN NAME OF MOTHER

Rachel Hale

13. BIRTHPLACE OF MOTHER

(State or Country)

Utah

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

Thos H Clark

(Address)

Oakley Idaho

15.

Filed

11/28191**3****E. P. Oldham**

Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH

Nov - 24 191**3**
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from

Nov - 22 191**3**, to **Nov - 24** 191**3**,
that I last saw him alive on **Nov - 22** 191**3**,

and that death occurred on the date stated above, at **3 P.M.**

The CAUSE OF DEATH* was as follows:

**Secondary Sarcomatosis
of lungs**

(Duration) **9** yrs. **9** mos. **—** ds.Contributory
(Secondary)

**Sarcoma of forearm
treated by x-ray 2 1/2 yrs.**

(Duration) **4** yrs. **6** mos. **—** ds.

(Signed)

E. P. Oldham, M. D.**11/28/13** (Address) **Oakley Idaho**

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death yrs. mos. days. In the State yrs. mos. days.

Where was disease contracted if not at place of death?

Former or usual residence.

19. PLACE OF BURIAL OR REMOVAL

Oakley Idaho

DATE OF BURIAL

11-29-1913

20. UNDERTAKER

E. P. Thomas

ADDRESS

Oakley Idaho

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Form V. S. No. 5 20M.1-16-12

CERTIFICATE OF DEATH

1. PLACE OF DEATH.

County of Cassia

City of Bakley

Registration District No. 120

Primary Registration District No. 2199

(No. _____, St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

Benton

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

File No. F 6353

Registered No. 4

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX

Male

4. COLOR OR RACE

White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED.

Single
(Write the word.)

6. DATE OF BIRTH

Dec. 5 1913
(Month) (Day) (Year)

7. AGE

2 yrs. 11 mos. 11 ds.

IF LESS than 1 day
how many hrs. or mins.

8. OCCUPATION

- (a) Trade, profession or particular kind of work
(b) General nature of industry, business, or establishment in which employed (or employer)

9. BIRTHPLACE

(State or Country) Idaho.

10. NAME OF FATHER

Willis Allen Benton

11. BIRTHPLACE OF FATHER

(State or Country) Texas.

12. MAIDEN NAME OF MOTHER

May Mechem

13. BIRTHPLACE OF MOTHER

(State or Country) Utah.

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) W. A. Benton

(Address) Bakley Idaho.

15.

Filed 12-10 1913 E. P. Oldham
Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH

Dec. 8 1913
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from

Dec. 5 1913, to Dec. 8 1913,

that I last saw him alive on Dec. 6 1913,

and that death occurred on the date stated above, at 10 A.

The CAUSE OF DEATH* was as follows:

Unknown.
He was a few weeks premature.
24 hours ds.

Contributory
(Secondary)

(Duration) yrs. mos. ds.

(Signed) E. P. Oldham M. D.

12/8 1913 (Address) Bakley Idaho

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death yrs. mos. days. In the State yrs. mos. days.

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

Bakley Idaho 12-8 1913

20. UNDERTAKER

ADDRESS

H. H. Forrester Bakley Idaho

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Form V. S. No. 5 20M.1-16-12

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH.

Registration District No. 34County of ElmorePrimary Registration District No. 2070City of Pine

(No. _____, St.)

File No. 6354Registered No. 29

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Joseph B. McQuire

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX

Male

4. COLOR OR RACE

White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED.

married
(Write the word.)

6. DATE OF BIRTH

unknown
(Month) (Day) (Year)

7. AGE

62 yrs. — mos. — ds.

IF LESS than 1 day
how many _____ hrs. or
_____ mins.?

8. OCCUPATION

(a) Trade, profession or particular kind of work
(b) General nature of industry, business, or establishment in which employed (or employer)

Rancher

9. BIRTHPLACE

(State or Country)

America

10. NAME OF FATHER

11. BIRTHPLACE OF FATHER

(State or Country)

12. MAIDEN NAME OF MOTHER

13. BIRTHPLACE OF MOTHER

(State or Country)

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Ed McQuire(Address) Pine, Idaho

15.

Filed Nov. 18th 1913.
B. W. Mather
Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH

Nov. 17th 1913
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from

191 , to 191 ,that I last saw h. alive on 191 ,and that death occurred on the date stated above, at M.

The CAUSE OF DEATH* was as follows:

Fracture of 6th & 7th cervical vertebrae, Runaway accident sudden

(Duration) _____ yrs. _____ mos. _____ ds.

Contributory
(Secondary)

(Duration) _____ yrs. _____ mos. _____ ds.

(Signed) B. W. Mather M. D.11/17 1913 (Address) Mountain Home

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death _____ yrs. _____ mos. _____ days. In the State _____ yrs. _____ mos. _____ days.

Where was disease contracted if not at place of death? _____

Former or usual residence _____

19. PLACE OF BURIAL OR REMOVAL DATE OF BURIAL

Pine, Idaho Nov. 19th 1913

20. UNDERTAKER ADDRESS

J. M. Cowen Mountain Home

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Form V. S. No. 5 20M.1-16-12

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics
File No. 6355
Registered No. 27

1. PLACE OF DEATH. Registration District No. 34
County of Idaho Primary Registration District No. 2020
City of Mountain Home (No. _____, St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Soren A. Davis

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX Male 4. COLOR OR RACE white 5. ~~SINGLE, MARRIED, WIDOWED OR DIVORCED~~
(Write the word.)

6. DATE OF BIRTH not known
(Month) (Day) (Year)

7. AGE about 55 yrs. IF LESS than 1 day how many hrs. or mins.?

8. OCCUPATION
(a) Trade, profession or particular kind of work Road house man
(b) General nature of industry business, or establishment in which employed (or employer)

9. BIRTHPLACE
(State or Country) don't know

10. NAME OF FATHER " "

11. BIRTHPLACE OF FATHER " "

12. MAIDEN NAME OF MOTHER " "

13. BIRTHPLACE OF MOTHER " "

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) S. H. E. Carter
(Address) Mountain Home, Ida.

15. Filed Nov. 9th. 1913 B. W. Walker
Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH Nov 6th 1913
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from 1913 to 1913, that I last saw him alive on 1913, and that death occurred on the date stated above, at M.

The CAUSE OF DEATH* was as follows:

Ran over by A. S. S. train No. 5 at King Hill station

(Duration) yrs. mos. ds.

Contributory carelessness on his
(Secondary) part

(Duration) yrs. mos. ds.

(Signed) S. H. E. Carter
19 (Address) Mountain Home, Ida.

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death yrs. mos. days. In the State yrs. mos. days.

Where was disease contracted if not at place of death?

Former or usual residence.

19. PLACE OF BURIAL OR REMOVAL Mountain Home, Ida. DATE OF BURIAL Nov 10 1913

20. UNDERTAKER J. M. Cowen ADDRESS Mountain Home

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Form V. S. No. 5. 12-14 M. 7-24-11

CERTIFICATE OF DEATH

State of Mass

BOARD OF HEALTH
Bureau of Vital Statistics

File No. 6355

Registered No. _____

If death occurred in a hospital, institution or camp give its name instead of street and number.

1. PLACE OF DEATH.
County of Weymouth
City of Dorchester

Registration District No. 97
Primary Registration District No. 9174
(No. _____, St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Robt Morgan

PERSONAL AND STATISTICAL PARTICULARS

3. SEX M 4. COLOR OR RACE W 5. SINGLE, MARRIED, WIDOWED OR DIVORCED. Single
(Write the word.)

6. DATE OF BIRTH Nov 23 1913
(Month) (Day) (Year)

7. AGE _____ yrs. _____ mos. 1 ds. IF LESS than 1 day how many _____ hrs. or _____ min.

8. OCCUPATION

(a) Trade, profession or particular kind of work.

none

(b) General nature of industry business or establishment in which employed (or employer)

9. BIRTHPLACE

(State or Country)

2 du.

10. NAME OF FATHER

Art Morgan

11. BIRTHPLACE OF FATHER

(State or Country)

Ida

12. MAIDEN NAME OF MOTHER

Stella Pierce

13. BIRTHPLACE OF MOTHER

(State or Country)

Ida

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Art Morgan

(Address) Sweetwater

15.

Filed Nov 24 1913 John M. Kelley
Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

Nov 24 1913
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from Nov 23 1913, to Nov 24 1913

that I last saw him alive on Nov 23 1913 and that death occurred on the date stated above, at 3 P.M.

The CAUSE OF DEATH* was as follows:

Pneumonia

(Duration) _____ yrs. _____ mos. 1 ds.

Contributory (Secondary)

not known

(Duration) _____ yrs. _____ mos. _____ ds.

(Signed)

John M. Kelley M. D.

Nov 24 1913 (Address) Dorchester Ida

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place _____ In the _____
of death _____ yrs. _____ mos. _____ ds. State _____ yrs. _____ mos. _____ ds.

Where was disease contracted,

If not at place of death?

Former or

usual residence.

19. PLACE OF BURIAL OR REMOVAL DATE OF BURIAL

Julietta Nov 25 1913

20. UNDERTAKER

ADDRESS

J. E. Groschore Julietta
Ida

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY.
CLAIMS should state CAUSE OF DEATH in plain terms, so that it may be properly classified.
ment of OCCUPATION is very important. See instructions on back of certificate.

Form V. S. No. 5. 10M. 6-20-11.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH.

Registration District No. 59 21

County of Blaine

Primary Registration District No. 2729 2024

City of Arco

(No. St.)

File No. 635

Registered No. 43

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

Estelle Jane Montgomery

If death occurred in a hospital, institution or camp give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX

Female

4. COLOR OR RACE 5. SINGLE, MARRIED, WIDOWED OR DIVORCED.

White

Married
(Write the word.)

6. DATE OF BIRTH

October 16 1913

(Month)

(Day)

(Year)

7. AGE

33

yrs.

mos.

ds.

IF LESS than 1 day
how many.....hrs.or
min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work

House wife

(b) General nature of industry business or establishment in which employed (or employer)

9. BIRTHPLACE

(State or Country)

Idaho

10. NAME OF FATHER

Thomas Mc Guire

11. BIRTHPLACE OF FATHER

(State or Country)

New York

12. MAIDEN NAME OF MOTHER

Lucy Smith

13. BIRTHPLACE OF MOTHER

(State or Country)

Illinois

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

Charles Mc Guire

(Address)

More - elda

15.

Filed

Nov 10 1913

Robert H. Wright

Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

Nov

(Month)

7

(Day)

1913

(Year)

17. I HEREBY CERTIFY, That I attended deceased from

11-5

1913

to 11-7

1913

that I last saw him alive on 11-7 1913

and that death occurred on the date stated above, at 3:00 P.M.

The CAUSE OF DEATH* was as follows:

Acute Brights Disease

(Duration) yrs. mos. 2 ds.

Contributory
(Secondary)

(Duration) yrs. mos. ds.

(Signed) M. D.

11-10 1913 (Address) More - elda

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death.....yrs.....mos.....ds. State.....yrs.....mos.....ds.

Where was disease contracted.

If not at place of death?

Former or

usual residence.

19. PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

More - elda

11-9 1913

20. UNDERTAKER

ADDRESS

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH.

Registration District No. 21County of BlainePrimary Registration District No. 2022City of Belleuve

(No. _____, St.)

Registered No. 451

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

Mrs. William White

If death occurred in a hospital, institution or camp give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX

F

4. COLOR OR RACE

W

5. SINGLE, MARRIED, WIDOWED OR DIVORCED.

(Married)
(Write the word.)

6. DATE OF BIRTH

Nov101878

(Month)

(Day)

(Year)

7. AGE

35

yrs.

- mos.

1

ds.

IF LESS than 1 day
how many hrs. or
..... min.?

8. OCCUPATION

(a) Trade, profession, or particular kind of work

H.W.

(b) General nature of industry business, or establishment in which employed (or employer)

9. BIRTHPLACE

(State or Country)

Mo

10. NAME OF FATHER

John Burke

11. BIRTHPLACE OF FATHER

(State or Country)

Mo.

12. MAIDEN NAME OF MOTHER

13. BIRTHPLACE OF MOTHER

(State or Country)

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

J. W. White

(Address)

Belleuve, Ida.

15.

Filed

Nov 14 1913Robert H. Wright

Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

Nov121913

(Month)

(Day)

(Year)

17. I HEREBY CERTIFY, That I attended deceased from

Oct 181913

to

Nov 121913that I last saw him alive on Nov 12 1913,and that death occurred on the date stated above, at 2:30 M.

The CAUSE OF DEATH* was as follows:

Myocarditis Endocarditis(Duration) yrs. mos. 28 ds.Contributory
(Secondary)

(Duration) yrs. mos. ds.

(Signed) W. K. Klemm M. D.Nov 12 1913 (Address) Harley

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place

In the

of death yrs. mos. ds. State yrs. mos. ds.

Where was Disease contracted,

If not at place of death?

Former or

usual residence

19. PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

Belleuve IdaNov 14 1913

20. UNDERTAKER

ADDRESS

R. D. HarrisHarleyMARGIN RESERVED FOR BINDING
WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
N. B.—Every item of information should be carefully supplied. AGE should be state EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Form V. S. No. 5. 10M. 6-20-11.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics
File No. **6359**
Registered No. **46**

1. PLACE OF DEATH.

Registration District No. **21**County of **Blaine**Primary Registration District No. **2022**City of **Hailey**

(No. _____)

St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

Columbus Marion Brooks

If death occurred in a hospital, institution or camp give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX

Male

4. COLOR OR RACE

wh.

5. SINGLE, MARRIED, WIDOWED OR DIVORCED.

Widowed
(Write the word.)

6. DATE OF BIRTH

April 8 1844
(Month) (Day) (Year)

7. AGE

69 yrs. 8 mos. 26 ds.

IF LESS than 1 day
how many _____ hrs. or
_____ min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work

Farmer.

(b) General nature of industry business or establishment in which employed (or employer)

9. BIRTHPLACE

(State or Country)

Missouri

10. NAME OF FATHER

Henry Brooks

11. BIRTHPLACE OF FATHER

(State or Country)

✓

12. MAIDEN NAME OF MOTHER

Frances Brooks

13. BIRTHPLACE OF MOTHER

(State or Country)

✓

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

A. S. Brooks

(Address)

Hailey, Ida.

15.

Filed

Dec 22 1913**Robert W. Wright**
Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

Nov 30

(Month)

(Day)

1913
(Year)

17. I HEREBY CERTIFY, That I attended deceased from

Nov 23 1913, to Nov 30 1913that I last saw him alive on **Nov 30 1913**and that death occurred on the date stated above, at **3:30 P.M.**

The CAUSE OF DEATH* was as follows:

Arteriosclerosis of liver(Duration) **six** yrs. **—** mos. **—** ds.

Contributory (Secondary)

Arteriosclerosis(Duration) **—** yrs. **—** mos. **—** ds.

(Signed)

W. H. H. M. D.
Nov 30 1913 (Address) **Hailey, Ida.**

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and 2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death _____ yrs. _____ mos. _____ ds. State _____ yrs. _____ mos. _____ ds.

Where was disease contracted, If not at place of death?

Former or usual residence.

19. PLACE OF BURIAL OR REMOVAL

Hailey

DATE OF BURIAL

Dec 24 1913

20. UNDERTAKER

Ralph Harris

ADDRESS

Hailey

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Form V. S. No. 5 20M.1-16-12

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital StatisticsFile No. **6361**

Registered No.

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

1. PLACE OF DEATH.

Registration District No. **5**County of **Canyon**Primary Registration District No. **2009**City of **New Plymouth**(No. **1**)

St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME **James Creasey**

PERSONAL AND STATISTICAL PARTICULARS

3. SEX **Male**4. COLOR OR RACE **White**5. SINGLE, MARRIED, WIDOWED OR DIVORCED.
Married
(Write the word.)6. DATE OF BIRTH **Mar 24 1829**

(Month)

(Day)

(Year)

7. AGE **84 yrs. 7 mos. 24 ds.**IF LESS than 1 day
how many hrs. or
..... mins.?8. OCCUPATION **Retired Farmer**

- (a) Trade, profession or particular kind of work
(b) General nature of industry, business, or establishment in which employed (or employer)

9. BIRTHPLACE **England**

(State or Country)

10. NAME OF FATHER **John Creasey**11. BIRTHPLACE OF FATHER **England**

(State or Country)

12. MAIDEN NAME OF MOTHER **Jackson**13. BIRTHPLACE OF MOTHER **England**

(State or Country)

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) **Lloyd J. Creasey**(Address) **New Plymouth**

15.

Filed **Nov 19 1913**

191

Wm J. Draydole

Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH **Nov 18 1913**

(Month)

(Day)

(Year)

17. I HEREBY CERTIFY, That I attended deceased from **Nov 16 1913**, to **Nov 17 1913**, that I last saw him alive on **Nov 17 1913**, and that death occurred on the date stated above, at **4 A.M.**

The CAUSE OF DEATH* was as follows:

Cerebral Hemorrhage(Duration) **many** yrs.

mos.

2 ds.Contributory **Arteriosclerosis**
(Secondary)(Duration) **many** yrs.

mos.

ds.

(Signed) **Wm J. Draydole**

M. D.

19

(Address)

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place

of death yrs. mos. days.

In the

State yrs. mos. days.

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL DATE OF BURIAL

New Plymouth **Nov 19 1913**20. UNDERTAKER **H. McChair Payette**ADDRESS **Idaho**

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Form V. S. No. 5 20M.1-16-12

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH. Registration District No. 86
County of Washington Primary Registration District No. 1010
City of Weiser (No. East Main St.)

File No. 6353Registered No. 16

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Baby Furniss

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX Female 4. COLOR OR RACE White 5. SINGLE, MARRIED, WIDOWED OR DIVORCED. single
(Write the word.)

6. DATE OF BIRTH Nov - 8 - 1913
(Month) (Day) (Year)

7. AGE _____ yrs. _____ mos. _____ ds. IF LESS than 1 day how many _____ hrs. or _____ mins.?

8. OCCUPATION

(a) Trade, profession or particular kind of work none

(b) General nature of industry business, or establishment in which employed (or employer)

9. BIRTHPLACE (State or Country) Weiser; Idaho

10. NAME OF FATHER F. S. Furniss

11. BIRTHPLACE OF FATHER St. Charles; Idaho
(State or Country)

12. MAIDEN NAME OF MOTHER Clarissa McNeal

13. BIRTHPLACE OF MOTHER State of Utah
(State or Country)

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) F. S. Furniss(Address) city

15. _____

Filed Nov 9th 1913 Dr. R. Hamulka

Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH Nov - 8 - 1913
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from 191, to 191,

that I last saw her alive on Nov 8 1913,

and that death occurred on the date stated above, at P. M.

The CAUSE OF DEATH* was as follows:

Practically a still birth just living 3 hours.

(Duration) _____ yrs. _____ mos. _____ ds.

Contributory (Secondary) X

(Duration) _____ yrs. _____ mos. _____ ds.

(Signed) James A. Jones M. D.11/ 1913 (Address) Weiser Idaho

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death _____ yrs. _____ mos. _____ days. In the State _____ yrs. _____ mos. _____ days.

Where was disease contracted if not at place of death? _____

Former or usual residence _____

19. PLACE OF BURIAL OR REMOVAL Weiser IdahoDATE OF BURIAL 11/9 191320. UNDERTAKER A. G. CordelleADDRESS Weiser, Ida.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Form V. S. No. 5 20M.1-16-12

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH.

County of WashingtonRegistration District No. 86City of WenatcheePrimary Registration District No. 1010(No. St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

Jacob WecklundFile No. 6361Registered No. 15

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX

Male

4. COLOR OR RACE

White5. SINGLE, MARRIED, WIDOWED OR DIVORCED;
Married
(Write the word.)

6. DATE OF BIRTH

Oct101854

(Month)

(Day)

(Year)

7. AGE

58

yrs.

mos. 27 ds.IF LESS than 1 day
how many hrs. or
..... mins.?

8. OCCUPATION

(a) Trade, profession or particular kind of work

Farmer

(b) General nature of industry, business, or establishment in which employed (or employer)

9. BIRTHPLACE

(State or Country)

Minnesota

10. NAME OF FATHER

Jacob Wecklund

11. BIRTHPLACE OF FATHER

(State or Country)

Sweden

12. MAIDEN NAME OF MOTHER

Ella Johnson

13. BIRTHPLACE OF MOTHER

(State or Country)

Sweden

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

Ella Wecklund

(Address)

Salem Ore.

15.

Filed

Mr. H.1913D. R. Kunkle

Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH

Nov71913

(Month)

(Day)

(Year)

17. I HEREBY CERTIFY, That I attended deceased from

Nov 11913, toNov 71913that I last saw him alive on Nov 7 1913and that death occurred on the date stated above, at 2:30 PM

The CAUSE OF DEATH* was as follows:

Shock following operation for
intestinal obstruction

(Duration)

yrs.

mos. 7 ds.Contributory
(Secondary)operation for appendicitis

(Duration)

yrs.

mos. 9 ds.

(Signed)

Samuel J. Edwards M. D.11/8 1913 (Address) Wenatchee, Ida

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place

of death

yrs.

mos.

days.

In the

State

yrs.

mos.

days.

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

Elmore, Utah1913

20. UNDERTAKER

ADDRESS

L. B. NorthrupWenatchee, Ida

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Form V. S. No. 5. 12½ M. 7-24-11

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics
File No. 636
Registered No. 12

1. PLACE OF DEATH
County of Washington
City of Winnemucca

Registration District No. 26 2nd 86
Primary Registration District No. 2163
(No. Winnemucca St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

Effie Campbell

If death occurred in a hospital, institution or camp give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX Female 4. COLOR OR RACE White 5. SINGLE, MARRIED, WIDOWED OR DIVORCED. Single
(Write the word.)

6. DATE OF BIRTH 10 (Month) 20 (Day) 1913 (Year)

7. AGE 6 yrs. 6 mos. 6 ds. IF LESS than 1 day how many hrs. or min?

8. OCCUPATION

- (a) Trade, profession or particular kind of work
(b) General nature of industry business or establishment in which employed (or employer)

None

9. BIRTHPLACE

(State or Country)

Heiser Valley

10. NAME OF FATHER

Jas W. Campbell

11. BIRTHPLACE OF FATHER

(State or Country)

Idaho

12. MAIDEN NAME OF MOTHER

Lena Ottman

13. BIRTHPLACE OF MOTHER

(State or Country)

Idaho

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

(Address)

James W. Campbell
Heiser, Idaho

15.

Filed Oct 20 1913

D. R. Hamilton

Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH

10 (Month) 20 (Day) 1913 (Year)

17. I HEREBY CERTIFY, That I attended deceased from 10/1 1913, to 10/20 1913

that I last saw her alive on Oct 20 1913 and that death occurred on the date stated above, at 2:30 PM

The CAUSE OF DEATH* was as follows:

Cholera

(Duration) yrs. mos. 5 ds.

Contributory (Secondary)

(Duration) yrs. mos. ds.

(Signed) A. R. Chivers M. D.

10/20 1913 (Address)

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted,

If not at place of death?

Former or

usual residence.

19. PLACE OF BURIAL OR REMOVAL DATE OF BURIAL

Heiser Ida Oct 2 1913

20. UNDERTAKER ADDRESS

A. W. Bowen Heiser, Ida.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Form V. S. No. 5 20M.1-16-12

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics
File No. **6368**
Registered No. **11**

1. PLACE OF DEATH.

County of *Washington*Registration District No. *86*City of *Mesa*Primary Registration District No. *1010*(No. *Theodore Whitney* St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

Theodore Whitney

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX

Male

4. COLOR OR RACE

Wht

5. SINGLE, MARRIED, WID-
OWED OR DIVORCED
married
(Write the word.)

6. DATE OF BIRTH

May 12 1868
(Month) (Day) (Year)

7. AGE

45 yrs. *4* mos. *27* ds.

IF LESS than 1 day
how many hrs. or
..... mins.?

8. OCCUPATION

(a) Trade, profession or
particular kind of work
(b) General nature of industry
business, or establishment in
which employed (or employer)

Barber

9. BIRTHPLACE

(State or Country)

Indiana

10. NAME OF FATHER

11. BIRTHPLACE OF FATHER

(State or Country)

12. MAIDEN NAME OF MOTHER

Sarah Murray

13. BIRTHPLACE OF MOTHER

(State or Country)

Ireland

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

Mary Whitney

(Address)

Boise Idaho

15.

Filed

Oct 10

1913

M. R. Hamblin

Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH

Oct 10 1913
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from

Oct 3 1913, to *Oct 10 1913*;

that I last saw him alive on *Oct 2 1913*,

and that death occurred on the date stated above, at *9 P. M.*

The CAUSE OF DEATH* was as follows:.

Veronal Poisoning
Suicidal?

(Duration) yrs. mos. *25* ds.

Contributory
(Secondary)

(Duration) yrs. mos. ds.

(Signed)

Samuel R. Samuels M. D.
Oct 11 1913 (Address) *Weiser Idaho*.

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death yrs. mos. days. In the State yrs. mos. days.

Where was disease contracted
if not at place of death?

Former or
usual residence.

19. PLACE OF BURIAL OR REMOVAL

Weiser

DATE OF BURIAL

Oct 12 1913

20. UNDERTAKER

L. B. Northrup

ADDRESS

Weiser Idaho

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Form V. S. No. 5 20M.1-16-12

CERTIFICATE OF DEATH

 State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH.

 County of Washington
City of Wenatchee
Registration District No. 86Primary Registration District No. 1010

(No. _____ St.)

File No. 6369Registered No. 10

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Herbert Borgman

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX

Male

4. COLOR OR RACE

Wht

5. SINGLE, MARRIED, WIDOWED OR DIVORCED.

Single
(Write the word.)

6. DATE OF BIRTH

Sept 29 1909
(Month) (Day) (Year)

7. AGE

3 yrs. 11 mos. 20 ds.

 IF LESS than 1 day
how many hrs. or
..... mins.?

8. OCCUPATION

- (a) Trade, profession or particular kind of work
(b) General nature of industry, business, or establishment in which employed (or employer)

9. BIRTHPLACE

(State or Country) Weiser

10. NAME OF FATHER

N. J. Borgman

11. BIRTHPLACE OF FATHER

(State or Country) Sweden

12. MAIDEN NAME OF MOTHER

Elizabeth Edstrom

13. BIRTHPLACE OF MOTHER

(State or Country) Sweden

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) H. J. Borgman(Address) Weiser Idaho

15.

Filed Oct 7 1913
D. R. Krumholz
Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH

September 19 1913
(Month) (Day) (Year)

 17. I HEREBY CERTIFY, That I attended deceased from Sept 9 1913, to September 19 1913, that I last saw him alive on September 19 1913, and that death occurred on the date stated above, at M.

The CAUSE OF DEATH* was as follows:

Scarlet fever(Duration) yrs. mos. 10 da.Contributory (Secondary) none

(Duration) yrs. mos. ds.

(Signed) James A. James M. D.
Sept 19 1913 (Address) Weiser Idaho

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death yrs. mos. days. In the State yrs. mos. days.

Where was disease contracted if not at place of death?

Former or usual residence.

19. PLACE OF BURIAL OR REMOVAL

Weiser Cemetery

DATE OF BURIAL

Sept 19 1913

20. UNDERTAKER

L. C. Northman

ADDRESS

Weiser Idaho

Form V. S. No. 5 20M.1-16-12

CERTIFICATE OF DEATH

 State of Idaho
 BOARD OF HEALTH
 Bureau of Vital Statistics

1. PLACE OF DEATH.

Registration District No. 96County of Nog RiverPrimary Registration District No. 1009City of Lewiston(No. 305, Main St.)File No. 0370Registered No. 64

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

BB Morgan

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX

Male

4. COLOR OR RACE

W.

5. SINGLE, MARRIED, WIDOWED OR DIVORCED.

Single
(Write the word.)

6. DATE OF BIRTH

1
(Month)1
(Day)1913
(Year)

7. AGE

35 yrs. — mos. — ds.
 IF LESS than 1 day
 how many hrs. or
 mins.?

8. OCCUPATION

(a) Trade, profession or particular kind of work

Barber

(b) General nature of industry business, or establishment in which employed (or employer)

9. BIRTHPLACE

(State or Country)

not known

10. NAME OF FATHER

11. BIRTHPLACE OF FATHER

(State or Country)

12. MAIDEN NAME OF MOTHER

13. BIRTHPLACE OF MOTHER

(State or Country)

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

J. J. Vassar

(Address)

Lewiston

15.

Filed

Dec-101913L. J. Perkins

Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH

Nov.261913

(Month)

(Day)

(Year)

17. I HEREBY CERTIFY, That I attended deceased from

1913, to 1913,1913,that I last saw him alive on 1913,and that death occurred on the date stated above, at 12 P.M.

The CAUSE OF DEATH* was as follows:

Gun shot wound— (Duration) — yrs. — mos. — ds.

Contributory

(Secondary)

— (Duration) — yrs. — mos. — ds.

(Signed)

J. J. Vassar

19

(Address)

Lewiston, Idaho

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place

of death — yrs. — mos. — days.

In the

State — yrs. — mos. — days.

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

Farlin, Iowa1913

20. UNDERTAKER

ADDRESS

C. J. VassarLewiston

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Form V. S. No. 5 20M.1-16-12

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH.

Registration District No. 92

County of Myer

Primary Registration District No. 1009

City of Lewiston

(No. Hospital St.)

File No. 6371

Registered No. 53

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

Tom Wong

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX

M

4. COLOR OR RACE

Chinese

5. SINGLE, MARRIED, WIDOWED OR DIVORCED.

married
(Write the word.)

6. DATE OF BIRTH

Dec

10

1

(Month)

(Day)

(Year)

7. AGE

52 yrs. 11 mos. 14 ds.

IF LESS than 1 day
how many hrs. or
..... mins.?

8. OCCUPATION

(a) Trade, profession or particular kind of work

Labover

(b) General nature of industry business, or establishment in which employed (or employer)

9. BIRTHPLACE

(State or Country)

China

10. NAME OF FATHER

Wong, Hing

11. BIRTHPLACE OF FATHER

(State or Country)

China

12. MAIDEN NAME OF MOTHER

See

13. BIRTHPLACE OF MOTHER

(State or Country)

China

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

W. Joe Jay U.S.

(Address)

Lewiston

15.

Filed

Dec 10

1913

L. J. Perkins

Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH

Nov

26

1913

(Month)

(Day)

(Year)

17. I HEREBY CERTIFY, That I attended deceased from

Nov 25 1913, to Nov 26 1913,

that I last saw him alive on Nov 26 1913,

and that death occurred on the date stated above, at 6 P. M.

The CAUSE OF DEATH* was as follows:

Asmia

(Duration) yrs. mos. ds.

Contributory (Secondary)

Unknown

(Duration) yrs. mos. ds.

(Signed)

Nov 25 1913 (Address) Lewiston Idaho

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death yrs. mos. days. In the State yrs. mos. days.

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

Lewiston

Nov 27 1913

20. UNDERTAKER

ADDRESS

C. J. Vassar

Lewiston

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Form V. S. No. 5 20M.1-16-12

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH. Registration District No. 96
County of Bozeman Primary Registration District No. 1009
City of Lewiston (No. 703, 10 St. St.)

File No. 6372
Registered No. 52

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Edward Fieban

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX M 4. COLOR OR RACE W 5. SINGLE, MARRIED, WIDOWED OR DIVORCED. married
(Write the word.)

6. DATE OF BIRTH October 25 1849
(Month) (Day) (Year)

7. AGE 64 yrs. 1 mos. 1 ds. IF LESS than 1 day how many hrs. or mins.?

8. OCCUPATION
(a) Trade, profession or particular kind of work Lumberman
(b) General nature of industry business, or establishment in which employed (or employer)

9. BIRTHPLACE (State or Country) Kilkenny Ireland

10. NAME OF FATHER James Fieban

11. BIRTHPLACE OF FATHER (State or Country)

12. MAIDEN NAME OF MOTHER Mary Hosland Fieban

13. BIRTHPLACE OF MOTHER (State or Country)

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Joie Fieban
(Address) Lewiston Idaho

15. Filed Dec 10 1913 R. G. Fieban
Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH Nov 26 1913
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from Nov 5 1913, to Nov 26 1913, that I last saw him alive on Nov 26 1913, and that death occurred on the date stated above, at 9 A.M.
The CAUSE OF DEATH* was as follows:

Carcinoma of Bill Duct

(Duration) 2 yrs. 2 mos. 2 ds.

Contributory (Secondary)

(Duration) 2 yrs. 2 mos. 2 ds.

(Signed) E. G. Biggs M. D.

Nov 26 1913 (Address) Lewiston Idaho

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death 2 yrs. 2 mos. 2 days. In the State 2 yrs. 2 mos. 2 days.

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL Lewiston DATE OF BURIAL Nov 27 1913

20. UNDERTAKER C. J. Fieban ADDRESS Lewiston

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Form V. S. No. 5 20M.1-16-12

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. **PLACE OF DEATH** Registration District No. 96
County of New Pacer Primary Registration District No. 1009
City of Leaverton (No. 910, W. Main St.)
If death occurs away from usual residence, give facts called for under special information.

2. **FULL NAME** Patronila Campania

File No. 6374
Registered No. 50
If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. **SEX** ♀ 4. **COLOR OR RACE** S 5. **SINGLE, MARRIED, WIDOWED OR DIVORCED.** Widow
(Write the word.)

6. **DATE OF BIRTH** August 1st 1830
(Month) (Day) (Year)

7. **AGE** 83 yrs. 2 mos. 24 ds.
IF LESS than 1 day how many hrs. or mins.?

8. **OCCUPATION**
(a) Trade, profession or particular kind of work None
(b) General nature of industry, business, or establishment in which employed (or employer)

9. **BIRTHPLACE** (State or Country) Cosala Mexico

10. **NAME OF FATHER** Marto Campania

11. **BIRTHPLACE OF FATHER** (State or Country) Not known

12. **MAIDEN NAME OF MOTHER** Josefa Beltran

13. **BIRTHPLACE OF MOTHER** (State or Country) Not known

14. **THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE**
(Informant) John J. Smith
(Address) Leaverton, Idaho

15. Filed Dec 10 1913 P. J. Perkins
Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. **DATE OF DEATH** Nov. 24 1913
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from July 1913, to Nov. 24 1913, that I last saw her alive on Nov. 17 1913 and that death occurred on the date stated above, at A. M.

The CAUSE OF DEATH* was as follows:
General senility
arterio-sclerosis

(Duration) yrs. mos. ds.

Contributory (Secondary)

(Duration) yrs. mos. ds.

(Signed) P. J. Perkins M. D.
11-25 1913 (Address) Leaverton

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. **LENGTH OF RESIDENCE** (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death yrs. mos. days. In the State yrs. mos. days.

Where was disease contracted if not at place of death?

Former or usual residence

19. **PLACE OF BURIAL OR REMOVAL** Leaverton **DATE OF BURIAL** Nov. 25 1913

20. **UNDERTAKER** Ed. Chasman **ADDRESS** Leaverton, Idaho

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Form V. S. No. 5 20M.1-16-12

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH

Registration District No. 96

County of 1897 Perce

Primary Registration District No. 1009

City of Lewiston

(No. Hospital St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

Wm. C. Curry

File No. 0370

Registered No. 49

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX M.

4. COLOR OR RACE W

5. SINGLE, MARRIED, WID-
OWED OR DIVORCED.

(Write the word.) Single

6. DATE OF BIRTH

Not known

(Month)

(Day)

(Year)

7. AGE

74

yrs.

mos.

ds.

IF LESS than 1 day
how many hrs. or
..... mins.

8. OCCUPATION

(a) Trade, profession or
particular kind of work

Trainer

(b) General nature of industry
business, or establishment in
which employed (or employer)

9. BIRTHPLACE

(State or Country)

Not known

10. NAME OF
FATHER

W. C.

11. BIRTHPLACE
OF FATHER

(State or Country)

W. C.

12. MAIDEN NAME
OF MOTHER

W. C.

13. BIRTHPLACE
OF MOTHER

(State or Country)

W. C.

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

L. J. Pugh

(Address)

Lewiston

15.

Filed

Dec 10

1913

L. J. Pugh

Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH

Nov

24

1913

(Month)

(Day)

(Year)

17. I HEREBY CERTIFY, That I attended deceased from

Nov 16

1913

to Nov 24

1913

that I last saw him alive on Nov 24 1913

and that death occurred on the date stated above, at 5:15 P.M.

The CAUSE OF DEATH* was as follows:

Valvular Heart Disease

(Duration)

yrs.

mos.

ds.

Contributory
(Secondary)

(Duration)

yrs.

mos.

ds.

(Signed)

J. H. Pugh

M. D.

Nov 24, 1913. (Address) Lewiston, Idaho

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place

of death.....yrs.....mos.....days.

In the

State.....yrs.....mos.....days.

Where was disease contracted
if not at place of death?Former or
usual residence

19. PLACE OF BURIAL OR REMOVAL

Lewiston

DATE OF BURIAL

Nov 24, 1913

20. UNDERTAKER

C. J. Vassar

ADDRESS

Lewiston

Form V. S. No. 5. 12½ M. 7-24-11

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH.

Registration District No. 96

County of Blaine

Primary Registration District No. 1009

City of

(No. County Poor Farm St.)

File No. 6389

Registered No. 444

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

Richard D Dooley

If death occurred in a hospital, institution or camp give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX

Male

4. COLOR OR RACE

White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED.

Single
(Write the word.)

6. DATE OF BIRTH

Mar

(Month)

(Day)

1844

(Year)

7. AGE

69

yrs.

mos.

ds.

IF LESS than 1 day

how many hrs. or min?

8. OCCUPATION

(a) Trade, profession or particular kind of work.

Common Laborer and Sailor

(b) General nature of industry business or establishment in which employed (or employer)

9. BIRTHPLACE

(State or Country)

Ireland

10. NAME OF FATHER

Michael Dooley

11. BIRTHPLACE OF FATHER

(State or Country)

Ireland

12. MAIDEN NAME OF MOTHER

Bridget Norton

13. BIRTHPLACE OF MOTHER

(State or Country)

Ireland

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

C. J. Stranahan

(Address)

Lewiston

15.

Filed

Dec. 10 1913

L. J. Perkins

Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH

Nov

(Month)

18

(Day)

1913

(Year)

17. I HEREBY CERTIFY, That I attended deceased from

July 27 1911, to Nov 18 1913

that I last saw him alive on Nov 18 1913

and that death occurred on the date stated above, at 1 PM

The CAUSE OF DEATH* was as follows:

Cancer of the Lungs

(Duration) 2 yrs. mos. ds.

Contributory (Secondary)

(Duration) yrs. mos. ds.

(Signed)

C. J. Stranahan M. D.

19 (Address) Supt. Co. Hosp.

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place County Hosp. In the City of Lewiston

of death 2 yrs. 4 mos. ds. State 1913

Where was disease contracted,

If not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL

Lewiston

DATE OF BURIAL

Nov 19 1913

20. UNDERTAKER

C. J. Vassar

ADDRESS

Lewiston

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Form V. S. No. 5 20M.1-16-12

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH

Registration District No. 91

County of *Boise*

Primary Registration District No. 1007

City of *Lewiston*(No. *1000* *By right of Way* St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

Chas H. Smith

File No. 6551

Registered No. 43

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX

4. COLOR OR RACE

5. SINGLE, MARRIED, WIDOWED OR DIVORCED.

*M**W.**Married*
(Write the word.)

6. DATE OF BIRTH

June 7 1869
(Month) (Day) (Year)

7. AGE

*44 yrs. 5 mos. 10 ds.*IF LESS than 1 day
how many hrs. or
..... mins.?

8. OCCUPATION

(a) Trade, profession or particular kind of work

(b) General nature of industry business, or establishment in which employed (or employer)

Bridge Carpenter
Camas Prairie RR

9. BIRTHPLACE

(State or Country)

Canada

10. NAME OF FATHER

James S. Smith

11. BIRTHPLACE OF FATHER

(State or Country)

Canada

12. MAIDEN NAME OF MOTHER

Sarah J. Hawkins

13. BIRTHPLACE OF MOTHER

(State or Country)

Conn.

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

J. E. Smith

(Address)

15.

Filed

Dec 10

1918

L. J. Pearson

Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

11 17 1918
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from

1918 to *1918*
that I last saw him alive on *1918*and that death occurred on the date stated above, at *M.*

The CAUSE OF DEATH* was as follows:

Accidental
Run over by car striking him

(Duration) yrs. mos. ds.

Contributory
(Secondary)

(Duration) yrs. mos. ds.

(Signed) *C. J. Vassar* M. D.19. (Address) *Lewiston*

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death yrs. mos. days. In the State yrs. mos. days.

Where was disease contracted if not at place of death?

Former or usual residence.

19. PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

*Lewiston**Nov 20 1918*

20. UNDERTAKER

ADDRESS

*C. J. Vassar**Lewiston*

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Form V. S. No. 5 20M.1-16-12

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics
File No. 6382

1. PLACE OF DEATH. Registration District No. 96
County of Boise Primary Registration District No. 1009
City of Lewiston (No. Ballinger Hotel St.)

Registered No. 42

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

Jwain Clark

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX Male 4. COLOR OR RACE White 5. SINGLE, MARRIED, WID-
OWED OR DIVORCED. Single
(Write the word.)

6. DATE OF BIRTH

Oct 19 1913
(Month) (Day) (Year)

7. AGE

..... yrs. mos. 28 ds.

IF LESS than 1 day
how many hrs. or
..... mins.?

8. OCCUPATION

- (a) Trade, profession or particular kind of work
(b) General nature of industry business, or dtablissement in which employed (or employer)

9. BIRTHPLACE

(State or Country)

Coules City Wash

10. NAME OF FATHER

San Clarke

11. BIRTHPLACE OF FATHER

(State or Country)

Oregon

12. MAIDEN NAME OF MOTHER

Elie Akin

13. BIRTHPLACE OF MOTHER

(State or Country)

Oregon

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

Kora Clark

(Address)

15.

Filed

Dec-101913L J Persias

Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH

Nov 16 1913
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from

Nov 16 1913, to Nov 16 1913,

that I last saw him alive on Nov 16 1913,

and that death occurred on the date stated above, at 11:15 PM.

The CAUSE OF DEATH* was as follows:

Mal nutrition

..... (Duration) yrs. mos. ds.

Contributory Same
(Secondary)

..... (Duration) yrs. mos. ds.

(Signed) Edgar L. White M.D.

Nov 16 1913 (Address) Lewiston Ida

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death yrs. mos. days. In the State yrs. mos. days.

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

Asotin Cy WashNov 17 1913

20. UNDERTAKER

ADDRESS

DR R. MerchantAsotin

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Form V. S. No. 5. 12½M.7-24-11

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital StatisticsFile No. 6383
Registered No. 40

1. PLACE OF DEATH. Registration District No. 96
County of Nez Perce Primary Registration District No. 1009
City of Lewiston, ID (No. , St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

John Albert Stephenson

If death occurred in a hospital, institution or camp give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX 4. COLOR OR RACE 5. SINGLE, MARRIED, WIDOWED OR DIVORCED.

Male White married (Write the word.)

6. DATE OF BIRTH

Nov 13 1881
(Month) (Day) (Year)

7. AGE

31 yrs. 11 mos. 29 ds.

IF LESS than 1 day
how many... hrs. or
... min?

8. OCCUPATION

(a) Trade, profession or particular kind of work
(b) General nature of industry business or establishment in which employed (or employer)

Common laborer

9. BIRTHPLACE

(State or Country)

10. NAME OF FATHER

Thomas Stephenson

11. BIRTHPLACE OF FATHER

(State or Country)

Canada

12. MAIDEN NAME OF MOTHER

Johnna Williams

13. BIRTHPLACE OF MOTHER

(State or Country)

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

C. T. Shanahan

(Address)

Lewiston, ID

15.

Filed Dec 10 1913

L. J. Perkins
Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH

Nov 10 1913
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from

Oct 6th 191, to Nov 10 1913

that I last saw him alive on Nov 10 1913

and that death occurred on the date stated above, at 8:45 PM.

The CAUSE OF DEATH* was as follows:

Tuberculosis of spine

(Duration) 3 yrs. — mos. — ds.

Contributory (Secondary)

(Duration) — yrs. — mos. — ds.

(Signed) C. T. Shanahan

19 (Address) Supt. Co Hospital

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place County Hosp In the Nez Perce Co
of death — yrs. — mos. — ds. State — yrs. — mos. — ds.

Where was disease contracted,
If not at place of death?

Former or
usual residence.

19. PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

Lewiston

12th 1913

20. UNDERTAKER

ADDRESS

C. J. Vassar

Lewiston

Form V. S. No. 5 20M.1-16-12

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH

Registration District No. 96

County of *Nez Perce*

Primary Registration District No. 1009

City of *Lewiston*(No. *Hospital* St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME *Oliver Chandler*

File No. 6381

Registered No. 89

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX *M*4. COLOR OR RACE *W.*

5. SINGLE, MARRIED, WIDOWED OR DIVORCED.

(Write the word.) *single*

6. DATE OF BIRTH

March 23

(Month)

(Day)

(Year) *1913*

7. AGE

23 yrs. *7* mos. *16* ds.IF LESS than 1 day
how many hrs. or
..... mins.?

8. OCCUPATION

(a) Trade, profession or particular kind of work

none

(b) General nature of industry business, or establishment in which employed (or employer)

9. BIRTHPLACE

(State or Country)

S. Dakota

10. NAME OF FATHER

G. H. Chandler

11. BIRTHPLACE OF FATHER

(State or Country)

Penn.

12. MAIDEN NAME OF MOTHER

Smith

13. BIRTHPLACE OF MOTHER

(State or Country)

Penn.

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

J. J. Vassar

(Address)

City

15.

Filed

Dec 10

1913

J. J. Vassar

Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH

Lewiston Ida Nov 9th 1913
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from

Nov 7th 1913, to *Nov 8th* 1913that I last saw him alive on *Nov 8th* 1913and that death occurred on the date stated above, at *1230 PM*

The CAUSE OF DEATH* was as follows:

Capillary Bronchitis

(Duration) yrs. mos. ds.

Contributory (Secondary)

Chronic Bronchitis

(Duration) yrs. mos. ds.

(Signed)

J. J. Vassar

M. D.

Nov 9 1913 (Address) *Lewiston*

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death yrs. mos. days. In the State yrs. mos. days.

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

*Cem De Aline**Nov* 1913

20. UNDERTAKER

ADDRESS

*C. J. Vassar**Lewiston*

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Form V. S. No. 5 20M.1-16-12

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics
File No. 6385

1. PLACE OF DEATH.

Registration District No. 96

County of Benewah

Primary Registration District No. 6009

City of Lewiston(No. 1206 15 th W St.)

Registered No. 37

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

Isabelle Miller

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX

F

4. COLOR OR RACE

W

5. SINGLE, MARRIED, WIDOWED OR DIVORCED.

Married
(Write the word.)

6. DATE OF BIRTH

Feb 23rd

(Month)

(Day)

1848
(Year)

7. AGE

65 yrs. 8 mos. 2 ds.

IF LESS than 1 day
how many hrs. or
..... mins.?

8. OCCUPATION

- (a) Trade, profession or particular kind of work
(b) General nature of industry, business, or establishment in which employed (or employer)

9. BIRTHPLACE

(State or Country)

Whitley Co Ind

10. NAME OF FATHER

William Cleland

11. BIRTHPLACE OF FATHER

(State or Country)

Whitley Co Ind

12. MAIDEN NAME OF MOTHER

Sarah Wolf

13. BIRTHPLACE OF MOTHER

(State or Country)

Benewah Co Ind

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

Mrs Ethel Hoffer

(Address)

15.

Filed

Dec 101913E J Perkins
Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH

Nov2nd1913

(Month)

(Day)

(Year)

17. I HEREBY CERTIFY, That I attended deceased from

Sept 5th1913to Nov 2nd1913that I last saw h. or alive on Nov 1st 1913and that death occurred on the date stated above, at 70-38

The CAUSE OF DEATH* was as follows:

cereamic comaIntermittent nephritis

(Duration) yrs. mos. ds.

Contributory
(Secondary)

(Duration) yrs. mos. ds.

(Signed)

O. C. Carson

M. D.

Nov 3rd 1913 (Address) 570 main st

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death yrs. mos. days. In the State yrs. mos. days.

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL

Lewiston

DATE OF BURIAL

Nov 4 1913

20. UNDERTAKER

C J Vassar - Lewiston

ADDRESS

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Form V. S. No. 5 20M.1-16-12

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH.

Registration District No. 3County of CanyonPrimary Registration District No. 2005City of Middleton

(No. _____ St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

Lorene CummingsFile No. 6385Registered No. 109

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX

Female

4. COLOR OR RACE

White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED.

Single (Write the word.)

6. DATE OF BIRTH

Sept.31913

(Month)

(Day)

(Year)

7. AGE

0 yrs. 2 mos. 28 ds.IF LESS than 1 day
how many hrs. or
..... mins.?

8. OCCUPATION

(a) Trade, profession or particular kind of work

(b) General nature of industry business, or establishment in which employed (or employer)

9. BIRTHPLACE

(State or Country)

Idaho

10. NAME OF FATHER

Ernest J. Cummings

11. BIRTHPLACE OF FATHER

(State or Country)

Kansas

12. MAIDEN NAME OF MOTHER

Hillman

13. BIRTHPLACE OF MOTHER

(State or Country)

Kansas

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

E. J. Cummings

(Address)

Middleton, Idaho

15.

Filed

Dec. 2-1913John F. Meyer
Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH

Dec11913

(Month)

(Day)

(Year)

17. I HEREBY CERTIFY, That I attended deceased from

Dec 11913to Dec 11913that I last saw her alive on Dec 1 1913and that death occurred on the date stated above, at 6:30 A.M.

The CAUSE OF DEATH* was as follows:

Spasmodic Croup

(Duration) yrs. mos. ds.

Contributory
(Secondary)

(Duration) yrs. mos. ds.

(Signed)

J. W. Haines

M. D.

Dec 1 1913 (Address) Middleton

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place

of death yrs. mos. days.

In the

State yrs. mos. days.

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

Middleton12/2 1913

20. UNDERTAKER

ADDRESS

W. C. DyerCalwell

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Form V. S. No. 5 20M.1-16-12

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH

Registration District No. 3County of CanyonPrimary Registration District No. 1005City of Calderwell

(No. _____ St.)

File No. 4387Registered No. 108

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Alice Innes

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX

4. COLOR OR RACE

5. SINGLE, MARRIED, WIDOWED OR DIVORCED.

femalewsingle
(Write the word.)

6. DATE OF BIRTH

Jan

(Month)

25th

(Day)

1906

(Year)

7. AGE

7 yrs. 10 mos. ds.IF LESS than 1 day
how many hrs. or
..... mins.?

8. OCCUPATION

(a) Trade, profession or

particular kind of work

(b) General nature of industry

business, or establishment in

which employed (or employer)

9. BIRTHPLACE

(State or Country)

Nebraska

10. NAME OF FATHER

C. H. Innes

11. BIRTHPLACE OF FATHER

(State or Country)

Iowa

12. MAIDEN NAME OF MOTHER

Annie Johnson

13. BIRTHPLACE OF MOTHER

(State or Country)

Ill.

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

C. H. Innes

(Address)

Calderwell

15.

Filed Nov. 25 1913

Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH

November 241913

(Month)

(Day)

(Year)

17. I HEREBY CERTIFY, That I attended deceased from Nov 10 1913 to Nov 24 1913that I last saw her alive on Nov 24 1913and that death occurred on the date stated above, at 5:13 P.M.

The CAUSE OF DEATH* was as follows:

General peritonitis(Duration) yrs. mos. 14 ds.

Contributory (Secondary)

Ruptured appendix(Duration) yrs. mos. 16 ds.

(Signed)

J. H. Innes M. D.11/25 1913 (Address) Calderwell, Id.

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death yrs. mos. days. In the State yrs. mos. days.

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

Canyon HillNov 25 1913

20. UNDERTAKER

ADDRESS

W. E. DyerCalderwell

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Form V. S. No. 5 20M.1-16-12

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH.

Registration District No. 3

County of Canyon

Primary Registration District No. 1005

City of Caldwell

(No. _____ St.)

File No. 6389

Registered No. 106

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Caroline Morrow

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX

F

4. COLOR OR RACE

W.

5. SINGLE, MARRIED, WIDOWED OR DIVORCED.

Married
(Write the word.)

6. DATE OF BIRTH

January 23 1892
(Month) (Day) (Year)

7. AGE

81 yrs. 9 mos. 23 ds.

IF LESS than 1 day
how many hrs. or
..... mins.?

8. OCCUPATION

(a) Trade, profession or particular kind of work

Housewife

(b) General nature of industry business, or establishment in which employed (or employer)

9. BIRTHPLACE

(State or Country)

Lincoln Missouri

10. NAME OF FATHER

William Cason

11. BIRTHPLACE OF FATHER

(State or Country)

Ky.

12. MAIDEN NAME OF MOTHER

Elizabeth Bunch

13. BIRTHPLACE OF MOTHER

(State or Country)

Ky.

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

Daisy F. Vinson

(Address)

Caldwell Idaho

15.

Filed

Nov. 17 - 1913

John S. Meyer

Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH

Nov. 16 1913
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from 7/1/13 1913, to 11/16/13 1913,

that I last saw her alive on 10/10/13 1913,

and that death occurred on the date stated above, at 12 M.

The CAUSE OF DEATH* was as follows:

Starvation
old age

(Duration) yrs. 6 mos. ds.

Contributory (Secondary)

(Duration) yrs. mos. ds.

(Signed)

Wm. H. Johnson M. D.

(Address) Caldwell Idaho

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death yrs. mos. days. In the State yrs. mos. days.

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

Canyon Hill

11/18 1913

20. UNDERTAKER

ADDRESS

W. B. Dyer

Caldwell

Idaho

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Form V. S. No. 5. 12½ M. 7-24-11

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH. Registration District No. 3
County of Canyon Primary Registration District No. 2005
City of Caldwell (No. _____ St.)

File No. 639
Registered No. 105

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME John Theodore Hyles

If death occurred in a hospital, institution or camp give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX M 4. COLOR OR RACE W 5. SINGLE, MARRIED, WIDOWED OR DIVORCED. Single
(Write the word.)

6. DATE OF BIRTH Oct 17 1912
(Month) (Day) (Year)

7. AGE 1 yrs. 23 ds. IF LESS than 1 day how many _____ hrs. or _____ min?

8. OCCUPATION
(a) Trade, profession or particular kind of work _____
(b) General nature of industry business or establishment in which employed (or employer) _____

9. BIRTHPLACE (State or Country) Rupert Id

10. NAME OF FATHER William Hyles

11. BIRTHPLACE OF FATHER (State or Country) North Carolina

12. MAIDEN NAME OF MOTHER Ruth Moore

13. BIRTHPLACE OF MOTHER (State or Country) North Carolina

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) William Hyles
(Address) 2012 Id

15. Filed Nov. 10 1913
John S. Meyer
Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH 11 10 1913
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from 11/7/13 191____, to 11/10 191____
that I last saw him alive on 11/10/13 191____
and that death occurred on the date stated above, at 5:30 AM.

The CAUSE OF DEATH* was as follows:

Enteric - Colitis

(Duration) _____ yrs. _____ mos. 10 ds.

Contributory (Secondary) _____

(Duration) _____ yrs. _____ mos. _____ ds.

(Signed) W. B. Johnson M. D.
11/10/13 19 (Address) Caldwell Id

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place _____ In the _____
of death _____ yrs. _____ mos. _____ ds. State _____ yrs. _____ mos. _____ ds.
Where was disease contracted, _____
If not at place of death? _____
Former or _____
usual residence _____

19. PLACE OF BURIAL OR REMOVAL DATE OF BURIAL

Luster Cemetery Nov 10 1913

20. UNDERTAKER ADDRESS

Platt Beckham & Caldwell

MARGIN RESERVED FOR BINDING
WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Form V. S. No. 5 20M.1-16-12

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH

Registration District No. 90

County of Blaine

Primary Registration District No. 2168

City of Crescent

(No. _____, _____ St.)

File No. 6391

Registered No. 47

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Albert W. DeBolt

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX

4. COLOR OR RACE

5. SINGLE, MARRIED, WID-
OWED OR DIVORCED.

Male

White

Married
(Write the word.)

6. DATE OF BIRTH

May
(Month)

15
(Day)

1855
(Year)

7. AGE

58 yrs.

mos.

ds.

IF LESS than 1 day
how many hrs. or
..... mins.?

8. OCCUPATION

(a) Trade, profession or
particular kind of work

Merchant

(b) General nature of industry
business, or establishment in
which employed (or employer)

9. BIRTHPLACE

(State or Country)

Indiana

10. NAME OF
FATHER

J. H. DeBolt

11. BIRTHPLACE
OF FATHER

(State or Country)

Ohio

12. MAIDEN NAME
OF MOTHER

May Libby

13. BIRTHPLACE
OF MOTHER

(State or Country)

Indiana

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

H. A. DeBolt

(Address)

Adrian Wash

15.

Filed

Nov 16 1913

J. M. Fairly
Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH

Nov
(Month)

14
(Day)

1913
(Year)

17. I HEREBY CERTIFY, That I attended deceased from

Nov 5 1913 to Nov 14 1913

that I last saw him alive on Nov 14 1913,

and that death occurred on the date stated above, at 10 A.M.

The CAUSE OF DEATH* was as follows:

Bronchitis - Motor paralysis
or Paralysis of arms & legs / Chronic
Mitral Regurgitation with Dilatation

(Duration) 2 yrs. mos. ds.

Contributory
(Secondary)

Edema of Lung

(Duration) 7 yrs. mos. 12 ds.

(Signed)

Earl W. Howell

M. D.

19. (Address) Crescent Ida.

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place

of death yrs. mos. days.

In the

State yrs. mos. days.

Where was disease contracted
if not at place of death?

Former or
usual residence

19. PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

Bureau City Wash

Nov 16 1913

20. UNDERTAKER

ADDRESS

H. C. Stoddard

Gifford Ida

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Form V. S. No. 5 20M.1-16-12

CERTIFICATE OF DEATH

1. PLACE OF DEATH.

Registration District No. 41

County of Lemhi

Primary Registration District No. 216

City of Salmon

(No. _____ St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

J. W. Jones

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

File No. 6392

Registered No. 19

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX

Male

4. COLOR OR RACE

White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED.

Single
(Write the word.)

6. DATE OF BIRTH

December 24 1849
(Month) (Day) (Year)

7. AGE

64 yrs. _____ mos. _____ ds.

IF LESS than 1 day
how many _____ hrs. or
_____ mins.

8. OCCUPATION

(a) Trade, profession or particular kind of work

Chiropractic

(b) General nature of industry, business, or establishment in which employed (or employer)

9. BIRTHPLACE

(State or Country) Michigan

10. NAME OF FATHER

L. B. Jones

11. BIRTHPLACE OF FATHER

(State or Country) N. Y.

12. MAIDEN NAME OF MOTHER

Sarah Reed

13. BIRTHPLACE OF MOTHER

(State or Country) N. Y.

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) L. R. Jones

(Address) Gibbonsville, Ida

15.

Filed December 7 1913 John L. Smith

Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH

Dec 24 1913
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from

Dec 24 1913, to Dec 24 1913,

that I last saw him alive on 24 1913,

and that death occurred on the date stated above, at 2 a. m.

The CAUSE OF DEATH* was as follows:

Same patient 3 hours before death in an unconscious condition - signs resuscitation of heart & diaphragm condition

(Duration) _____ yrs. _____ mos. _____ ds.

Contributory (Secondary)

Not known

(Duration) _____ yrs. _____ mos. _____ ds.

(Signed)

F. D. Wright

M. D.

Dec 24 1913 (Address) Salmon

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death _____ yrs. _____ mos. _____ days. In the State _____ yrs. _____ mos. _____ days.

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL DATE OF BURIAL

Gibbonsville, Ida Dec 24 1913

20. UNDERTAKER

ADDRESS

W. C. Joebler Salmon
Ida

Form V. S. No. 5 20M.1-16-12

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics
File No. 6393

1. PLACE OF DEATH.

Registration District No. *Pahnamore District*County of *Lemhi*Primary Registration District No. *Lemhi Co 2116*

File No.

City of *Pearl-May*

(No. _____ St.)

Registered No. *18*

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

James Randall Calvin

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX

Male

4. COLOR OR RACE

White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED.

Single
(Write the word.)

6. DATE OF BIRTH

Dec.
(Month)*25-*
(Day)*1911*
(Year)

7. AGE

1 yrs. *10* mos. *9* ds.IF LESS than 1 day
how many hrs. or
..... mins.?

8. OCCUPATION

(a) Trade, profession or particular kind of work

Child At Home

(b) General nature of industry, business, or establishment in which employed (or employer)

9. BIRTHPLACE

(State or Country)

Idaho

10. NAME OF FATHER

John W. Calvin

11. BIRTHPLACE OF FATHER

(State or Country)

Missouri

12. MAIDEN NAME OF MOTHER

Myrtle Campbell

13. BIRTHPLACE OF MOTHER

(State or Country)

Missouri

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

(Address)

John W. Calvin
May, Idaho

15.

Filed *12-2* 191*3*

Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

Nov.
(Month)*3*
(Day)*1913*
(Year)

17. I HEREBY CERTIFY, That I attended deceased from

191... to 191...

that I last saw him alive on 191...

and that death occurred on the date stated above, at M.

The CAUSE OF DEATH* was as follows:

Accidental Drowning

(Duration) yrs. mos. ds.

Contributory
(Secondary)

(Duration) yrs. mos. ds.

(Signed) M. D.

19 (Address)

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death yrs. mos. days. In the State yrs. mos. days.

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

*May Cemetery**Nov. 5, 1913*

20. UNDERTAKER

ADDRESS

None available

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Form V. S. No. 5. 12½M.7-24-11

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH.
County of Thoshone
City of Mullan

Registration District No. 122
Primary Registration District No. _____
(No. _____, St.)

File No. 639*
Registered No. _____

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Marnie Adair Carter
If death occurred in a hospital, institution or camp give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX Female 4. COLOR OR RACE White 5. SINGLE, MARRIED, WIDOWED OR DIVORCED. Married
(Write the word.)

6. DATE OF BIRTH March 6 1877
(Month) (Day) (Year)

7. AGE 36 yrs. 5 mos. 8 ds. IF LESS than 1 day how many ____ hrs. or ____ min?

8. OCCUPATION
(a) Trade, profession or particular kind of work. Housewife.
(b) General nature of industry business or establishment in which employed (or employer) _____

9. BIRTHPLACE Indian Territory
(State or Country)

10. NAME OF FATHER James Brown

11. BIRTHPLACE OF FATHER Mo.
(State or Country)

12. MAIDEN NAME OF MOTHER Julia Biggs

13. BIRTHPLACE OF MOTHER Mo.
(State or Country)

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) O.W. Carter
(Address) _____

15. Aug 15 1913
Nov. 15 '13 F.W. Ralph
Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH August 14 1913
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from Aug 7 1913 to Aug 14 1913 that I last saw her alive on Aug 14 1913 and that death occurred on the date stated above, at 11:20 p.m.
The CAUSE OF DEATH* was as follows:
Endocarditis
Rheumatism
(Duration) ____ yrs. ____ mos. 2 ds.
Contributory (Secondary) 3 ds.
(Duration) ____ yrs. ____ mos. 3 ds.
(Signed) J. A. R. Dean M. D.
Aug 14 1913 (Address) Mullan Ida
*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place _____ In the _____
of death ____ yrs. ____ mos. ____ ds. State ____ yrs. ____ mos. ____ ds.
Where was disease contracted, _____
If not at place of death? _____
Former or usual residence. _____

19. PLACE OF BURIAL OR REMOVAL Wallace Ida DATE OF BURIAL Aug 18 1913

20. UNDERTAKER Ward Undertaking ADDRESS Wallace Ida

SYNDYORK CO., PRINTERS & BINDERS, BOISE 17143

MARGIN RESERVED FOR BINDING
WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Form V. S. No. 5. 12½ M. 7-24-11

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics
File No. 6395
Registered No. _____

1. PLACE OF DEATH. Registration District No. 122
County of Shoshone Primary Registration District No. 2108
City of Mullan (No. _____, _____ St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

William Magor

If death occurred in a hospital, institution or camp give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX M 4. COLOR OR RACE W 5. SINGLE, MARRIED, WIDOWED OR DIVORCED. Single
(Write the word.)

6. DATE OF BIRTH Sept 27 1888
(Month) (Day) (Year)

7. AGE 28 yrs. 11 mos. 1 ds. IF LESS than 1 day how many _____ hrs. or _____ min?

8. OCCUPATION

(a) Trade, profession or particular kind of work Mining
(b) General nature of industry business or establishment in which employed (or employer) Mining Dept Silver

9. BIRTHPLACE

(State or Country) England

10. NAME OF FATHER

William Magor

11. BIRTHPLACE OF FATHER

(State or Country) England

12. MAIDEN NAME OF MOTHER

Mary Pascoe

13. BIRTHPLACE OF MOTHER

(State or Country) England

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) James Magor
(Address) Meadersville, Mont.

15.

Filed Sept 8 1913 FW Ralph Local Registrar
Nov 15 13 W. A. Mowbray

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH

Aug 28 1913
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from _____ 191____, to _____ 191____

that I last saw him alive on 27 Aug 1913
and that death occurred on the date stated above, at 8 a.m.

The CAUSE OF DEATH* was as follows:

Mine accident

_____ (Duration) _____ yrs. _____ mos. Instant ds.

Contributory (Secondary)

_____ (Duration) _____ yrs. _____ mos. Instant ds.

(Signed) FW Ralph M. D.

Sept 8 1913 (Address) Mullan Id.

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place C In the _____
of death _____ yrs. _____ mos. _____ ds. State _____ yrs. _____ mos. _____ ds.

Where was disease contracted,

If not at place of death?

Former or

usual residence.

19. PLACE OF BURIAL OR REMOVAL DATE OF BURIAL

Removal Sept 8 1913

20. UNDERTAKER

ADDRESS

Ward's Undertaking Co Wallace Id.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Form V. S. No. 5. 12½ M. 7-24-11

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics
File No. 6395

1. PLACE OF DEATH. Registration District No. 53
County of Bear Lake Primary Registration District No. 2132
City of Blomington (No. _____ St.)

Registered No. _____

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

Joseph Wood

If death occurred in a hospital, institution or camp give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX Male 4. COLOR OR RACE W. 5. SINGLE, MARRIED, WIDOWED OR DIVORCED. Single
(Write the word.)

6. DATE OF BIRTH Nov. 30 1913
(Month) (Day) (Year)

7. AGE _____ yrs. _____ mos. _____ ds. IF LESS than 1 day how many _____ hrs. or _____ min?

8. OCCUPATION

(a) Trade, profession or particular kind of work. Paly.
(b) General nature of industry business or establishment in which employed (or employer)

9. BIRTHPLACE

(State or Country)

Blomington

10. NAME OF FATHER

Thomas B. Wood.

11. BIRTHPLACE OF FATHER

(State or Country)

Blomington

12. MAIDEN NAME OF MOTHER

Adeline Thompson

13. BIRTHPLACE OF MOTHER

(State or Country)

Blomington

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

(Address)

Peter Wood
Blomington, Ida

15.

Filed

Dec 1 1913

Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH

Nov 30 1913
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from

Nov. 31 1913, to Nov. 30 1913

that I last saw him alive on Nov 30 1913

and that death occurred on the date stated above, at 3 P. M.

The CAUSE OF DEATH* was as follows:
Pneumonia (hypocritical)

(Duration) _____ yrs. _____ mos. _____ ds.

Contributory (Secondary)

(Duration) _____ yrs. _____ mos. _____ ds.

(Signed) _____ M. D.

Dec 1 1913 (Address) _____

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; (2) whether ACCIDENTAL, SUICIDAL OR HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place _____ yrs. _____ mos. _____ ds. In the _____ yrs. _____ mos. _____ ds.

Where was disease contracted,

If not at place of death?

Former or

usual residence.

19. PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

Blomington

Dec 1 1913

20. UNDERTAKER

ADDRESS

Get 7 James Jacobsen

Blomington

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Form V. S. No. 5. 12½M.7-24-11

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH
County of Bear Lake
City of Bloomington

Registration District No. 53
Primary Registration District No. 2132
(No. _____, _____ St.)

File No. 6397
Registered No. _____

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Hannah Elizabeth Thompson

If death occurred in a hospital, institution or camp give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX Female 4. COLOR OR RACE White 5. SINGLE, MARRIED, WIDOWED OR DIVORCED. married
(Write the word.)

6. DATE OF BIRTH June 16 1864
(Month) (Day) (Year)

7. AGE 50 yrs. 6 mos. 28 ds. IF LESS than 1 day how many _____ hrs. or _____ min?

8. OCCUPATION
(a) Trade, profession or particular kind of work Housekeeper
(b) General nature of industry business or establishment in which employed (or employer)

9. BIRTHPLACE (State or Country) Jarmington, Utah

10. NAME OF FATHER Swan Arnell

11. BIRTHPLACE OF FATHER (State or Country) England

12. MAIDEN NAME OF MOTHER Agnes Pierce

13. BIRTHPLACE OF MOTHER (State or Country) New Jersey

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Peter Thompson
(Address) Bloomington, Ida

15. Nov 21 1913 Wm L Rich
Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH November 18 1913
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from February 24 1913, to Nov. 18 1913
that I last saw her alive on July 15—1913
and that death occurred on the date stated above, at 245 M.

The CAUSE OF DEATH* was as follows:
Cerebral Hemorrhage on April 4
In July blood pressure was 71°
(Duration) _____ yrs. _____ mos. 3 hours ds.
Contributory Chronic Parenchymatous Nephritis
(Secondary) (Duration) 6 yrs. _____ mos. no ds.
(Signed) Wm L Rich M. D.
Nov. 20 1913 (Address) Paris, Idaho

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place _____ In the _____
of death _____ yrs. _____ mos. _____ ds. State _____ yrs. _____ mos. _____ ds.
Where was disease contracted, _____
If not at place of death? _____
Former or _____
usual residence _____

19. PLACE OF BURIAL OR REMOVAL Bloomington DATE OF BURIAL Nov 21 1913
UNDER-TAKER Mrs Nina Culme ADDRESS Bloomington

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. N. B.—Every item of information should be carefully supplied. AGE should be state EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Form V. S. No. 5. 10M. 6-20-11.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics
File No. 6393
Registered No. 18

1. PLACE OF DEATH.

Registration District No. 106County of IdahoPrimary Registration District No. 2184City of Slite

(No. _____, _____ St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

Genevieve Ethel Wallace

If death occurred in a hospital, institution or camp give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX

Female

4. COLOR OR RACE

White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED.

Single
(Write the word.)

6. DATE OF BIRTH

June 8 1913
(Month) (Day) (Year)

7. AGE

4 yrs. 28 mos. 28 ds.

IF LESS than 1 day
how many _____ hrs. or
_____ min.?

8. OCCUPATION

- (a) Trade, profession or particular kind of work
(b) General nature of industry business or establishment in which employed (or employer)

9. BIRTHPLACE

(State or Country)

Idaho Co

10. NAME OF FATHER

Clark Wallace

11. BIRTHPLACE OF FATHER

(State or Country)

Idaho

12. MAIDEN NAME OF MOTHER

Edith Allen

13. BIRTHPLACE OF MOTHER

(State or Country)

Washington

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

Clark M. Wallace

(Address)

107 N. Street Spokane

15.

Filed Nov 8 1913

J. M. Verbeekmaas
Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

Nov 6 1913
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from

1913, to 1913

that I last saw h. _____ alive on 1913

and that death occurred on the date stated above, at _____ M.

The CAUSE OF DEATH* was as follows:

Probably acute ihs colitis

(Duration) _____ yrs. _____ mos. _____ ds.

Contributory
(Secondary)

(Duration) _____ yrs. _____ mos. _____ ds.

(Signed) J. M. Verbeekmaas M. D.

Nov 8 1913 (Address) Spokane Idaho

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death _____ yrs. _____ mos. _____ ds. State _____ yrs. _____ mos. _____ ds.

Where was disease contracted.

If not at place of death?

Former or
usual residence.

19. PLACE OF BURIAL OR REMOVAL

J. O. O. F. Cemetery Cule

DATE OF BURIAL

Nov 9 1913

20. UNDERTAKER

None

ADDRESS

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. N. B.—Every item of information should be carefully supplied. AGE should be state EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Form V. S. No. 5. 10M. 6-20-11.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics
File No. 6399

1. PLACE OF DEATH.

Registration District No. 106County of IdahoPrimary Registration District No. 2184City of Idaho

(No. _____, _____ St.)

Registered No. 19

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

Edith Dagmar Larson

If death occurred in a hospital, institution or camp give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX

Female

4. COLOR OR RACE

White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED.

Single
(Write the word.)

6. DATE OF BIRTH

Nov
(Month)12
(Day)1913
(Year)

7. AGE

_____ yrs. _____ mos. _____ ds.

IF LESS than 1 day
how many _____ hrs. or
_____ min. 7

8. OCCUPATION

- (a) Trade, profession or particular kind of work
(b) General nature of industry business or establishment in which employed (or employer)

9. BIRTHPLACE

(State or Country)

Idaho Co.

10. NAME OF FATHER

Kustav Otto Larson

11. BIRTHPLACE OF FATHER

(State or Country)

Sweden

12. MAIDEN NAME OF MOTHER

Selma Christina Johnson

13. BIRTHPLACE OF MOTHER

(State or Country)

Sweden

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Mrs. S. F. Lickens(Address) Idaho Co. Idaho

15.

Filed Nov 14 1913J. M. Verbeekmaas

Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

Nov
(Month)12
(Day)1913
(Year)

17. I HEREBY CERTIFY, That I attended deceased from

Nov 12 1913, to Nov 13 1913that I last saw h. a alive on Nov 12 1913,and that death occurred on the date stated above, at 7:20 a. M.

The CAUSE OF DEATH* was as follows:

Atherosclerosis

(Duration) _____ yrs. _____ mos. _____ ds.

Contributory (Secondary)

Achondroplasia

(Duration) _____ yrs. _____ mos. _____ ds.

(Signed) _____ M. D.

19 (Address)

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death _____ yrs. _____ mos. _____ ds. State _____ yrs. _____ mos. _____ ds.

Where was disease contracted.

If not at place of death? _____

Former or usual residence. _____

19. PLACE OF BURIAL OR REMOVAL

Mountain Rest Cemetery Idaho

DATE OF BURIAL

Nov 13 1913

20. UNDERTAKER

ADDRESS

None

WHITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Form V. S. No. 5 20M.1-16-12

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH.

Registration District No.

County of

Primary Registration District No.

City of

(No.)

File No.

Registered No.

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX

4. COLOR OR RACE

5. SINGLE, MARRIED, WIDOWED OR DIVORCED.

6. DATE OF BIRTH

7. AGE

IF LESS than 1 day
how many hrs. or
mins.?

8. OCCUPATION

(a) Trade, profession or particular kind of work

(b) General nature of industry business, or establishment in which employed (or employer)

9. BIRTHPLACE

(State or Country)

10. NAME OF FATHER

11. BIRTHPLACE OF FATHER

(State or Country)

12. MAIDEN NAME OF MOTHER

13. BIRTHPLACE OF MOTHER

(State or Country)

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

(Address)

15.

Filed

1913

Thorbert P. Mowery
Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH

17. I HEREBY CERTIFY, That I attended deceased from

that I last saw him alive on

and that death occurred on the date stated above, at 10 A.M.

The CAUSE OF DEATH* was as follows:

Contributory
(Secondary)

(Signed)

Nov 11 1913

(Address)

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death. yrs. mos. days. In the State. yrs. mos. days.

Where was disease contracted if not at place of death?

Former or usual residence.

19. PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

Wallace Idaho

Nov 9 1913

20. UNDERTAKER

ADDRESS

Bruce G. Mowery

Wallace

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. MARGIN RESERVED FOR BINDING. N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Form V. S. No. 10M. 6-20-11.

CERTIFICATE

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics
File No. **6401**

1. PLACE OF DEATH

Registration District

County of *Phoshone*

Primary Registration

City of *Keelogg*

(No. *Pager Hotel* St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

John Earl Dyer

Registered No.

If death occurred in a hospital, institution or camp give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX

M.

4. COLOR OR RACE

W.

5. SINGLE, MARRIED, WIDOWED OR DIVORCED.

married
(Write the word.)

6. DATE OF BIRTH

Dec 24 1890
(Month) (Day) (Year)

7. AGE

24 yrs. *10* mos. *21* ds.

IF LESS than 1 day
how many.....hrs. or
.....min.?

8. OCCUPATION

- (a) Trade, profession or particular kind of work
(b) General nature of industry business or establishment in which employed (or employer)

Laborer

9. BIRTHPLACE

(State or Country)

Nebraska

10. NAME OF FATHER

Mr. Dyer

11. BIRTHPLACE OF FATHER

(State or Country)

Nancy A. Dyer

12. MAIDEN NAME OF MOTHER

Nebraska

13. BIRTHPLACE OF MOTHER

(State or Country)

15.

(Informant) *Mrs. A. S. Dyer*
(Address) *Wallback Idaho*

Filed

Nov 14 1913 *G. S. Lecher*
Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

Nov 13 1913
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from

191, to 191

that I last saw h. alive on 191

and that death occurred on the date stated above, at M.

The CAUSE OF DEATH* was as follows:

*Suicide - drank
carbolic acid*

(Duration) yrs. mos. ds.

Contributory (Secondary)

(Duration) yrs. mos. ds.

(Signed) *John C. Bradley actg. M. D.*

Nov 14 1913 (Address) *Coonrod J. P.*

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death.....yrs.....mos.....ds. State.....yrs.....mos.....ds.

Where was disease contracted.

If not at place of death?

Former or

usual residence.

19. PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

Hebron Neb

191

20. UNDERTAKER

ADDRESS

Wm. S. Wooten

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Form V. S. No. 5 20M.1-16-12

CERTIFICATE OF DEATH

State of Ill.
BOARD OF HEALTH
Bureau of Vital Statistics
File No. 6402
Registered No. _____

1. PLACE OF DEATH. _____
County of Shoshone
City of Osborn
(No. _____, St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Cyrus Everett French

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX Male 4. COLOR OR RACE White 5. SINGLE, MARRIED, WIDOWED OR DIVORCED. married
(Write the word.)

6. DATE OF BIRTH Feb 16 1859
(Month) (Day) (Year)

7. AGE 54 yrs. 9 mos. 21 ds.
IF LESS than 1 day how many hrs. or mins.?

8. OCCUPATION
(a) Trade, profession or particular kind of work Farmer
(b) General nature of industry business, or establishment in which employed (or employer)

9. BIRTHPLACE Grand Rapids Mich
(State or Country)

10. NAME OF FATHER

11. BIRTHPLACE OF FATHER
(State or Country)

12. MAIDEN NAME OF MOTHER

13. BIRTHPLACE OF MOTHER
(State or Country)

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Mrs E G French
(Address) _____

15. Filed Nov 12 1913 Herbert P. Mowbray
Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH November 10 1913
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from Aug 1 1913 to Nov 10 1913
that I last saw him alive on Nov 2 1913
and that death occurred on the date stated above, at _____ M.

The CAUSE OF DEATH* was as follows:

myocarditis

(Duration) _____ yrs. _____ mos. _____ ds.

Contributory (Secondary)

(Duration) _____ yrs. _____ mos. _____ ds.

(Signed) _____ M. D.

10-11 1913 (Address) Wash D C

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death _____ yrs. _____ mos. _____ days. In the State _____ yrs. _____ mos. _____ days.

Where was disease contracted if not at place of death?

Former or usual residence _____

19. PLACE OF BURIAL OR REMOVAL Osborn Ida DATE OF BURIAL Nov 12 1913

20. UNDERTAKER W. H. Varstee ADDRESS Walla

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Form V. S. No. 5 20M.1-16-12

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH.

Registration District No. 122

County of Shoshone

Primary Registration District No. 2200

City of Burke

(No. Hecal, Mine St.)

File No. 6403

Registered No. _____

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Benj. F. Hemphill

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX

male

4. COLOR OR RACE

white

5. SINGLE, MARRIED, WIDOWED OR DIVORCED.

Widowed

(Write the word.)

6. DATE OF BIRTH

(Month) (Day) (Year)

7. AGE

35 yrs. -- mos. -- ds.

IF LESS than 1 day
how many hrs. or mins.?

8. OCCUPATION

(a) Trade, profession or particular kind of work miner
(b) General nature of industry business, or establishment in which employed (or employer)

9. BIRTHPLACE

(State or Country) Kansas

10. NAME OF FATHER

John Hemphill

11. BIRTHPLACE OF FATHER

(State or Country) Illinois

12. MAIDEN NAME OF MOTHER

Lizzie England

13. BIRTHPLACE OF MOTHER

(State or Country) Illinois

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Oscar Chaff

(Address) Black Bear, Idaho

15.

Filed Nov 20 1913 Harbert C. Mowry Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH

Nov 20 1913
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from

191 , to 191 ,
that I last saw h alive on 191 ,

and that death occurred on the date stated above, at M.

The CAUSE OF DEATH* was as follows:

Crush Injury & Shock

(Duration) yrs. mos. ds.

Contributory (Secondary)

(Duration) yrs. mos. ds.

(Signed)

Nov 21 1919 (Address) Dr. Mowry Wallace, Ida.

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death. yrs. mos. days. In the State. yrs. mos. days.

Where was disease contracted if not at place of death?

Former or usual residence.

19. PLACE OF BURIAL OR REMOVAL

Wallace, Idaho,

DATE OF BURIAL

Nov 20th 1913

20. UNDERTAKER

Bruce G. Nowtice

ADDRESS

Wallace, Ida.

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Form V. S. No. 5 20M.1-16-12

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics
File No. 640

1. PLACE OF DEATH. Registration District No. 122
County of Shoshone Primary Registration District No. 2200
City of Burke (No. _____, St.)

Registered No. _____
If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

If death occurs away from usual residence, give facts called for under special information. 2. FULL NAME Vernor Bennett

PERSONAL AND STATISTICAL PARTICULARS

3. SEX male 4. COLOR OR RACE white 5. SINGLE, MARRIED, WIDOWED OR DIVORCED. single
(Write the word.)

6. DATE OF BIRTH _____
(Month) (Day) (Year)

7. AGE _____ yrs. _____ mos. 2 ds.
IF LESS than 1 day how many _____ hrs. or _____ mins.?

8. OCCUPATION
(a) Trade, profession or particular kind of work none
(b) General nature of industry business, or establishment in which employed (or employer)

9. BIRTHPLACE
(State or Country) Burke

10. NAME OF FATHER Fred Bennett

11. BIRTHPLACE OF FATHER
(State or Country) Nebr.

12. MAIDEN NAME OF MOTHER Berdeen Myers.

13. BIRTHPLACE OF MOTHER
(State or Country) Ill.

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Fred Bennett
(Address) Burke Ida.

15. Filed Nov. 12 1913 Herbert C. Mowry
Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH Oct 24 1913
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from Oct 23 1913, to Oct 24 1913
that I last saw him alive on Oct 24 1913
and that death occurred on the date stated above, at 12 M.

The CAUSE OF DEATH* was as follows:
Lobar pneumonia
& asthma

(Duration) _____ yrs. _____ mos. 2 ds.
Contributory (Secondary) Prematurity
(Duration) _____ yrs. _____ mos. _____ ds.
(Signed) John Wallace M. D.
Oct 25 1913 (Address) Wallace

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death _____ yrs. _____ mos. _____ days. In the State _____ yrs. _____ mos. _____ days.

Where was disease contracted if not at place of death?
Former or usual residence _____

19. PLACE OF BURIAL OR REMOVAL Mullan DATE OF BURIAL Oct 25 1913

20. UNDERTAKER Hard Undertaking Co. Wallace ADDRESS _____

2da

MARGIN RESERVED FOR BINDING
WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Form V. S. No. 5. 12½ M. 7-24-11

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics
File No. 6405
Registered No. _____

1. PLACE OF DEATH. Registration District No. 122
County of Shoshone Primary Registration District No. 2108
City of _____ (No. _____, St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Kenneth Leon Aris

If death occurred in a hospital, institution or camp give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX Boy 4. COLOR OR RACE White 5. SINGLE, MARRIED, WIDOWED OR DIVORCED. Infant
(Write the word.)

6. DATE OF BIRTH March 29 1913
(Month) (Day) (Year)

7. AGE 5 yrs. 1 mos. 1 ds. IF LESS than 1 day
how many hrs. or min?

8. OCCUPATION

(a) Trade, profession or particular kind of work
(b) General nature of industry business or establishment in which employed (or employer)

9. BIRTHPLACE

(State or Country) Washington

10. NAME OF FATHER Charles Walter Aris

11. BIRTHPLACE OF FATHER

(State or Country) New York

12. MAIDEN NAME OF MOTHER

Martha E. E. Hanisch

13. BIRTHPLACE OF MOTHER

(State or Country) France, Paris

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Mrs. Martha E. E. Aris
(Address) Mullan Id.

15.

Filed Aug 30 1913 F. W. Rolfe Local Registrar
1913

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH

Aug 30 1913
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from Aug 28 1913, to Aug 30 1913, that I last saw him alive on Aug 30 1913 and that death occurred on the date stated above, at 8:20 a.m.

The CAUSE OF DEATH* was as follows:

Pneumonia complicated with Meningitis

(Duration) 3 yrs. 1 mos. 1 ds.

Contributory (Secondary)

Meningitis

(Duration) 1 yrs. 1 mos. 1 ds.

(Signed) F. W. Rolfe M. D.
Aug 30 1913 (Address) Mullan Id.

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place In the
of death yrs. mos. ds. State yrs. mos. ds.

Where was disease contracted,

If not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL DATE OF BURIAL

Wallace

Aug 30 1913

20. UNDERTAKER

ADDRESS

Ward's Undertaking Est. Wallace Id.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Form V. S. No. 5. 12½ M. 7-24-11

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics
File No. 6405
Registered No.

1. PLACE OF DEATH. Registration District No. 122
County of Shoshone Primary Registration District No.
City of Millan (No., St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

Edward Robert Payson

If death occurred in a hospital, institution or camp give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX m 4. COLOR OR RACE w 5. SINGLE, MARRIED, WIDOWED OR DIVORCED. Single (Write the word.)

6. DATE OF BIRTH June 3 1912 (Month) (Day) (Year)

7. AGE — yrs. 9 mos. 16 ds. IF LESS than 1 day how many yrs. or min?

8. OCCUPATION

(a) Trade, profession or particular kind of work. none
(b) General nature of industry business or establishment in which employed (or employer) none

9. BIRTHPLACE Idaho (State or Country)

10. NAME OF FATHER Chas Coyne

11. BIRTHPLACE OF FATHER Kansas (State or Country)

12. MAIDEN NAME OF MOTHER Carrie Hutten

13. BIRTHPLACE OF MOTHER Kansas (State or Country)

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE (Informant) J. Dean (Address) Millan, Ida

15. Filed Nov 15 1913 Herbert P. Mowbray Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH April 16 1913 (Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from March 21 1913, to Apr 16 1913 that I last saw him alive on Apr 16 1913 and that death occurred on the date stated above, at 6:00 P.M. The CAUSE OF DEATH* was as follows:

Broncho pneumonia (Duration) — yrs. — mos. 26 ds.

Contributory (Secondary) (Duration) yrs. mos. ds. (Signed) James K. Dean M. D. 16 (Address) Millan, Ida

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place In the of death. yrs. mos. ds. State. yrs. mos. ds. Where was disease contracted, If not at place of death? Former or usual residence.

19. PLACE OF BURIAL OR REMOVAL DATE OF BURIAL Wallace H. P. Ward Undertaking 1913

20. UNDERTAKER ADDRESS H. P. Ward Undertaking Wallace

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Form V. S. No. 5. 10M. 6-20-11.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

File No. 640

Registered No.

If death occurred in a hospital, institution or camp give its NAME instead of street and number.

1. PLACE OF DEATH. Registration District No. _____
County of Canyon Primary Registration District No. _____
City of Nampa (No. _____, St.) _____

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

James Duffas

PERSONAL AND STATISTICAL PARTICULARS

3. SEX 4. COLOR OR RACE 5. SINGLE, MARRIED, WIDOWED OR DIVORCED.

Male White Single
(Write the word.)

6. DATE OF BIRTH

December 19 1913
(Month) (Day) (Year)

7. AGE

54 yrs. _____ mos. _____ ds. IF LESS than 1 day
how many _____ hrs. or _____ min.?

8. OCCUPATION

(a) Trade, profession, or particular kind of work Plasterer
(b) General nature of industry, business, or establishment in which employed (or employer) _____

9. BIRTHPLACE

(State or Country) Cumminsville Cent. Can.

10. NAME OF FATHER

John Duffas

11. BIRTHPLACE OF FATHER

(State or Country) Forbes Scotland

12. MAIDEN NAME OF MOTHER

Elizabeth Parrier

13. BIRTHPLACE OF MOTHER

(State or Country) Forbes Scotland

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Margaret Duffas

(Address) Nampa

15.

Filed Nov 22 1913 D. D. Colacore
Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

Nov 22 1913
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from

Nov 19 1913, to Nov 22 1913

that I last saw him alive on Nov 22 1913, and that death occurred on the date stated above, at 8:30 A.M.

The CAUSE OF DEATH* was as follows:

Peritonitis

(Duration) _____ yrs. _____ mos. 7 ds.

Contributory (Secondary)

(Duration) _____ yrs. _____ mos. _____ ds.

(Signed) J. H. Murray M. D.

Nov 22 1913 (Address) Nampa Idaho

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place _____ In the _____
of death _____ yrs. _____ mos. _____ ds. State _____ yrs. _____ mos. _____ ds.

Where was Disease contracted,
If not at place of death?
Former or
usual residence _____

19. PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

Kohlerlaunz Cem 11/23 1913

20. UNDERTAKER

ADDRESS

Fred H. Johnson Nampa Ida

-SUPPLEMENTARY DEATH CERTIFICATE-

(Please reply on this sheet to
the registrar of Vital Statistics)

Death Certificate No. _____

Name _____ James Duffes _____

Date of Death _____ November 22 _____

Cause of Death _____

Contributory Cause of death _____

(See over) (Sign here) _____ M.D.

San Francisco Dec 11 1912

I did not see deceased until shortly before death.
Gave history of prolonged constipation or obstruction.
Think he took severe physic into an
obstructed bowel. When I saw him he was
in extreme collapse - Hiccoughs - weak pulse
+ dilated pupils. Abdomen very distended
+ bowels vomiting involuntarily.

I suppose it might be called a case of
Traumatic Peritonitis.
Further than this I do not know as he had
no medical treatment except what he
administered himself.

J. H. Murray M.D.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Form V. S. No. 5 20M.1-16-12

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics
File No. 649

1. PLACE OF DEATH.

Registration District No. 121

County of Bingham

Primary Registration District No. 1007

City of Blackfoot(No. Hospital Apartment St.)

Registered No. 109

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

Alfred Joseph Long

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX

Male

4. COLOR OR RACE

White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED.

Single
(Write the word.)

6. DATE OF BIRTH

Nov
(Month)9
(Day)1913
(Year)

7. AGE

1 yrs. 11 mos. 11 ds.

IF LESS than 1 day
how many hrs. or
mins.?

8. OCCUPATION

- (a) Trade, profession or particular kind of work
(b) General nature of industry business, or establishment in which employed (or employer)

9. BIRTHPLACE

(State or Country)

Oregon

10. NAME OF FATHER

Joseph Long

11. BIRTHPLACE OF FATHER

(State or Country)

Kansas

12. MAIDEN NAME OF MOTHER

Mary Stewart

13. BIRTHPLACE OF MOTHER

(State or Country)

Nebraska

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

Mary Sang

(Address)

Blackfoot

15.

Filed

Nov. 20th 1913W. E. Patric

Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH

Nov
(Month)20
(Day)1913
(Year)

17. I HEREBY CERTIFY, That I attended deceased from

Nov 12 1913, to Nov 20 1913,that I last saw him alive on Nov 20 1913,and that death occurred on the date stated above, at 7:30 M.

The CAUSE OF DEATH* was as follows:

Tubercular meningitis

(Duration) yrs. mos. ds.

Contributory

(Secondary)

Entericallitis

(Duration) yrs. mos. ds.

(Signed)

H. J. Simmons M. D.Nov 20 1913 (Address) Blackfoot

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death.

yrs. mos. days.

In the

State. yrs. mos. days.

Where was disease contracted if not at place of death?

Former or

usual residence.

19. PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

Funerary societyNov 20 1913

20. UNDERTAKER

ADDRESS

E. J. ParkBlackfoot

-SUPPLEMENTARY DEATH CERTIFICATE-

(Please reply on this sheet to
the registrar of Vital Statistics)

Death Certificate No.

Name..... Alfred Joseph Long

Date of Death..... November 20th

Cause of Death..... Tubercular Meningitis

Contributory Cause of death..... Tuberculosis

(Sign here) A. J. Simmons M.D.

MARGIN RESERVED FOR BINDING
WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
N. B.—Every item of information should be carefully supplied. AGE should be state EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Form V. S. No. 5. 10M. 6-20-11.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH.
County of Canyon
City of Naupaka

Registration District No.
Primary Registration District No. 7
(No. St.)

File No. 6409

Registered No.
If death occurred in a hospital, institution or camp give its NAME instead of street and number.

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

Otha Carrie White

PERSONAL AND STATISTICAL PARTICULARS

3. SEX Female 4. COLOR OR RACE White 5. SINGLE, MARRIED, WIDOWED OR DIVORCED. Married
(Write the word.)

6. DATE OF BIRTH April 30 1879
(Month) (Day) (Year)

7. AGE 34 yrs. 4 mos. 17 ds.
IF LESS than 1 day how many hrs. or min.?

8. OCCUPATION
(a) Trade, profession, or particular kind of work House wife
(b) General nature of industry business, or establishment in which employed (or employer)

9. BIRTHPLACE Ind
(State or Country)

10. NAME OF FATHER James C. Rogers

11. BIRTHPLACE OF FATHER Ind
(State or Country)

12. MAIDEN NAME OF MOTHER Cathern Bales

13. BIRTHPLACE OF MOTHER Ind
(State or Country)

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) C. A. Rogers

(Address) Naupaka Ida

15. Filed 1913 P. D. Caluya
Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH Sept 19 1913
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from Aug 1 1913, to Sept 19 1913
that I last saw her alive on Sept 18 1913,
and that death occurred on the date stated above, at 34 M.

The CAUSE OF DEATH* was as follows:
traumatic Cong
chronic Bright disease

(Duration) 4 yrs. 2 mos. 2 ds.
Contributory (Secondary) Bright disease
Bright disease

(Duration) 2 yrs. 2 mos. 2 ds.
(Signed) O. B. Beller M. D.
9/18/1913 (Address) Naupaka Ida

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL,

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place In the
of death. yrs. mos. ds. State. yrs. mos. ds.
Where was Disease contracted,
If not at place of death?

19. PLACE OF BURIAL OR REMOVAL Kohler Lawn DATE OF BURIAL 9/19 1913

20. UNDERTAKER P. B. Schellhager ADDRESS Naupaka Ida

-SUPPLEMENTARY DEATH CERTIFICATE-

(Please reply on this sheet to
the registrar of Vital Statistics)

Death Certificate No.

Name..... Etta Carrie White

Date of Death..... September 18, 1913

Cause of Death..... Chronic Brights

Contributory Cause of death..... Still Birth

(Sign here)..... J. B. Beller. M.D.

Nampa Ida 12/10/3

Ralph Jack M.D.

Boise Ida.

Dear Doctor: - This was an acute
exacerbation of chronic Bright's
exaggerated by child birth.

Respect

Dr. O. B. Miller.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Form V. S. No. 5 20M.1-16-12

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH.

Registration District No. 23

County of Lincoln

Primary Registration District No. 1017-1027

City of Jerome

(No. St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

Alfred George Nelson

File No. 641

Registered No.

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX

M

4. COLOR OR RACE

white

5. SINGLE, MARRIED, WIDOWED OR DIVORCED.

Single
(Write the word.)

6. DATE OF BIRTH

May 31 1888
(Month) (Day) (Year)

7. AGE

25 yrs. 5 mos. ds.

IF LESS than 1 day
how many hrs. or mins.

8. OCCUPATION

(a) Trade, profession or particular kind of work

Clerk

(b) General nature of industry business, or establishment in which employed (or employer)

9. BIRTHPLACE

(State or Country)

Chicago Ill

10. NAME OF FATHER

Gustaf Nelson

11. BIRTHPLACE OF FATHER

(State or Country)

Sweden

12. MAIDEN NAME OF MOTHER

Emma Carlson

13. BIRTHPLACE OF MOTHER

(State or Country)

Sweden

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

Mr Gustaf Nelson

(Address)

Chicago

15.

Filed

Oct 11 1913 E.D. Piper
Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH

Oct 9 1913
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from

Oct 3 1913, to Oct 9 1913,

that I last saw him alive on Oct 9 1913,

and that death occurred on the date stated above, at 11:30 P.M.

The CAUSE OF DEATH* was as follows:

Tuberculosis of Lungs

(Duration) 5 yrs. mos. ds.

Contributory Hemorrhage from Lungs
(Secondary)

(Duration) yrs. mos. 6 ds.

(Signed) E.D. Piper M. D.

Oct 11 1913 (Address) Jerome Ida

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death. yrs. mos. days. In the State. yrs. mos. days.

Where was disease contracted if not at place of death?

Former or usual residence.

19. PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

Chicago Ill Oct 12 1913

20. UNDERTAKER

ADDRESS

Da L. Harrison Jerome Ida

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Form V. S. No. 5 20M.1-16-12

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics
File No. **6411**

1. PLACE OF DEATH.

Registration District No. **23**

County of **Lincoln**

Primary Registration District No. **1018-1027**

City of **Jerome**

(No. _____ St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

Frederick William Popke

Registered No. _____

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX

Male

4. COLOR OR RACE

white

5. SINGLE, MARRIED, WIDOWED OR DIVORCED.

married
(Write the word.)

6. DATE OF BIRTH

May 2 1857
(Month) (Day) (Year)

7. AGE

62 yrs. 9 mos. 26 ds.

IF LESS than 1 day
how many _____ hrs. or
_____ mins.?

8. OCCUPATION

(a) Trade, profession or particular kind of work

Farmer

(b) General nature of industry business, or establishment in which employed (or employer)

9. BIRTHPLACE

(State or Country)

Germany

10. NAME OF FATHER

Frederick W. Popke Sr.

11. BIRTHPLACE OF FATHER

(State or Country)

Germany

12. MAIDEN NAME OF MOTHER

Mari Louise Shultz

13. BIRTHPLACE OF MOTHER

(State or Country)

Germany

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

Mr. F. W. Popke

(Address)

Jerome Idaho

15.

Filed

Dec 1

191**3**

E. D. Piper

Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH

Nov 28 1913
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from

Nov 18 1913, to **Nov 28 1913**,

that I last saw him alive on **Nov 28 1913**,

and that death occurred on the date stated above, at **8¹⁵ A.M.**

The CAUSE OF DEATH* was as follows:

Lobar pneumonia

(Duration) _____ yrs. _____ mos. **10** ds.

Contributory **mitral insufficiency**
(Secondary)

(Duration) _____ yrs. **6** mos. _____ ds.

(Signed) **John F. Schmerschall M. D.**

Nov 28 1913 (Address) **Jerome Idaho**

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death _____ yrs. _____ mos. _____ days. In the State _____ yrs. _____ mos. _____ days.

Where was disease contracted if not at place of death? _____

Former or usual residence _____

19. PLACE OF BURIAL OR REMOVAL

Jerome Cemetery

DATE OF BURIAL

Nov 30 1913

20. UNDERTAKER

Da Herrison

ADDRESS

Jerome

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Form V. S. No. 5 20M.1-16-12

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH

Registration District No. 100

County of

Primary Registration District No. 2178

City of

(No.

St.)

File No.

Registered No.

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

PERSONAL AND STATISTICAL PARTICULARS

3. SEX

4. COLOR OR RACE

5. SINGLE, MARRIED, WIDOWED OR DIVORCED.

Female Japanese

(Write the word.)

6. DATE OF BIRTH

Sept 10 1913

(Month)

(Day)

(Year)

7. AGE

yrs. 2 mos. 13 ds.

IF LESS than 1 day
how many hrs. or
..... mins.?

8. OCCUPATION

(a) Trade, profession or particular kind of work

(b) General nature of industry business, or establishment in which employed (or employer)

9. BIRTHPLACE

(State or Country)

Rexburg

10. NAME OF FATHER

S. S. Hanami

11. BIRTHPLACE OF FATHER

(State or Country)

Japan

12. MAIDEN NAME OF MOTHER

Asa Sapi

13. BIRTHPLACE OF MOTHER

(State or Country)

Japan

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

(Address)

S. S. Hanami
Rexburg

15.

Filed

11-24

1913

J. G. Espe

Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH

11 (Month)

23 (Day)

1913 (Year)

17. I HEREBY CERTIFY, That I attended deceased from

191...

191...

that I last saw him alive on 191...

and that death occurred on the date stated above, at M.

The CAUSE OF DEATH* was as follows:

gastro-enteritis

(Duration) yrs. mos. ds.

Contributory (Secondary)

(Duration) yrs. mos. ds.

(Signed)

J. G. Espe

M. D.

19 (Address)

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death yrs. mos. days. In the State yrs. mos. days.

Where was disease contracted if not at place of death?

Former or usual residence.

19. PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

Rexburg

11/24 1913

20. UNDERTAKER

ADDRESS

John Phillips

Rexburg

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Form V. S. No. 5 20M.1-16-12

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics
File No. 6414

Registered No. FS

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

1. PLACE OF DEATH.

County of FremontCity of SugarRegistration District No. 100Primary Registration District No. 2178

(No. _____ St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

Altha Tucker

PERSONAL AND STATISTICAL PARTICULARS

3. SEX

Female

4. COLOR OR RACE

White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED.

(Write the word.)

6. DATE OF BIRTH

Nov171913

(Month)

(Day)

(Year)

7. AGE

_____ yrs. _____ mos. _____ ds.

IF LESS than 1 day
how many _____ hrs. or
_____ mins.

30

8. OCCUPATION

(a) Trade, profession or particular kind of work

(b) General nature of industry business, or establishment in which employed (or employer)

9. BIRTHPLACE

(State or Country)

Idaho

10. NAME OF FATHER

Jos. W. Tucker

11. BIRTHPLACE OF FATHER

(State or Country)

Idaho

12. MAIDEN NAME OF MOTHER

Matthe Ingram

13. BIRTHPLACE OF MOTHER

(State or Country)

Utah

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

(Address)

Jos. W. Tucker
Sugar City

15.

Filed 11-18 1913

Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH

11

(Month)

17

(Day)

1913

(Year)

17. I HEREBY CERTIFY, That I attended deceased from

1913, to1913,

that I last saw him alive on

1913,

and that death occurred on the date stated above, at

M.

The CAUSE OF DEATH* was as follows:

Electrocution

(Duration) _____ yrs. _____ mos. _____ ds.

Contributory
(Secondary)

(Duration) _____ yrs. _____ mos. _____ ds.

(Signed)

J. R. Shupe

M. D.

19

(Address)

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death _____ yrs. _____ mos. _____ days. In the State _____ yrs. _____ mos. _____ days.

Where was disease contracted if not at place of death?

Former or usual residence.

19. PLACE OF BURIAL OR REMOVAL

Sugar

DATE OF BURIAL

Nov 18 1913

20. UNDERTAKER

John Phillips

ADDRESS

Rexburg

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Form V. S. No. 5 20M.1-16-12

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics
File No. **6415**
Registered No. **34**

1. PLACE OF DEATH. Registration District No. **100**
County of **Fremont** Primary Registration District No. **2178**
City of **Reynoldsburg** (No. _____, St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME **Juliana Yadge**

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX **Female** 4. COLOR OR RACE **White** 5. SINGLE, MARRIED, WIDOWED OR DIVORCED. **Widowed**
(Write the word.)

6. DATE OF BIRTH **Feb. 6 1829**
(Month) (Day) (Year)

7. AGE **84 yrs. 9 mos. 2 ds.**
IF LESS than 1 day how many _____ hrs. or _____ mins.?

8. OCCUPATION
(a) Trade, profession or particular kind of work **Housewife**
(b) General nature of industry business, or establishment in which employed (or employer)

9. BIRTHPLACE **Germany**
(State or Country)

10. NAME OF FATHER **Fred Schrader**

11. BIRTHPLACE OF FATHER **Germany**
(State or Country)

12. MAIDEN NAME OF MOTHER **Charlotte Schuke**

13. BIRTHPLACE OF MOTHER **Germany**
(State or Country)

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) **Mrs. Emma Wally**
(Address) **Benton**

15. Filed **11-8** 191**3** **G. L. Cooke**
Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH **11 8 1913**
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from **1913**, to **1913**,
that I last saw h. **alive on 1913**,
and that death occurred on the date stated above, at **M.**
The CAUSE OF DEATH* was as follows:

Chronic Interstitial Nephritis
(Duration) **Unknown** yrs. mos. ds.

Contributory (Secondary) _____
(Duration) _____ yrs. mos. ds.

(Signed) **J. W. Vetter** M. D.
Nov 10, 1913 (Address) **Reynoldsburg**

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death. _____ yrs. _____ mos. _____ days. In the State. _____ yrs. _____ mos. _____ days.

Where was disease contracted if not at place of death? _____

Former or usual residence. _____

19. PLACE OF BURIAL OR REMOVAL DATE OF BURIAL

Reynoldsburg **11-10-1913**
20. UNDERTAKER ADDRESS
John J. Schuck **Reynoldsburg**

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH.

Registration District No. 61County of SalahPrimary Registration District No. 2141City of Moscow

(No. _____, _____ St.)

File No. 64120

Registered No. _____

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

Russella Taylor

If death occurred in a hospital, institution or camp give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX

F

4. COLOR OR RACE

W

5. SINGLE, MARRIED, WIDOWED OR DIVORCED.

(Write the word.)

6. DATE OF BIRTH

Aug 21 1830
(Month) (Day) (Year)

7. AGE

83 yrs. _____ mos. _____ ds.IF LESS than 1 day
how many _____ hrs. or
_____ min?

8. OCCUPATION

- (a) Trade, profession or particular kind of work
-
- (b) General nature of industry business or establishment in which employed (or employer)

9. BIRTHPLACE

(State or Country)

Pa

10. NAME OF FATHER

Mitchell

11. BIRTHPLACE OF FATHER

(State or Country)

Pa

12. MAIDEN NAME OF MOTHER

Don't know

13. BIRTHPLACE OF MOTHER

(State or Country)

Pa

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

(Address)

W. O. Lander
Moscow

15.

Filed

Nov 24 1913L. F. Rae
Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH

Nov 23 1913
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from

Aug 5 1913, to Nov 20th 1913

that I last saw him alive on _____ 191____

and that death occurred on the date stated above, at 10 P.M.

The CAUSE OF DEATH* was as follows:

Similarity(Duration) _____ yrs. 0 mos. _____ ds.Contributory
(Secondary)

(Duration) _____ yrs. _____ mos. _____ ds.

(Signed) W. A. Adams M. D.Nov 24 1913 (Address) Moscow Idaho

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place _____ In the _____
of death _____ yrs. _____ mos. _____ ds. State _____ yrs. _____ mos. _____ ds.

Where was disease contracted,

If not at place of death?

Former or

usual residence.

19. PLACE OF BURIAL OR REMOVAL DATE OF BURIAL

Moscow Nov 25 1913

20. UNDERTAKER

ADDRESS

Geo. Stoff MoscowTHIS IS A PERMANENT RECORD. AGE should be stated EXACTLY. Exact state-
ment of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Form V. S. No. 5 20M.1-16-12

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH

Registration District No. 61

County of Latah

Primary Registration District No. 2141

City of Moscow

(No. , St.)

File No. 641

Registered No. 122

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

Oma Oatney

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX

Female

4. COLOR OR RACE

White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED.

Single
(Write the word.)

6. DATE OF BIRTH

Nov

20

1913

(Month)

(Day)

(Year)

7. AGE

yrs. 9 mos. ds.

IF LESS than 1 day
how many hrs. or mins.?

8. OCCUPATION

(a) Trade, profession or particular kind of work

(b) General nature of industry business, or establishment in which employed (or employer)

9. BIRTHPLACE

(State or Country)

Idaho

10. NAME OF FATHER

Arthur L Oatney

11. BIRTHPLACE OF FATHER

(State or Country)

Maine

12. MAIDEN NAME OF MOTHER

Minnie L Baker

13. BIRTHPLACE OF MOTHER

(State or Country)

Oregon

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

Cathryn L Oatney

(Address)

Idaho

15.

Filed

Nov 30

191

S F Rae

Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH

Nov

29

1913

(Month)

(Day)

(Year)

17. I HEREBY CERTIFY, That I attended deceased from

Nov 20

1913

to Nov 29

1913

that I last saw her alive on Nov 20 1913

and that death occurred on the date stated above, at 8 P. M.

The CAUSE OF DEATH* was as follows:

Result of premature birth

(Duration) yrs. 9 mos. ds.

Contributory

(Secondary)

(Duration) yrs. mos. ds.

(Signed)

J H Clarke

M. D.

(Address) Moscow

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death yrs. mos. days. In the State yrs. mos. days.

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL

Idaho

DATE OF BURIAL

Nov 30 1913

20. UNDERTAKER

Mrs Doyle

ADDRESS

Idaho

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Form V. S. No. 5 20M.1-16-12

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH

Registration District No. 61County of ValleyPrimary Registration District No. 2141File No. 6418Registered No. 123

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Jacey Maxwell

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX Female4. COLOR OR RACE White5. SINGLE, MARRIED, WIDOWED OR DIVORCED. Married6. DATE OF BIRTH Nov 24 1840

(Month)

(Day)

(Year)

7. AGE 73 yrs. 6 mos. 4 ds.

IF LESS than 1 day
how many hrs. or
..... mins.?

8. OCCUPATION Housewife

(a) Trade, profession or particular kind of work

(b) General nature of industry, business, or establishment in which employed (or employer)

9. BIRTHPLACE Kentucky

(State or Country)

10. NAME OF FATHER Chas. Adgent11. BIRTHPLACE OF FATHER Kentucky

(State or Country)

12. MAIDEN NAME OF MOTHER not known13. BIRTHPLACE OF MOTHER Kentucky

(State or Country)

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Mrs E B Palmer(Address) Viola Idaho15. Nov 30 1913Filed Nov 30 1913

1913

Local Registrar J F Rao

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH Nov 28 1913

(Month)

(Day)

(Year)

17. I HEREBY CERTIFY, That I attended deceased Nov 27 1913 to Nov 27 1913that I last saw her alive on Nov 27 1913and that death occurred on the date stated above, at M.The CAUSE OF DEATH* was as follows: old age

(Duration) yrs. mos. ds.

Contributory (Secondary)

(Duration) yrs. mos. ds.

(Signed) W M Hayfield19 (Address) Viola Idaho

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death yrs. mos. days. In the State yrs. mos. days.

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL Viola IdahoDATE OF BURIAL Nov 30 191320. UNDERTAKER E AnderssonADDRESS Palmer Mark

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Form V. S. No. 5. 12½M.7-24-11

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH.

Registration District No. 61

County of _____

Primary Registration District No. 1011

City of _____

(No. _____

St.) _____

File No. 6419

Registered No. 118

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

John Clement Livingston

If death occurred in a hospital, institution or camp give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX

Male

4. COLOR OR RACE

White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED.

Single
(Write the word.)

6. DATE OF BIRTH

April
(Month)

18th
(Day)

1909
(Year)

7. AGE

4 yrs. 6 mos. 17 ds.

IF LESS than 1 day
how many _____ hrs. or
_____ min?

8. OCCUPATION

(a) Trade, profession or particular kind of work.
(b) General nature of industry business or establishment in which employed (or employer)

None

9. BIRTHPLACE

(State or Country)

Sonora, Mexico

10. NAME OF FATHER

Douglas Clement Livingston

11. BIRTHPLACE OF FATHER

(State or Country)

London, England

12. MAIDEN NAME OF MOTHER

Phoebe Alice Baynes Reed

13. BIRTHPLACE OF MOTHER

(State or Country)

London Ontario

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

(Address)

J. C. Livingston
Moscow, Idaho

15.

Filed

7/25/15 1915

D. F. Reed

Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH

Nov 14 1913
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from

Nov 13 1913, to Nov 14 1913

that I last saw him alive on Nov 14 1913

and that death occurred on the date stated above, at 10 A.M.

The CAUSE OF DEATH* was as follows:

Gangrenous appendicitis

(Duration) _____ yrs. _____ mos. 2 ds.

Contributory (Secondary)

Peritonitis Diffuse

(Duration) _____ yrs. _____ mos. _____ ds.

(Signed)

Joseph Aspray M. D.
Nov 14 1913 (Address) Moscow Idaho

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death _____ yrs. _____ mos. _____ ds. State _____ yrs. _____ mos. _____ ds.
Where was disease contracted, If not at place of death? _____
Former or usual residence _____

19. PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

Moscow

Nov 15 1913

20. UNDERTAKER

ADDRESS

Geo Stoltz

Moscow

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Form V. S. No. 5. 12½ M. 7-24-11

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics
File No. 6420
Registered No. 119

1. PLACE OF DEATH. Registration District No. 61
County of Lalah Primary Registration District No. 1011
City of Moscow (No. _____, St. _____)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Iver O. Ruston

If death occurred in a hospital, institution or camp give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX Male 4. COLOR OR RACE White 5. SINGLE, MARRIED, WIDOWED OR DIVORCED. Single
(Write the word.)

6. DATE OF BIRTH March 1876
(Month) (Day) (Year)

7. AGE 37 yrs. mos. ds. IF LESS than 1 day how many hrs. or min?

8. OCCUPATION Former
(a) Trade, profession or particular kind of work.
(b) General nature of industry business or establishment in which employed (or employer)

9. BIRTHPLACE Norway
(State or Country)

10. NAME OF FATHER Ruston

11. BIRTHPLACE OF FATHER Norway
(State or Country)

12. MAIDEN NAME OF MOTHER Carri's Iverson

13. BIRTHPLACE OF MOTHER Norway
(State or Country)

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Marins P. Brandt.
(Address) Orofino

15. Filed Nov 8 1913 S. F. Rao
Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH Nov. 7 1913
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from Sept. 8 1913, to Nov. 7 1913
that I last saw him alive on Nov. 7 1913
and that death occurred on the date stated above, at 9:30 A.M.

The CAUSE OF DEATH* was as follows:

Empyema of thorax
superinduced by suppurative
appendicitis
(Duration) yrs. mos. ds.

Contributory (Secondary)
(Duration) yrs. mos. ds.
(Signed) Chas. L. Gittinger M. D.
Nov. 5 1913 (Address) Moscow, Ida.

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place In the
of death yrs. mos. ds. State yrs. mos. ds.
Where was disease contracted,
If not at place of death?
Former or
usual residence.

19. PLACE OF BURIAL OR REMOVAL DATE OF BURIAL

Orofino Idaho Nov 9 1913
20. UNDERTAKER ADDRESS

Geo. St. L. Moscow

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Form V. S. No. 5 20M.1-16-12

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH.

Registration District No. 61

County of _____

Primary Registration District No. 1017

City of _____

(No. _____, St.)

File No. 6421Registered No. 117

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Thomas Edward Condell

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX Male 4. COLOR OR RACE White 5. SINGLE, MARRIED, WIDOWED OR DIVORCED. Married
(Write the word.)6. DATE OF BIRTH August 17
Aug 17 1893
(Month) (Day) (Year)7. AGE 70 yrs. 2 mos. 19 ds.
IF LESS than 1 day
how many hrs. or
..... mins.?

8. OCCUPATION

(a) Trade, profession or particular kind of work Farmer
(b) General nature of industry, business, or establishment in which employed (or employer)

9. BIRTHPLACE

(State or Country) Id.10. NAME OF FATHER F. E. Condell11. BIRTHPLACE OF FATHER don't know
(State or Country)12. MAIDEN NAME OF MOTHER Eliza Smith13. BIRTHPLACE OF MOTHER Id.
(State or Country)

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) P. E. Condell
(Address) Troy Idaho15. Filed Nov 6 1913 S. F. Rae
Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH

Nov 6 1913
(Month) (Day) (Year)17. I HEREBY CERTIFY, That I attended deceased from Nov 1913, to Nov 6 1913,
that I last saw him alive on Nov 3 1913,
and that death occurred on the date stated above, at 3:30 M.

The CAUSE OF DEATH* was as follows:

Auto Intoxication

(Duration) yrs. mos. ds.

Contributory Injury received in
(Secondary) run over

(Duration) yrs. mos. ds.

(Signed) C. L. Ginter M. D.19 (Address) Moore Idaho

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death yrs. mos. days. In the State yrs. mos. days.

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL DATE OF BURIAL

Moscow Nov 7 1913

20. UNDERTAKER

ADDRESS

Geo. S. S. S. Moscow

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Form V. S. No. 5. 12½ M. 7-24-11

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics
File No. 6429
Registered No. 121

1. PLACE OF DEATH. Registration District No. 61
County of Latah Primary Registration District No. 1011
City of Moscow (No. _____ St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

Eric Benedickson

If death occurred in a hospital, institution or camp give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX Male 4. COLOR OR RACE White 5. SINGLE, MARRIED, WIDOWED OR DIVORCED. Married
(Write the word.)
6. DATE OF BIRTH Dec. 12 1894
(Month) (Day) (Year)

7. AGE 69 yrs. 10 mos. 15 ds. IF LESS than 1 day how many _____ hrs. or _____ min?

8. OCCUPATION Farmer
(a) Trade, profession or particular kind of work.
(b) General nature of industry business or establishment in which employed (or employer)

9. BIRTHPLACE Norway
(State or Country)

10. NAME OF FATHER Benedickson Benedickson

11. BIRTHPLACE OF FATHER Norway
(State or Country)

12. MAIDEN NAME OF MOTHER _____

13. BIRTHPLACE OF MOTHER Norway
(State or Country)

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) R. C. Erickson
(Address) Moscow

15. Filed Nov 30 1913 D. F. Rae
Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH Nov 27 1913
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from _____ 191____, to _____ 191____
that I last saw h _____ alive on _____ 191____
and that death occurred on the date stated above, at _____ M.
The CAUSE OF DEATH* was as follows:
Killed by brain accident

_____ (Duration) _____ yrs. _____ mos. _____ ds.
Contributory _____
(Secondary)
(Signed) L. B. M. C. at a. Coroner M. D.
Nov 29 1913 (Address) Moscow

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place _____ In the _____
of death _____ yrs. _____ mos. _____ ds. State _____ yrs. _____ mos. _____ ds.
Where was disease contracted, _____
If not at place of death? _____
Former or _____
usual residence _____

19. PLACE OF BURIAL OR REMOVAL Moscow DATE OF BURIAL Nov 30 1913

20. UNDERTAKER Geo Stetz ADDRESS Moscow

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Form V. S. No. 5 20M.1-16-12

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH.

Registration District No. 23County of LincolnPrimary Registration District No. 1017-2017File No. 6423City of Jerome

(No. _____, _____ St.)

Registered No. _____

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Harman Dell Cornell

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX

m

4. COLOR OR RACE

white

5. SINGLE, MARRIED, WIDOWED OR DIVORCED.

Infant
(Write the word.)

6. DATE OF BIRTH

Oct301913

(Month)

(Day)

(Year)

7. AGE

_____ yrs. _____ mos. 28 ds.IF LESS than 1 day
how many _____ hrs. or
_____ mins.?

8. OCCUPATION

(a) Trade, profession or particular kind of work

Infant

(b) General nature of industry business, or establishment in which employed (or employer)

9. BIRTHPLACE

(State or Country)

Idaho

10. NAME OF FATHER

Dell E Cornell

11. BIRTHPLACE OF FATHER

(State or Country)

nebraska

12. MAIDEN NAME OF MOTHER

Felithia Pease

13. BIRTHPLACE OF MOTHER

(State or Country)

Indiana

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

Mr Dell Cornell

(Address)

Jerome Idaho

15.

Filed

Dec 11913E D Piper

Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH

Nov281913

(Month)

(Day)

(Year)

17. I HEREBY CERTIFY, That I attended deceased from

Nov 201913to Nov 281913that I last saw him alive on Nov 28 1913and that death occurred on the date stated above, at 59 M.

The CAUSE OF DEATH* was as follows:

Erysipelas

(Duration)

yrs.

mos. 8

ds.

Contributory
(Secondary)Peritonitis

(Duration)

yrs.

mos. 2

ds.

(Signed)

E. D. Piper

M. D.

Dec 1 1913

(Address)

Jerome Idaho

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death

yrs.

mos.

days.

In the State

yrs.

mos.

days.

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

Jerome CemeteryDec 1 1913

20. UNDERTAKER

ADDRESS

Dell Cornell (Father)JeromeO. A. L. Harrison

Form V. S. No. 5. 10M. 6-20-11.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics
File No. 6424

1. PLACE OF DEATH.

Registration District No. 58County of BlainePrimary Registration District No. 2438City of Blaine

(No. _____)

St.)

Registered No. 7

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

Clark C. Croner

If death occurred in a hospital, institution or camp give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX

4. COLOR OR RACE 5. SINGLE, MARRIED, WIDOWED OR DIVORCED.

MaleWhiteSingle
(Write the word.)

6. DATE OF BIRTH

Aug 15 1903
(Month) (Day) (Year)

7. AGE

10 yrs 2 mos 25 dsIF LESS than 1 day
how many _____ hrs. or
_____ min.?

8. OCCUPATION

- (a) Trade, profession, or
-
- particular kind of work
-
- (b) General nature of industry
-
- business, or establishment in
-
- which employed (or employer)

9. BIRTHPLACE

(State or Country)

Ore.

10. NAME OF FATHER

Frank Croner

11. BIRTHPLACE OF FATHER

(State or Country)

Ida

12. MAIDEN NAME OF MOTHER

Levella Warner

13. BIRTHPLACE OF MOTHER

(State or Country)

Ida

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Frank Croner(Address) Blaine Ida

15.

Filed 11-6 1913Dell W. Higgs M.D.
Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

Nov 5 1913
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from

Oct 30 1913, to Nov 5 1913that I last saw him alive on Nov 4 1913and that death occurred on the date stated above, at 7 A. M.

The CAUSE OF DEATH* was as follows:

Britonitis(Duration) _____ yrs. _____ mos. 6 ds.Contributory Injury received from head
(Secondary) of Blunt force falling on him(Duration) _____ yrs. _____ mos. 1 ds.(Signed) Dell W. Higgs M. D.11-6- 1913 (Address) Saldin Ida

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place _____ In the _____
of death _____ yrs. _____ mos. _____ ds. State _____ yrs. _____ mos. _____ ds.

Where was Disease contracted,

If not at place of death?

Former or

usual residence.

19. PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

Saldin Ida11-7 1913

20. UNDERTAKER

ADDRESS

Liz MarcellSaldin Ida

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
N. B.—Every item of information should be carefully supplied. AGE should be state EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Form V. S. No. 5. 10M. 6-20-11.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH.

Registration District No. 1County of AdaPrimary Registration District No. 2003City of Meridian (No. _____ St.)

Registered No. _____

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

Dorothy Hickman

If death occurred in a hospital, institution or camp give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX

4. COLOR OR RACE

5. SINGLE, MARRIED, WIDOWED OR DIVORCED.

Female whiteSingle
(Write the word.)

6. DATE OF BIRTH

July - 9 1911
(Month) (Day) (Year)

7. AGE

3 yrs. 4 mos. 25 ds.

IF LESS than 1 day
how many hrs. or
min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work

(b) General nature of industry business or establishment in which employed (or employer)

9. BIRTHPLACE

(State or Country)

Meridian, Idaho

10. NAME OF FATHER

Jos C. Hickman

11. BIRTHPLACE OF FATHER

(State or Country)

Idaho

12. MAIDEN NAME OF MOTHER

Anna L. Hoyle

13. BIRTHPLACE OF MOTHER

(State or Country)

Idaho

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

(Address)

H. F. Neal
Meridian, Idaho

15.

Filed Dec-5- 1913C. L. Denton
Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

Dec. 4 1913
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from

Dec 3 1913, to Dec 4 1913that I last saw her alive on Dec 4 1913,and that death occurred on the date stated above, at 8 P. M.

The CAUSE OF DEATH* was as follows:

Gastroenteritis from
bowels.(Duration) yrs. mos. 5 ds.

Contributory (Secondary)

Rickets

(Duration) yrs. mos. ds.

(Signed) H. F. Neal M. D.Dec 5 1913 (Address) Meridian

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death yrs. mos. ds. State yrs. mos. ds.

Where was disease contracted?

If not at place of death?

Former or usual residence.

19. PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

Meridian, Idaho Dec 10 1913

20. UNDERTAKER

ADDRESS

W. Henderson Meridian

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Form V. S. No. 5. 10M. 6-20-11.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH.

Registration District No. 1County of AdaPrimary Registration District No. 2003City of Clwychee

(No. _____, _____ St.)

Registered No. _____

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

Unnamed infant

If death occurred in a hospital, institution or camp give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX

4. COLOR OR RACE 5. SINGLE, MARRIED, WIDOWED OR DIVORCED.

M.W.Single
(Write the word.)

6. DATE OF BIRTH

Nov301913

(Month)

(Day)

(Year)

7. AGE

_____ yrs. _____ mos. _____ ds.

IF LESS than 1 day
how many 5 hrs. or
_____ min.

8. OCCUPATION

(a) Trade, profession, or particular kind of work

(b) General nature of industry business, or establishment in which employed (or employer)

None

9. BIRTHPLACE

(State or Country)

Idaho

10. NAME OF FATHER

Wm Elmer Nelson

11. BIRTHPLACE OF FATHER

(State or Country)

Ill.

12. MAIDEN NAME OF MOTHER

Bertha Gouldin

13. BIRTHPLACE OF MOTHER

(State or Country)

Nebr.

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

J. E. Mangle

(Address)

Boise

15.

Filed

Dec 141913C. L. Sutton

Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

Dec11913

(Month)

(Day)

(Year)

17. I HEREBY CERTIFY, That I attended deceased from

Nov 30 1913, to Dec 1 1913that I last saw him alive on Nov 30 1913,and that death occurred on the date stated above, at 3:00 a.m.

The CAUSE OF DEATH* was as follows:

Immaturity
7 1/2 mo fetus.(Duration) _____ yrs. _____ mos. 1 ds.Contributory
(Secondary)

(Duration) _____ yrs. _____ mos. _____ ds.

(Signed) J. E. Mangle M. D.Dec 1 1913 (Address) Boise

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place

In the

of death _____ yrs. _____ mos. _____ ds. State _____ yrs. _____ mos. _____ ds.

Where was Disease contracted,

If not at place of death?

Former or

usual residence.

19. PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

ClwycheeDec 1 1913

20. UNDERTAKER

ADDRESS

Wm Elmer NelsonClwychee

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. N. B.—Every item of information should be carefully supplied. AGE should be state EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Form V. S. No. 5. 10M. 6-20-11.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH.

Registration District No. 1

County of Ada

Primary Registration District No. 2003

City of Meridian

(No. , St.)

File No. 642

Registered No.

If death occurred in a hospital, institution or camp give its NAME instead of street and number.

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

Milton Burns

PERSONAL AND STATISTICAL PARTICULARS

3. SEX

Male

4. COLOR OR RACE

White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED.

Married
(Write the word.)

6. DATE OF BIRTH

September

28

1895
(Month) (Day) (Year)

7. AGE

68 yrs. one mos. 1 ds.

IF LESS than 1 day
how many hrs. or
min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work

Farmer

(b) General nature of industry business or establishment in which employed (or employer)

9. BIRTHPLACE

(State or Country)

Missouri

10. NAME OF FATHER

Eimmons F. Burns

11. BIRTHPLACE OF FATHER

(State or Country)

North Carolina

12. MAIDEN NAME OF MOTHER

Esther Beeman

13. BIRTHPLACE OF MOTHER

(State or Country)

N. Carolina

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

S. M. Burns

(Address)

Meridian Idaho

15.

Filed Oct. 30th 1913

C. L. Dutton

Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

Oct -

29 -

1913
(Month) (Day) (Year)17. I HEREBY CERTIFY, That I attended deceased from Oct 20th 1913, to Oct 29th 1913

that I last saw him alive on Oct 29 - 1913, and that death occurred on the date stated above, at 2 P. M.

The CAUSE OF DEATH* was as follows:

Chronic Nephritis -
Interstitial type - with
arteriosclerosis

(Duration) yrs. mos. ds.

Contributory (Secondary)

About 4 yrs. mos. ds.
(Duration)

(Signed)

C. L. Dutton

M. D.

Oct. 30th 1913 (Address)

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and 2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place

In the

of death. yrs. mos. ds. State. yrs. mos. ds.

Where was disease contracted,

If not at place of death?

Former or

usual residence.

19. PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

Jefferson Cemetery

Oct 30 1913

20. UNDERTAKER

ADDRESS

Schreibers Sidenfaden Bros

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Form V. S. No. 5 20M.1-16-12

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH.

Registration District No. 1County of AdaPrimary Registration District No. 2003City of Meridian

(No. _____ St.)

File No. 642

Registered No. _____

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

George Matlock

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX

Male

4. COLOR OR RACE

White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED.

(Write the word.)

6. DATE OF BIRTH

Oct — 28th 1913.
(Month) (Day) (Year)

7. AGE

____ yrs. ____ mos. ____ ds.

IF LESS than 1 day
how many 12 hrs. or
..... mins.?

8. OCCUPATION

(a) Trade, profession or particular kind of work

none

(b) General nature of industry, business, or establishment in which employed (or employer)

none

9. BIRTHPLACE

(State or Country)

Ada

10. NAME OF FATHER

Henry Matlock

11. BIRTHPLACE OF FATHER

(State or Country)

Missouri

12. MAIDEN NAME OF MOTHER

Georgia Hicks

13. BIRTHPLACE OF MOTHER

(State or Country)

Arkansas

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

Georgie Matlock

(Address)

Meridian, Ida 851

15.

Filed Oct 28th 1913C. L. Sutton

Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH

Oct. 28th 1913.
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from

Oct - 28th 1913, to Oct - 29th 1913,

that I last saw him alive on Oct 28 1913,

and that death occurred on the date stated above, at 6³⁰ A.M.

The CAUSE OF DEATH* was as follows:

Failure of coronary valve to close

(Duration) ____ yrs. ____ mos. ____ ds.

Contributory
(Secondary)

(Duration) ____ yrs. ____ mos. ____ ds.

(Signed)

C. L. Sutton

M. D.

Oct 29 1913 (Address) Meridian, Ida

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death ____ yrs. ____ mos. ____ days. In the State ____ yrs. ____ mos. ____ days.

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

Meridian Cemetery Oct 29 1913

20. UNDERTAKER

ADDRESS

Mrs. Myers Acting Mer.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Form V. S. No. 5 20M.1-16-12

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics
File No. 6439

1. PLACE OF DEATH.

Registration District No.

County of Cassia

Primary Registration District No.

City of Burley

(No. St.)

Registered No.

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

Haney Jensen

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX

4. COLOR OR RACE

5. SINGLE, MARRIED, WID-
OWED OR DIVORCED.Male whiteSingle (Write the word.)

6. DATE OF BIRTH

(Month)

(Day)

(Year)

7. AGE

1 yrs. 5 mos. ds.

IF LESS than 1 day
how many hrs. or
..... mins.

8. OCCUPATION

(a) Trade, profession or
particular kind of workAt home(b) General nature of industry
business, or establishment in
which employed (or employer)

9. BIRTHPLACE

(State or Country)

Burley, Cassia Co., Ida.10. NAME OF
FATHERIke Jensen11. BIRTHPLACE
OF FATHER

(State or Country)

Utah12. MAIDEN NAME
OF MOTHERClara Prescott13. BIRTHPLACE
OF MOTHER

(State or Country)

Idaho.

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

Ike Jensen

(Address)

Burley Idaho

15.

Filed

Nov 28

1913

B. L. Story
Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH

November 26 1913
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from
November 10 1913, to November 26 1913.

that I last saw him alive on November 26 1913

and that death occurred on the date stated above, at 4 A.M.

The CAUSE OF DEATH* was as follows:

Poison due to
Salamini (Wild Tomato)

(Duration) yrs. mos. 20 ds.

Contributory

(Secondary)

(Duration) yrs. mos. ds.

(Signed)

Dec 5 1913

(Address)

Burley Ida

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions,
Transients or Recent Residents.)

At place of death yrs. mos. days. In the State yrs. mos. days.

Where was disease contracted
if not at place of death?

Former or
usual residence

19. PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

Burley Ida Nov 27 1913

20. UNDERTAKER

ADDRESS

L. B. Halliday Burley Ida

Form V. S. No. 5 20M.1-16-12

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH.

Registration District No. 10

County of Ada

Primary Registration District No. 2002

City of Eagle

(No. Near Eagle Sta. St.)

File No. 6431

Registered No. 2

If death occurs away from usual residence, give facts called for under special instruction.

2. FULL NAME

Donald Preston

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX

4. COLOR OR RACE

5. SINGLE, MARRIED, WIDOWED OR DIVORCED.

Male White Single (Write the word.)

6. DATE OF BIRTH

May 13 1913
(Month) (Day) (Year)

7. AGE

yrs. 6 mos. 18 ds.

IF LESS than 1 day
how many hrs. or
..... mins.?

8. OCCUPATION

(a) Trade, profession or particular kind of work
(b) General nature of industry business, or establishment in which employed (or employer)

None

9. BIRTHPLACE

(State or Country)

Idaho

10. NAME OF FATHER

Wilson Preston

11. BIRTHPLACE OF FATHER

(State or Country)

Canada

12. MAIDEN NAME OF MOTHER

Besiedy Preston

13. BIRTHPLACE OF MOTHER

(State or Country)

Not obtainable

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

Wilson Preston

(Address)

Eagle 2da

15.

Filed

Dec 3 1913

20M.1-16-12

L.B. Hauris

Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH

Dec 2 1913
(Month) (Day) (Year)

17. I HEREBY CERTIFY That I attended deceased from

May 13 1913 to Dec 2 1913

that I last saw him alive on Dec 1 1913

and that death occurred on the date stated above, at 9 A.M.

The CAUSE OF DEATH was as follows:

Pneumonia

(Duration) 1 yr. 10 mos. 18 ds.

Contributory
(Secondary)

(Duration) yrs. mos. ds.

(Signed) A. W. Hauris M. D.

19 (Address) Star Ida

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death yrs. mos. days. In the State yrs. mos. days.

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

Proctor's Hill

Dec 4 1913

20. UNDERTAKER

ADDRESS

J. W. Summers

Boise Ida

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Form V. S. No. 5. 12½ M. 7-24-11

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics
File No. 6432
Registered No.

1. PLACE OF DEATH. Registration District No. 26
County of Canda Primary Registration District No. 2069
City of Daniels (No. St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

John Hill

If death occurred in a hospital, institution or camp give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX Male 4. COLOR OR RACE White 5. SINGLE, MARRIED, WIDOWED OR DIVORCED Married
(Write the word.)

6. DATE OF BIRTH November 18th 1892
(Month) (Day) (Year)

7. AGE 41 yrs. 1 mos. 1 ds. IF LESS THAN 1 day how many hrs. or min?

8. OCCUPATION Farmer
(a) Trade, profession or particular kind of work.
(b) General nature of industry business or establishment in which employed (or employer)

9. BIRTHPLACE Idaho
(State or Country)

10. NAME OF FATHER Matthew Hill

11. BIRTHPLACE OF FATHER Scotland
(State or Country)

12. MAIDEN NAME OF MOTHER Catherine Nelson

13. BIRTHPLACE OF MOTHER Missouri
(State or Country)

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) M. J. Hill
(Address) St. John Idaho

15. Filed Nov 17 4 1913 J. C. Ray
Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH November 19th 1913
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from Nov 19 1913, to Nov 19 1913
that I last saw him alive on Nov 19 1913
and that death occurred on the date stated above, at 3:30 PM.

The CAUSE OF DEATH* was as follows:
Inquest held November 21st 1913 and adjourned until December 4th 1913 to secure analysis of deceased organs. Verdict per "death from staphylococcus poisoning administered to him by some unknown person"
(Duration) yrs. mos. ds.

Contributory (Secondary)
(Duration) yrs. mos. ds.
(Signed) Wm. J. Hill M. D.
17 4 1913 (Address) St. John Idaho

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place In the
of death yrs. mos. ds. State yrs. mos. ds.
Where was disease contracted,
If not at place of death?
Former or usual residence

19. PLACE OF BURIAL OR REMOVAL DATE OF BURIAL
St. John Canda Co Idaho Nov 25 1913

20. UNDERTAKER ADDRESS
J. E. Johnson - Malad City

State of Idaho)
 ss.
County of Oneida)

On this 24th day of November, 1913, before me, T. E. Ray, a
Notary public in and for said County and State, personally appeared
Alma Josephson, known to me to be the coroner in and for the County
and the person whose name is subscribed to the within instrument
of Oneida State of Idaho, and acknowledged to me that he executed the
same as such coroner.

In witness whereof I have hereunto set my hand and affixed my
official seal at Malad City, Idaho, the day and year in this certificate
first above written.



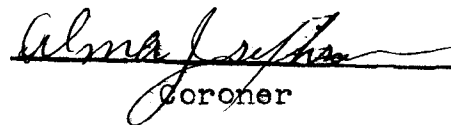
Notary public.

Malad city, Idaho, November 24th 1913.

Dr. D.C. Ray,

Local Registrar, Oneida County, Idaho,
registration district Number, 26.

You are hereby authorized to issue a burial permit for the burial of the body of John Hill, deceased, who died on November 19th 1913, at 9.30 P.M. at Daniels in the County of Oneida, State of Idaho, Death certificate stating the cause of death will be duly furnished to you after the inquisition is finished, which will be on December ~~19th~~ 1913, after an analysis of the contents of said deceased stomach and other parts by the State Chemist of the State of Utah, is duly furnished to me and the coroners jury.


Coroner

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Form V, S. No. 5 20M.1-16-12

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH.

Registration District No. 26

County of Quada

Primary Registration District No. 2071

City of Halbrook

(No. William L. Bellie St.)

File No. 6433

Registered No. 84

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

William L. Bellie

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX

4. COLOR OR RACE

5. SINGLE, MARRIED, WIDOWED OR DIVORCED.

Male White

Married
(Write the word.)

6. DATE OF BIRTH

March 10 1881
(Month) (Day) (Year)

7. AGE

32 yrs. 7 mos. 26 ds.

IF LESS than 1 day
how many hrs. or
..... mins.?

8. OCCUPATION

(a) Trade, profession or particular kind of work
(b) General nature of industry, business, or establishment in which employed (or employer)

Farmer

9. BIRTHPLACE

(State or Country)

Mendon Utah

10. NAME OF FATHER

William Bellie

11. BIRTHPLACE OF FATHER

(State or Country)

Salt Lake City Utah

12. MAIDEN NAME OF MOTHER

Mary Ann Buensaker

13. BIRTHPLACE OF MOTHER

(State or Country)

Brigham Utah

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

(Address)

James Willie
Halbrook Ida

15.

Filed

11-6 1913

L. G. Ray

Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH

November 4 1913
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from

Nov 2 1913 to Nov 4 1913

that I last saw him alive on Nov 4 1913

and that death occurred on the date stated above, at 108 M.

The CAUSE OF DEATH* was as follows:

Typhoid fever

(Duration) yrs. mos. 21 ds.

Contributory (Secondary)

Suppurative pneumonia

(Duration) yrs. mos. 10 ds.

(Signed)

W. C. Ray M. D.
11-6 1913 (Address) Malad City Ida

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death yrs. mos. days. In the State yrs. mos. days.

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

Halbrook Ida Nov 9 1913

20. UNDERTAKER

ADDRESS

L. G. Johnson Malad Ida

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Form V. S. No. 5 20M.1-16-12

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics
File No. **643+**

1. PLACE OF DEATH. Registration District No. **27**
County of **Franklin** Primary Registration District No. **2119**
City of **Pearson** (No. _____ St.)

Registered No. **26**

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME **Eliphaz Williams**

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX **Female** 4. COLOR OR RACE **White** 5. SINGLE, MARRIED, WID-
OWED OR DIVORCED. **single**
(Write the word.)

6. DATE OF BIRTH

November 3 1897
(Month) (Day) (Year)

7. AGE

15 yrs. 9 mos. 0 ds.

IF LESS than 1 day
how many _____ hrs. or
_____ mins.?

8. OCCUPATION

(a) Trade, profession or
particular kind of work
(b) General nature of industry
business, or establishment in
which employed (or employer)

At home

9. BIRTHPLACE

(State or Country)

Franklin

10. NAME OF FATHER

Chas W. Williams

11. BIRTHPLACE OF FATHER

(State or Country)

Idaho

12. MAIDEN NAME OF MOTHER

Elizabeth J. Clements

13. BIRTHPLACE OF MOTHER

(State or Country)

Idaho

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

C. W. Williams

(Address)

C. W. Williams #1

15.

Filed

12/10

1913

Allen C. Cullen
Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH

8 3 1913
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from

July 12 1913 to July 30 1913

that I last saw her alive on **July 30 1913**

and that death occurred on the date stated above, at **3 AM**

The CAUSE OF DEATH* was as follows:

Primary Tuberculosis (acute)

(Duration) _____ yrs. **1** mos. **14** ds.

Contributory
(Secondary)

(Duration) _____ yrs. _____ mos. _____ ds.

(Signed)

D. J. Parkins

7/3 1913 (Address) **Pearson Idaho**

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death _____ yrs. _____ mos. _____ days. In the State _____ yrs. _____ mos. _____ days.

Where was disease contracted
if not at place of death?

Former or
usual residence

19. PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

Franklin Idaho**Aug 5 1913**

20. UNDERTAKER

ADDRESS

D. J. Hansen**Pearson**

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Form V. S. No. 5 20M.1-16-12

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH.

Registration District No. 27

County of Franklin

Primary Registration District No. 2119

City of Mahan

(No. ,

St.)

File No. 6435

Registered No. 20

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

Bryham Swannick

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX

Male

4. COLOR OR RACE

White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED.

(Write the word.)

6. DATE OF BIRTH

Aug 4 1888
(Month) (Day) (Year)

7. AGE

54 yrs. 3 mos. ds.

IF LESS than 1 day
how many hrs. or
..... mins.?

8. OCCUPATION

(a) Trade, profession or particular kind of work

Farmer

(b) General nature of industry business, or establishment in which employed (or employer)

9. BIRTHPLACE

(State or Country)

Iowa

10. NAME OF FATHER

Samuel Swann

11. BIRTHPLACE OF FATHER

(State or Country)

Not Known

12. MAIDEN NAME OF MOTHER

Mary Cole

13. BIRTHPLACE OF MOTHER

(State or Country)

Maine

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

L. J. Swannick

(Address)

Preston R. 10 #1

15.

Filed 11/7

1913

E. H. Reeder
Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH

Nov. 5 1913
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from

May 15 1913, to Nov. 5 1913,

that I last saw him alive on Oct 25 1913,

and that death occurred on the date stated above, at 1:30 M.

The CAUSE OF DEATH* was as follows:

Carcinoma of bowels

(Duration) 1 yrs. mos. ds.

Contributory
(Secondary)

(Duration) 5 yrs. mos. ds.

(Signed)

E. H. Swannick M. D.

Nov. 6 1913 (Address) Preston Idaho

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death yrs. mos. days. In the State yrs. mos. days.

Where was disease contracted if not at place of death?

Former or usual residence.

19. PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

Mahan, Idaho

Nov 7 1913

20. UNDERTAKER

ADDRESS

J. H. Swannick

Preston

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Form V. S. No. 5 20M.1-16-12

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH.

Registration District No. 29

County of Franklin

Primary Registration District No. 2119

City of Princeton

(No. _____ St.)

File No. 643

Registered No. 22

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Charles C McCarroll

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX

male

4. COLOR OR RACE

White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED.

(Write the word.)

6. DATE OF BIRTH

July

5

1860

(Month)

(Day)

(Year)

7. AGE

53 yrs. 4 mos. ds.

IF LESS than 1 day
how many hrs. or
 mins.?

8. OCCUPATION

(a) Trade, profession or particular kind of work
(b) General nature of industry, business, or establishment in which employed (or employer)

Farmer

9. BIRTHPLACE

(State or Country)

Utah

10. NAME OF FATHER

Jesse McCarroll

11. BIRTHPLACE OF FATHER

(State or Country)

Mo

12. MAIDEN NAME OF MOTHER

Amanda Wood

13. BIRTHPLACE OF MOTHER

(State or Country)

Canada

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

Wm. C. O. McCarroll

(Address)

Treasure Cove Idaho

15.

Filed 11/18

1913

Alvin Butler
Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH

11

14

1919

(Month)

(Day)

(Year)

17. I HEREBY CERTIFY, That I attended deceased from

11/10 1919, to 11/14 1919,

that I last saw him alive on 11/14 1919,

and that death occurred on the date stated above, at 11 P. M.

The CAUSE OF DEATH* was as follows:

Acute dilatation of heart with valvular insufficiency

(Duration) yrs. mos. ds.

Contributory (Secondary)

Defect heart

(Duration) yrs. 6 mos. ds.

(Signed)

Alvin Butler M. D.

19 (Address) Princeton Idaho

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death yrs. mos. days. In the State yrs. mos. days.

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

Princeton Idaho

11 1919

20. UNDERTAKER

ADDRESS

Wm. C. O. McCarroll

Princeton

Form V. S. No. 5 20M.1-16-12

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH.

Registration District No. 27County of BlainePrimary Registration District No. 2119City of Camp 3

(No. _____ St.)

File No. 6438Registered No. 18

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

S. Hagberg

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX

M.

4. COLOR OR RACE

White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED.

Single
(Write the word.)

6. DATE OF BIRTH

Not known
1869
(Month) (Day) (Year)

7. AGE

34 yrs. mos. ds.IF LESS than 1 day
how many hrs. or
..... mins.?

8. OCCUPATION

- (a) Trade, profession or particular kind of work
-
- (b) General nature of industry, business, or establishment in which employed (or employer)

Carpenter

9. BIRTHPLACE

(State or Country)

Sweden

10. NAME OF FATHER

Not known

11. BIRTHPLACE OF FATHER

(State or Country)

Not known

12. MAIDEN NAME OF MOTHER

Not known

13. BIRTHPLACE OF MOTHER

(State or Country)

Not known

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Curis Bland(Address) Preston, Idaho

15.

Filed 11/7 1917 W. H. Bland
Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH

October 21 1913
(Month) (Day) (Year)17. I HEREBY CERTIFY, That I attended deceased from
October 2 1913, to October 21 1913,
that I last saw him alive on October 21 1913,
and that death occurred on the date stated above, at 10 P. M.
The CAUSE OF DEATH* was as follows:Typhoid fever(Duration) yrs. mos. 19 ds.Contributory Hemorrhage - intestinal
(Secondary)(Duration) yrs. mos. 1 ds.(Signed) Curis Bland M. D.Oct 21 1913 (Address) Preston, Idaho

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death yrs. 2 mos. 21 days. In the State yrs. 2 mos. 21 days.

Where was disease contracted if not at place of death?

Former or usual residence Winshah Reservation, Utah

19. PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

Preston Oct 22 1913

20. UNDERTAKER

ADDRESS

P. J. Harrison Preston Idaho

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Form V. S. No. 5 20M.1-16-12

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics
File No. 6431

1. PLACE OF DEATH.

Registration District No. 27

County of Franklin

Primary Registration District No. 2119

City of Preston

(No. _____, _____ St.)

Registered No. 21

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME James William Stevens

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX 4. COLOR OR RACE 5. SINGLE, MARRIED, WIDOWED OR DIVORCED.

Male

White

(Write the word.)

6. DATE OF BIRTH

August 13th. 1913
(Month) (Day) (Year)

7. AGE

36 yrs. 3 mos. 4 ds.

IF LESS than 1 day
how many _____ hrs. or
_____ mins.?

8. OCCUPATION

(a) Trade, profession or particular kind of work Implement Merchant
(b) General nature of industry business, or establishment in which employed (or employer)

9. BIRTHPLACE

(State or Country) Utah

10. NAME OF FATHER

Sidney Stevens

11. BIRTHPLACE OF FATHER

(State or Country) England

12. MAIDEN NAME OF MOTHER

Mary Jane Thick

13. BIRTHPLACE OF MOTHER

(State or Country) England

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Sidney O. Stevens

(Address) Logan

15.

Filed 11/18 1913 Allen R. Kutt
Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH

November 17th. 1913
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from

Nov. 16th. 1913, to Nov. 17 1913,

that I last saw him alive on Nov. 17 1913,

and that death occurred on the date stated above, at 8:20 P.M.

The CAUSE OF DEATH* was as follows:

Acute Nephritis

(Duration) _____ yrs. _____ mos. 1 1/2 ds.

Contributory
(Secondary)

(Duration) _____ yrs. _____ mos. _____ ds.

(Signed)

Dr. H. C. Caulfield M. D.

Nov 17 1913 (Address) Preston Idaho

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death _____ yrs. _____ mos. _____ days. In the State _____ yrs. _____ mos. _____ days.

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

Ogden, Utah

Nov 20 1913

20. UNDERTAKER

ADDRESS

G. A. Lindquist

Logan, Ut.

Form V. S. No. 5. 12½ M. 7-24-11

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH. Registration District No. 27
 County of Franklin Primary Registration District No. 279
 City of Rivdale (No. _____, _____ St.)

File No. 641
 Registered No. 25

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

Ruby Bennett Smith

If death occurred in a hospital, institution or camp give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX 4. COLOR OR RACE 5. SINGLE, MARRIED, WIDOWED OR DIVORCED.

MaleWhiteSingle
(Write the word.)

6. DATE OF BIRTH

Dec. 5 1913
 (Month) (Day) (Year)

7. AGE

5 yrs. 5 mos. 5 ds.

IF LESS than 1 day
 how many hrs. or min?

8. OCCUPATION

(a) Trade, profession or particular kind of work.
 (b) General nature of industry business or establishment in which employed (or employer)

None9. BIRTHPLACE
(State or Country)Rivdale Idaho

10. NAME OF FATHER

Robert Z Smith11. BIRTHPLACE OF FATHER
(State or Country)Rivdale Idaho

12. MAIDEN NAME OF MOTHER

Doris Bennett13. BIRTHPLACE OF MOTHER
(State or Country)Rivdale Idaho

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

(Address)

Franklin Bennett
Rivdale Idaho

15.

Filed Dec 10 1913

Allen K. Curtis
 Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH

May 4 1913
 (Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from no doctor in attendance
191 to 191

that I last saw him alive on 191and that death occurred on the date stated above, at M.

The CAUSE OF DEATH* was as follows:

Not Known - Died
very sudden before
help could be obtained

(Duration) yrs. mos. ds.

Contributory
(Secondary)

(Duration) yrs. mos. ds.

(Signed) Allen K. Curtis M. D.19 (Address) Rivdale Idaho

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place In the
 of death yrs. mos. ds. State yrs. mos. ds.

Where was disease contracted,

If not at place of death?

Former or

usual residence.

19. PLACE OF BURIAL OR REMOVAL DATE OF BURIAL

Rivdale Idaho5/6 1913

20. UNDERTAKER

ADDRESS

None—

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Form V. S. No. 5. 12½ M. 7-24-11

CERTIFICATE OF DEATH

1. PLACE OF DEATH. Registration District No. 27
County of Quada Primary Registration District No. 2119
City of Preston (No. _____, _____ St.)

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

File No. 6441
Registered No. 9

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

Emily Duxbury

If death occurred in a hospital, institution or camp give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX Female 4. COLOR OR RACE white 5. SINGLE, MARRIED, WIDOWED OR DIVORCED married
(Write the word.)

6. DATE OF BIRTH May 18 1852
(Month) (Day) (Year)

7. AGE 61 yrs. 7 mos. 18 ds. IF LESS than 1 day how many _____ hrs. or _____ min?

8. OCCUPATION

- (a) Trade, profession or particular kind of work.
(b) General nature of industry business or establishment in which employed (or employer)

Housewife

9. BIRTHPLACE

(State or Country)

Northampton, Eng.

10. NAME OF FATHER

11. BIRTHPLACE OF FATHER

(State or Country)

12. MAIDEN NAME OF MOTHER

Eliza Gent

13. BIRTHPLACE OF MOTHER

(State or Country)

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) _____
(Address) _____

15. Filed 8-22 1913 D. C. Ray
Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH Jan. 6 1913
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from Dec. 3, 1913 to 1-6 1913
that I last saw her alive on 1-2 1913
and that death occurred on the date stated above, at 11:45 P.M.

The CAUSE OF DEATH* was as follows:

Defective heart (valvular defect)
Pneumonia and
Dropsy.

(Duration) _____ yrs. _____ mos. _____ ds.

Contributory (Secondary) Kidney & Bladder difficulties

(Duration) One yrs. _____ mos. _____ ds.

(Signed) _____ M. D.

_____ 19____ (Address)

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place _____ In the _____
of death _____ yrs. _____ mos. _____ ds. State _____ yrs. _____ mos. _____ ds.

Where was disease contracted,
If not at place of death?
Former or
usual residence _____

19. PLACE OF BURIAL OR REMOVAL DATE OF BURIAL

Preston, Ida. 1-8 1913

20. UNDERTAKER ADDRESS

C. J. Hanson Preston, Id.

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Form V. S. No. 5 20M.1-16-12

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH.

Registration District No.

County of Franklin

Primary Registration District No.

City of Chilton

(No. St.)

File No. 6442

Registered No.

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME William Arthur Henderson

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX

Male

4. COLOR OR RACE

White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED.

(Write the word.)

6. DATE OF BIRTH

Dec

14

1909

(Month)

(Day)

(Year)

7. AGE

3

11

mos.

29

ds.

IF LESS than 1 day
how many hrs. or
..... mins.?

8. OCCUPATION

(a) Trade, profession or particular kind of work
(b) General nature of industry, business, or establishment in which employed (or employer)

9. BIRTHPLACE

(State or Country)

Riversdale

10. NAME OF FATHER

Haskell

11. BIRTHPLACE OF FATHER

(State or Country)

Chilton

12. MAIDEN NAME OF MOTHER

Henderson

13. BIRTHPLACE OF MOTHER

(State or Country)

Idaho

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

Mrs E. J. Howell

(Address)

Preston

15.

Filed 12/10

1913

Albert R. Lester

Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

September

13

1913

(Month)

(Day)

(Year)

17. I HEREBY CERTIFY, That I attended deceased from

July 2 1913, to Sept 13 1913

that I last saw him alive on Sept 8 1913

and that death occurred on the date stated above, at 10 a. m.

The CAUSE OF DEATH* was as follows:

Acute Military Tuberculosis

(Duration)

yrs.

mos.

ds.

Contributory
(Secondary)

(Duration)

yrs.

mos.

ds.

(Signed)

G. W. Bates

M. D.

19

(Address)

Preston Idaho

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death

yrs.

mos.

days.

In the State

yrs.

mos.

days.

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

Not Buried Chilton

Sept 14 1913

20. UNDERTAKER

ADDRESS

Not any

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Form V. S. No. 5 20M.1-16-12

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics
File No. 6443
Registered No. 17

1. PLACE OF DEATH.

Registration District No. 27County of FranklinPrimary Registration District No. 2119

City of _____

(No. _____, _____ St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

Guil M. Jenson

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX

male

4. COLOR OR RACE

White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED.

(Write the word.)

6. DATE OF BIRTH

10 (Month)16 (Day)1902 (Year)

7. AGE

1 yrs. 1 mos. _____ ds.IF LESS than 1 day
how many _____ hrs. or
_____ mins.?

8. OCCUPATION

- (a) Trade, profession or particular kind of work
(b) General nature of industry business, or establishment in which employed (or employer)

9. BIRTHPLACE

(State or Country)

Minck Creek

10. NAME OF FATHER

Marinus Jenson

11. BIRTHPLACE OF FATHER

(State or Country)

Denmark

12. MAIDEN NAME OF MOTHER

Hansen

13. BIRTHPLACE OF MOTHER

(State or Country)

Lugan Utah

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

Marinus Jenson

(Address)

Minck Creek

15.

Filed

10/201913Allen R. Cuda

Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH

Oct. (Month)13 (Day)1913 (Year)

17. I HEREBY CERTIFY, That I attended deceased from

10/91913,to 10/131913,that I last saw him alive on 10/13 1913,and that death occurred on the date stated above, at 5:00 P.M.

The CAUSE OF DEATH* was as follows:

Pneumonia

(Duration)

yrs.

mos.

4 ds.Contributory
(Secondary)Scald on face & chest

(Duration)

yrs.

mos.

4 ds.

(Signed)

Dr. C. A. Couglet M. D.

19

(Address)

Paulsen Idaho

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place

of death

yrs.

mos.

days.

In the

State

yrs.

mos.

days.

Where was disease contracted if not at place of death?

Former or usual residence.

19. PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

Minck CreekOct 19 1913

20. UNDERTAKER

ADDRESS

Dr. J. HansenFranklin

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Form V. S. No. 5 20M.1-16-12

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH.

Registration District No.

County of Blaine

Primary Registration District No.

City of Island

(No. St.)

File No. 6441

Registered No.

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME June Crammy

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX

Female

4. COLOR OR RACE

White

5. SINGLE, MARRIED, WID-
OWED OR DIVORCED.

Single
(Write the word.)

6. DATE OF BIRTH

June 7 1912
(Month) (Day) (Year)

7. AGE

11 yrs. 16 mos. 16 ds.

IF LESS than 1 day
how many hrs. or
..... mins.?

8. OCCUPATION

(a) Trade, profession or
particular kind of work
(b) General nature of industry
business, or establishment in
which employed (or employer)

9. BIRTHPLACE

(State or Country) Idaho

10. NAME OF
FATHER

Wilbur T. Crammy

11. BIRTHPLACE
OF FATHER

(State or Country) Utah

12. MAIDEN NAME
OF MOTHER

Rose Munk

13. BIRTHPLACE
OF MOTHER

(State or Country) Utah

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

(Address)

15.

Filed

191

Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH

May 12 1912
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from

May 2 1912 to May 12 1912,

that I last saw her alive on May 10 1912

and that death occurred on the date stated above, at 5:40 A.M.

The CAUSE OF DEATH* was as follows:

Measles

(Duration) yrs. mos. 14 ds.

Contributory
(Secondary)

(Duration) yrs. mos. 10 ds.

(Signed)

E. Polohang M. D.
6/13/12 (Address) Oakley, Idaho

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions,
Transients or Recent Residents.)

At place of death yrs. mos. days. In the State yrs. mos. days.

Where was disease contracted
if not at place of death?

Former or
usual residence.

19. PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

Harvey Sessions

May 15th 1912

20. UNDERTAKER

ADDRESS

Madison

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Form V. S. No. 5. 12½ M. 7-24-11

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH. Registration District No. 26
County of Oneida Primary Registration District No. 2069
City of Malad (No. _____ St.)

File No. 644
Registered No. 83

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

Annir O'Bray

If death occurred in a hospital, institution or camp give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX female 4. COLOR OR RACE white 5. SINGLE, MARRIED, WIDOWED OR DIVORCED married
(Write the word.)

6. DATE OF BIRTH Dec. 29 1871
(Month) (Day) (Year)

7. AGE 42 yrs. 10 mos. 14 ds.
IF LESS than 1 day how many... hrs. or min?

8. OCCUPATION

(a) Trade, profession or particular kind of work.
(b) General nature of industry business or establishment in which employed (or employer)

Housewife

9. BIRTHPLACE

(State or Country)

Utah

10. NAME OF FATHER

Richard P. Howells

11. BIRTHPLACE OF FATHER

(State or Country)

England.

12. MAIDEN NAME OF MOTHER

Ann Smith

13. BIRTHPLACE OF MOTHER

(State or Country)

England

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Samuel O'Bray
(Address) Paradise, Ut.

15.

Filed Oct 16 1913 J. C. Ray
Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH

Oct 12 1913
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from Oct-13 1913, to Oct 12 1913
that I last saw her alive on Oct 12 1913
and that death occurred on the date stated above, at 5 PM.
The CAUSE OF DEATH* was as follows:

Uremia
chronic nephritis

(Duration) _____ yrs. _____ mos. 5 ds.

Contributory
(Secondary)

(Duration) _____ yrs. _____ mos. _____ ds.

(Signed) _____ M. D.

10-17 1913 (Address) Dr. R. L. Ray

*State the DISEASE CAUSING DEATH; or in deaths from violence, state (1) MEANS OF INJURY; (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place _____ In the _____
of death _____ yrs. _____ mos. _____ ds. State _____ yrs. _____ mos. _____ ds.

Where was disease contracted,

If not at place of death?

Former or
usual residence.

19. PLACE OF BURIAL OR REMOVAL DATE OF BURIAL

Paradise, Ut. Oct 19 1913

20. UNDERTAKER

ADDRESS

C. Thompson Paradise
Utah

-SUPPLEMENTARY DEATH CERTIFICATE-

(Please reply on this sheet to
the registrar of Vital Statistics)

Death Certificate No.

Name.....Annie O'Bray.....

Date of Death.....Oct. 15th.....

Cause of Death.....chronic nephritis.....

Contributory Cause of death.....Uremia.....

(Sign here) J. C. Ray M.D.

Form V. S. No. 5 20M.1-16-12

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH..... Registration District No.....
County of *Twins Falls* Primary Registration District No.....
City of *Tiler* (No., St.)

File No. *644*Registered No. *1*

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

Tillie Turfee

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX *Female* 4. COLOR OR RACE *White* 5. SINGLE, MARRIED, WIDOWED OR DIVORCED *Married*

6. DATE OF BIRTH

Aug. 4 1877
(Month) (Day) (Year)

7. AGE

36 yrs. *6* mos. *10* ds.

IF LESS than 1 day
how many hrs. or
..... mins.?

8. OCCUPATION

(a) Trade, profession or particular kind of work

(b) General nature of industry, business, or establishment in which employed (or employer)

House wife

9. BIRTHPLACE

(State or Country)

Idaho.

10. NAME OF FATHER

E. D. Brackenberry

11. BIRTHPLACE OF FATHER

(State or Country)

Utah

12. MAIDEN NAME OF MOTHER

Tillie Burratt

13. BIRTHPLACE OF MOTHER

(State or Country)

Iowa

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

John Turfee

(Address)

Tiler, Ida.

15.

Filed

191

A. A. Newberry

Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH

Nov. 14 1913
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from *Nov. 7 1913* to *Nov 14 1913*

that I last saw her alive on *Nov 13 1913*

and that death occurred on the date stated above, at *3:30* P. M.

The CAUSE OF DEATH* was as follows:

Acute Nephritis
uraemia

(Duration) yrs. mos. ds.

Contributory
(Secondary)

(Duration) yrs. mos. ds.

(Signed)

A. A. Newberry M. D.

19

(Address)

Tiler, Ida

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place

of death. yrs. mos. days.

In the

State. yrs. mos. days.

Where was disease contracted if not at place of death?

Former or

usual residence.

19. PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

*Tiler**Nov. 15 1913*

20. UNDERTAKER

ADDRESS

*J. J. Groseman**Twins Falls*

-SUPPLEMENTARY DEATH CERTIFICATE-

(Please reply on this sheet to
the registrar of Vital Statistics)

Death Certificate No. 12

Name Tillah Durfee

Date of Death Nov. 14, 1913

Cause of Death Acute Nephritis

Contributory Cause of death _____

(Sign here) A A Newberry M.D.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Form V. S. No. 5. 12½ M. 7-24-11

CERTIFICATE OF DEATH

1. PLACE OF DEATH.

County of Satah

City of _____

Registration District No. _____

Primary Registration District No. 1011

(No. _____, _____ St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

Oscar C Thompson

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

File No. 644Registered No. 124

If death occurred in a hospital, institution or camp give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX

male

4. COLOR OR RACE

White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED.

married
(Write the word.)

6. DATE OF BIRTH

Mar 26 1953
(Month) (Day) (Year)

7. AGE

58 yrs. 8 mos. 5 ds.

IF LESS than 1 day
how many hrs. or
..... min?

8. OCCUPATION

(a) Trade, profession or particular kind of work.

Farmer

(b) General nature of industry business or establishment in which employed (or employer)

9. BIRTHPLACE

(State or Country)

New York

10. NAME OF FATHER

not known

11. BIRTHPLACE OF FATHER

(State or Country)

not known

12. MAIDEN NAME OF MOTHER

not known

13. BIRTHPLACE OF MOTHER

(State or Country)

not known

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

(Address)

Mrs Oscar C Thompson
Harvard Idaho

15.

Filed

Dec 3 1913

J. F. Roe
Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH

December 1 1913
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from

Sept 2 1913, to 1913

that I last saw him alive on Nov 24 1913and that death occurred on the date stated above, at 11 a. m.

The CAUSE OF DEATH* was as follows:

Myocardial Degeneration
Heart Disease

(Duration) unknown mos. ds.

Contributory

(Secondary)

(Duration) yrs. mos. ds.

(Signed)

M. L. Over M. D.
Dec 3 1913 (Address) Princeton Idaho

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place

In the

of death yrs. mos. ds. State yrs. mos. ds.

Where was disease contracted,

If not at place of death?

Former or

usual residence.

19. PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

Mendocino County Dec 3 1913

20. UNDERTAKER

ADDRESS

E. C. Culleray Palouse

-SUPPLEMENTARY DEATH CERTIFICATE-

(Please reply on this sheet to
the registrar of Vital Statistics)

Death Certificate No.

Name..... Oscar C. Thompson.....

Date of Death..... December 1st, 1913.....

Cause of Death..... *Heart Regurgitation*.....

Contributory Cause of death..... *Valvular Weakness*.....

(Sign here)..... *Subcott* M.D.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Form V. S. No. 5 20M.1-16-12

CERTIFICATE OF DEATH

 State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH.

 County of Jerome
City of Butte
Registration District No. 98Primary Registration District No. 2176

(No. _____, St.)

File No. 6450Registered No. 21

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Anna Elizabeth Lawder

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX

4. COLOR OR RACE

5. SINGLE, MARRIED, WIDOWED OR DIVORCED.

 7 W
(Write the word.)

6. DATE OF BIRTH

Mar 20 1899
(Month) (Day) (Year)

7. AGE

16 yrs. 6 mos. 1 ds.
IF LESS than 1 day
how many _____ hrs. or
_____ mins.

8. OCCUPATION

 (a) Trade, profession or particular kind of work
(b) General nature of industry, business, or establishment in which employed (or employer)
Genl.

9. BIRTHPLACE

(State or Country)

Idaho.

10. NAME OF FATHER

R. T. Lawder

11. BIRTHPLACE OF FATHER

(State or Country)

Va.

12. MAIDEN NAME OF MOTHER

Anna Anderson

13. BIRTHPLACE OF MOTHER

(State or Country)

Sweden

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

R. T. Lawder

(Address)

Forney RFD. 7

15.

Filed

Dec 10 1913 Ray St. Hille

Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH

Sept 21 1913
(Month) (Day) (Year)

 17. I HEREBY CERTIFY, That I attended deceased from Apr 18 1913, to Sept 21 1913, that I last saw h. er alive on Sept 1 1913, and that death occurred on the date stated above, at 34 M.

The CAUSE OF DEATH* was as follows:

Endocarditis.
mitral Regurgitation.
(Duration) _____ yrs. _____ mos. _____ ds.
Contributory
(Secondary)

(Duration) _____ yrs. _____ mos. _____ ds.

(Signed)

Ray St. Hille M. D.
Seco 1913 (Address) and Dr. Egley.

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death _____ yrs. _____ mos. _____ days. In the State _____ yrs. _____ mos. _____ days.

Where was disease contracted if not at place of death?

Former or usual residence.

19. PLACE OF BURIAL OR REMOVAL

Little Butte Cemetery Sept 23 1913

20. UNDERTAKER

M. G. Eckert Sons Rigley, Ida.

DATE OF BURIAL

Sept 23 1913

ADDRESS

Rigley, Ida.

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Form V. S. No. 5 20M.1-16-12

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH.
County of Shoshone
City of Wallace

Registration District No. 70
Primary Registration District No. 6011
(No. _____, St.)

File No. 6453
Registered No. 87

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Nellie Clark Sheppard

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX Female 4. COLOR OR RACE white 5. SINGLE, MARRIED, WIDOWED OR DIVORCED. married
(Write the word.)

6. DATE OF BIRTH _____
(Month) (Day) (Year)

7. AGE 36 yrs. _____ mos. _____ ds.
IF LESS than 1 day how many _____ hrs. or _____ mins.?

8. OCCUPATION
(a) Trade, profession or particular kind of work housewife
(b) General nature of industry, business, or establishment in which employed (or employer)

9. BIRTHPLACE
(State or Country) Kansas

10. NAME OF FATHER Jas. Clark

11. BIRTHPLACE OF FATHER
(State or Country) unknown

12. MAIDEN NAME OF MOTHER Agnes M. Warwick

13. BIRTHPLACE OF MOTHER
(State or Country) unknown

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) A. N. Shepard
(Address) Spokane Wash.

15. Filed Nov 4 1913 H. L. Simpson
Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH Nov 3 1913
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from Nov 3 1913, to Nov 3 1913, that I last saw her alive on Nov 3 1913, and that death occurred on the date stated above, at 4:20 P.M.

The CAUSE OF DEATH* was as follows:

Acute Embolism

(Duration) 30-45 mins yrs. _____ mos. _____ ds.

Contributory
(Secondary)

(Duration) _____ yrs. _____ mos. _____ ds.

(Signed) D. Mowery A. P.
Nov 4 1913 (Address) Wallace Ida

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death _____ yrs. _____ mos. _____ days. In the State _____ yrs. _____ mos. _____ days.

Where was disease contracted if not at place of death?

Former or usual residence.

19. PLACE OF BURIAL OR REMOVAL Spokane DATE OF BURIAL Nov 5 1913

20. UNDERTAKER Ward Undertaking ADDRESS Wallace Ida

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Form V. S. No. 5 20M.1-16-12

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH. Registration District No. 70
County of Shoshone Primary Registration District No. 1011-
City of Ruske (No. _____ St.)

File No. 6454

Registered No. 87

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Lore Sullivan

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX male 4. COLOR OR RACE white 5. SINGLE, MARRIED, WIDOWED OR DIVORCED. single
(Write the word.)

6. DATE OF BIRTH _____
(Month) (Day) (Year)

7. AGE 42 yrs. _____ mos. _____ ds.
IF LESS than 1 day how many _____ hrs. or _____ mins.?

8. OCCUPATION
(a) Trade, profession or particular kind of work beamster
(b) General nature of industry business, or establishment in which employed (or employer) _____

9. BIRTHPLACE
(State or Country) Missouri

10. NAME OF FATHER John Sullivan

11. BIRTHPLACE OF FATHER Kentucky
(State or Country)

12. MAIDEN NAME OF MOTHER Mary Summers

13. BIRTHPLACE OF MOTHER Tenn
(State or Country)

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Mr. H. E. Kerr

(Address) 61506 Washington St

15. Nov 5 - Spokane Wash.
Filed Nov 5 - 1913 Spokane Wash.

Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH Nov 3 1913
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from Nov 3 1913, to Nov 3 1913
that I last saw him alive on Nov 3 1913,
and that death occurred on the date stated above, at 114 M.

The CAUSE OF DEATH was as follows:
Acute Alcoholism

(Duration) Few mins ds.

Contributory (Secondary)

(Duration) _____ yrs. _____ mos. _____ ds.
(Signed) DR. Mowery
Nov 13 1913 (Address) Wallace Ida

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death _____ yrs. _____ mos. _____ days. In the State _____ yrs. _____ mos. _____ days.

Where was disease contracted if not at place of death? _____

Former or usual residence _____

19. PLACE OF BURIAL OR REMOVAL Dayton Wash DATE OF BURIAL Nov 5 1913

20. UNDERTAKER Hard Underdeking Co ADDRESS Wallace

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Form V. S. No. 5 20M.1-16-12

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics
File No. 6455

1. PLACE OF DEATH.

Registration District No. 70

County of Shoshone

Primary Registration District No. 1011

City of Wallace

(No. Providence Hospital St.)

Registered No. 85

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

Michael J. Leahy

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX

Male

4. COLOR OR RACE

White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED.

Married

(Write the word.)

6. DATE OF BIRTH

(Month)

(Day)

(Year)

1875

7. AGE

38

yrs. mos. ds.

IF LESS than 1 day
how many hrs. or
mins.?

8. OCCUPATION

(a) Trade, profession or
particular kind of work

blacksmith

(b) General nature of industry
business, or establishment in
which employed (or employer)

9. BIRTHPLACE

(State or Country)

British Columbia

10. NAME OF FATHER

not given

11. BIRTHPLACE OF FATHER

(State or Country)

12. MAIDEN NAME OF MOTHER

13. BIRTHPLACE OF MOTHER

(State or Country)

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

Basil Rizzonelli

(Address)

Wallace Idaho

15.

Filed

Nov 5

1913

St. Leo Dingley

Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH

Nov

2

1913

(Month)

(Day)

(Year)

17. I HEREBY CERTIFY, That I attended deceased from
Oct 15 1913 to Nov 2 1913

that I last saw him alive on Nov 1 1913

and that death occurred on the date stated above, at 12:45 P.M.

The CAUSE OF DEATH* was as follows:

Alcoholism

(Duration)

yrs. mos. ds.

Contributory (Secondary)

Simple fracture humerus.

(Duration)

yrs. mos. ds.

(Signed)

Nov 3 1913 (Address) Wallace Idaho

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death. yrs. mos. ds. In the State. yrs. mos. ds.

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

Wallace Id

Nov 5 1913

20. UNDERTAKER

ADDRESS

Rue & Worsley

Wallace

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Form V. S. No. 5 20M.1-16-12

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH.

Registration District No. 70County of ShoshonePrimary Registration District No. 1011City of Wallace(No. Hope, Hospital _____ St.)File No. 6456Registered No. 86

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Sadie A. Gault

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX

female

4. COLOR OR RACE

white

5. SINGLE, MARRIED, WIDOWED OR DIVORCED.

married
(Write the word.)

6. DATE OF BIRTH

(Month)

(Day)

(Year)

7. AGE

50 yrs. -- mos. -- ds.IF LESS than 1 day
how many hrs. or
..... mins.?

8. OCCUPATION

(a) Trade, profession or particular kind of work

none

(b) General nature of industry, business, or establishment in which employed (or employer)

9. BIRTHPLACE

(State or Country)

Canada,

10. NAME OF FATHER

not given

11. BIRTHPLACE OF FATHER

(State or Country)

"

"

12. MAIDEN NAME OF MOTHER

"

"

13. BIRTHPLACE OF MOTHER

(State or Country)

"

"

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

(Address)

Wallace, Idaho.

15.

Filed

Nov. 21913

Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH

(Month)

(Day)

1913
(Year)

17. I HEREBY CERTIFY, That I attended deceased from

October 30th, 1913, to October 31, 1913,that I last saw him alive on October 30, 1913,and that death occurred on the date stated above, at 10 P. M.

The CAUSE OF DEATH* was as follows:

Chronic Pulmonary Tuberculosis

(Duration) yrs. mos. ds.

Contributory
(Secondary)

(Duration) yrs. mos. ds.

(Signed)

11/1 1913

(Address)

Wallace, Idaho

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death yrs. mos. days. In the State yrs. mos. days.

Where was disease contracted if not at place of death?

Former or usual residence

Wallace, Idaho

19. PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

Wallace, Idaho.11/2 1913

20. UNDERTAKER

ADDRESS

Bruce & Wooten Wallace, Id.

Form V. S. No. 5 20M.1-16-12

CERTIFICATE OF DEATH

 State of Idaho
 BOARD OF HEALTH
 Bureau of Vital Statistics

1. PLACE OF DEATH.

Registration District No. 70County of ShoshonePrimary Registration District No. 1011City of Wallace

(No. _____, _____ St.)

File No. 645Registered No. 89

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Alex Swanson

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX

4. COLOR OR RACE

5. SINGLE, MARRIED, WIDOWED OR DIVORCED.

malewhitesingle
(Write the word.)

6. DATE OF BIRTH

(Month)

(Day)

(Year)

7. AGE

57

yrs.

mos.

ds.

 IF LESS than 1 day
 how many _____ hrs. or
 _____ mins.?

8. OCCUPATION

(a) Trade, profession or particular kind of work

miner

(b) General nature of industry business, or establishment in which employed (or employer)

9. BIRTHPLACE

(State or Country)

unknown

10. NAME OF FATHER

11. BIRTHPLACE OF FATHER

(State or Country)

12. MAIDEN NAME OF MOTHER

13. BIRTHPLACE OF MOTHER

(State or Country)

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) H. Thompson(Address) Wallace Idaho

15.

Filed

Nov. 4,1913H. Leo Dingle

Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH

Nov. 1st

(Month)

(Day)

1913

(Year)

17. I HEREBY CERTIFY, That I attended deceased from

191..., to191...,

that I last saw him alive on

191...,

and that death occurred on the date stated above, at

M.

The CAUSE OF DEATH* was as follows:

Exposure =
Pneumonia

(Duration)

yrs.

mos.

ds.

Contributory
(Secondary)

(Duration)

yrs.

mos.

ds.

(Signed)

H. Leo Dingle

M. D.

Nov. 1913 (Address)

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place

of death

In the

State

Where was disease contracted if not at place of death?

Former or usual residence.

19. PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

Wallace IdaNov 71913

20. UNDERTAKER

ADDRESS

Ward Undertaking Co WallaceIda

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Form V. S. No. 5 20M.1-16-12

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH
County of Shoshone
City of Wallace
Registration District No.
Primary Registration District No.
(No. Crowder Hospital St.)
If death occurs away from usual residence, give facts called for under special information. 2. FULL NAME Fred Smith

File No. 645
Registered No. 88
If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX Male 4. COLOR OR RACE White 5. SINGLE, MARRIED, WIDOWED OR DIVORCED. Single
(Write the word.)

6. DATE OF BIRTH
(Month) (Day) (Year)

7. AGE 35 yrs. - mos. - ds.
IF LESS than 1 day
how many hrs. or mins.?

8. OCCUPATION
(a) Trade, profession or particular kind of work Teamster
(b) General nature of industry business, or establishment in which employed (or employer)

9. BIRTHPLACE
(State or Country) Wisconsin

10. NAME OF FATHER Samuel Smith

11. BIRTHPLACE OF FATHER
(State or Country) not given

12. MAIDEN NAME OF MOTHER "

13. BIRTHPLACE OF MOTHER
(State or Country) "

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Geo K Garrett
(Address) Wallace

15. Filed Nov 8 1913 H. L. Dingle
Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH
Nov 5 1913
(Month) (Day) (Year)

I HEREBY CERTIFY, That I attended deceased from Oct 31 1913, to Nov 5 1913, that I last saw him alive on Nov 4 1913, and that death occurred on the date stated above, at 6²⁰ M.

The CAUSE OF DEATH* was as follows:

Lobar Pneumonia
(Duration) yrs. mos. 3 ds.

Contributory (Secondary)
(Duration) yrs. mos. ds.
(Signed) Dr Mowery M. D.
Nov 8 1913 (Address) Wallace Ida

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death yrs. mos. days. In the State yrs. mos. days.

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL Frederick, Wisconsin DATE OF BURIAL Nov 9 1913

20. UNDERTAKER Bruce & Moustall ADDRESS Wallace

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Form V. S. No. 5 20M.1-16-12

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH. Registration District No. 70
County of Shoshone Primary Registration District No. 1011-
City of Wallace (No. _____ St.)
If death occurs away from usual residence, give facts called for under special information. 2. FULL NAME Victor Schabomman

File No. 646
Registered No. 91
If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX male 4. COLOR OR RACE white 5. SINGLE, MARRIED, WIDOWED OR DIVORCED. Single
(Write the word.)

6. DATE OF BIRTH _____
(Month) (Day) (Year)

7. AGE 50 yrs. _____ mos. _____ ds.
IF LESS than 1 day how many _____ hrs. or _____ mins.?

8. OCCUPATION
(a) Trade, profession or particular kind of work laborer
(b) General nature of industry, business, or establishment in which employed (or employer) _____

9. BIRTHPLACE
(State or Country) unknown

10. NAME OF FATHER _____

11. BIRTHPLACE OF FATHER
(State or Country) _____

12. MAIDEN NAME OF MOTHER _____

13. BIRTHPLACE OF MOTHER
(State or Country) _____

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) H. Thompson
(Address) Wallace Ida.

15. Filed Nov 2 1913 H. Lesinsky
Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH Nov 10 1913
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from Nov 7 1913, to Nov 10 1913
that I last saw him alive on Nov 10 1913
and that death occurred on the date stated above, at 6 P.M.

The CAUSE OF DEATH was as follows:
Acute Alcoholism

(Duration) _____ yrs. 3 ds.

Contributory (Secondary) _____
(Duration) _____ yrs. _____ mos. _____ ds.
(Signed) Dr. Mowery M. D.
Nov 12 1913 (Address) Wallace Ida.

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death _____ yrs. _____ mos. _____ days. In the State _____ yrs. _____ mos. _____ days.
Where was disease contracted if not at place of death? _____
Former or usual residence _____

19. PLACE OF BURIAL OR REMOVAL Wallace Idaho DATE OF BURIAL Nov 12 1913

20. UNDERTAKER Hardy Undertaking Co ADDRESS Wallace Ida.

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Form V. S. No. 5 20M.1-16-12

CERTIFICATE OF DEATH

State of
BOARD OF
Bureau of Vital

1. PLACE OF DEATH.

Registration District No.

County of Shoshone

Primary Registration District No.

City of Wallace

(No. Providence Hospital St.)

File No. 6461

Registered No. 92

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME John Larson

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX

4. COLOR OR RACE

5. SINGLE, MARRIED, WIDOWED OR DIVORCED.

male

white

married
(Write the word.)

6. DATE OF BIRTH

9 17 1913.
(Month) (Day) (Year)

7. AGE

37 yrs. 2 mos. 8 ds.

IF LESS than 1 day
how many hrs. or
mins.?

8. OCCUPATION

(a) Trade, profession or particular kind of work miner
(b) General nature of industry business, or establishment in which employed (or employer)

9. BIRTHPLACE

(State or Country) Sweeden

10. NAME OF FATHER

not given

11. BIRTHPLACE OF FATHER

" "

(State or Country)

12. MAIDEN NAME OF MOTHER

" "

13. BIRTHPLACE OF MOTHER

" "

(State or Country)

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) M. John Larson

(Address) Mace, Idaho.

15.

Filed Nov. 28 1913 F. L. Jones Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH

Nov. 25 1913
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from

1913, to 1913,

that I last saw him alive on Nov. 25 1913

and that death occurred on the date stated above, at

The CAUSE OF DEATH* was as follows:

Shock from severe trauma from accident

(Duration) yrs. mos. 9
Contributed to (Secondary) Severe trauma from gunshot & thigh

(Signed) Dr. Mowbray M. P. 11/27/13 (Address) Wallace, Idaho

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death yrs. mos. days. In the State yrs. mos. days.

Where was disease contracted if not at place of death?

Former or usual residence.

19. PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

Wallace, Idaho.

Nov. 29 1913

20. UNDERTAKER

ADDRESS

Bruce G. Wooten Wallace

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Form V. S. No. 5. 12½ M. 7-24-11

NO. 12-129.
CERTIFICATE OF DEATH

1. PLACE OF DEATH. Registration District No. 78
County of Banner Primary Registration District No. 2153
City of Sandpoint (No. _____, _____ St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Lucinda Shea

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

File No. 6462

Registered No. 450

If death occurred in a hospital, institution or camp give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX 4. COLOR OR RACE 5. SINGLE, MARRIED, WIDOWED OR DIVORCED.

Female White Married
(Write the word.)

6. DATE OF BIRTH

Apr 1843
(Month) (Day) (Year)

7. AGE

70 yrs. _____ mos. _____ ds.
IF LESS than 1 day how many _____ hrs. or _____ min?

8. OCCUPATION

(a) Trade, profession or particular kind of work.
(b) General nature of industry business or establishment in which employed (or employer)

Housewife

9. BIRTHPLACE

(State or Country)

Maine.

10. NAME OF FATHER

Unknown

11. BIRTHPLACE OF FATHER

(State or Country)

Id.

12. MAIDEN NAME OF MOTHER

Do

13. BIRTHPLACE OF MOTHER

(State or Country)

Id.

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

M. Shea
(Address) Sandpoint 1182 4th

15.

Filed Nov 28 1913 W. M. McKinnon
Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH

Oct 31 1913
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from Spt 27 1913, to Oct 31 1913

that I last saw her alive on Oct 31 1913
and that death occurred on the date stated above, at 11 P. M.

The CAUSE OF DEATH* was as follows:

Cerebral Haemorrhage

_____ (Duration) _____ yrs. _____ mos. _____ ds.

Contributory
(Secondary)

_____ (Duration) _____ yrs. _____ mos. _____ ds.

(Signed) M. McKinnon M. D.
Nov 2 1913 (Address) Sandpoint

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place _____ In the _____
of death _____ yrs. _____ mos. _____ ds. State _____ yrs. _____ mos. _____ ds.
Where was disease contracted,
If not at place of death? _____
Former or
usual residence _____

19. PLACE OF BURIAL OR REMOVAL DATE OF BURIAL

Schuyler, Nebr. 11/2 1913

20. UNDERTAKER ADDRESS

Ernst Brown SP.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Form V. S. No. 5. 12½ M. 7-24-11

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics
File No. 6463
Registered No. 449

1. PLACE OF DEATH. Registration District No. 78
County of Bonner Primary Registration District No. 2153
City of Sandpoint (No. St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

K. Kobayashi

If death occurred in a hospital, institution or camp give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX Male 4. COLOR OR RACE yellow 5. SINGLE, MARRIED, WIDOWED OR DIVORCED Single
(Write the word.)

6. DATE OF BIRTH 1 (Month) (Day) (Year)

7. AGE 38 yrs. mos. ds. IF LESS than 1 day how many hrs. or min?

8. OCCUPATION (a) Trade, profession or particular kind of work. Labor on S.D. R.R. Section.
(b) General nature of industry business or establishment in which employed (or employer)

9. BIRTHPLACE (State or Country) Japan

10. NAME OF FATHER Unknown

11. BIRTHPLACE OF FATHER (State or Country) "

12. MAIDEN NAME OF MOTHER "

13. BIRTHPLACE OF MOTHER (State or Country) "

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Dr. Knapp
(Address) Sp. Ida

15. m. McKinnon

Filed Oct. 11, 1913

Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH Oct. 11, 1913
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from 191 to 191 that I last saw h. alive on 191 and that death occurred on the date stated above, at M.

The CAUSE OF DEATH* was as follows:

Struck by train on Street 12012 east town

(Duration) yrs. mos. ds.

Contributory (Secondary)

(Duration) yrs. mos. ds.
(Signed) W. H. H. 19 (Address) Hope

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place In the of death yrs. mos. ds. State. yrs. mos. ds. Where was disease contracted, If not at place of death? Former or usual residence.

19. PLACE OF BURIAL OR REMOVAL DATE OF BURIAL

Spokane, Id. 10/12 1913

20. UNDERTAKER ADDRESS

C. M. Brower Sandpoint.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Form V. S. No. 5. 12½ M. 7-24-11

CERTIFICATE OF DEATH

State of Idaho

1. PLACE OF DEATH.
County of Banner
City of Merton

Registration District No. 782
Primary Registration District No. 2155
(No. _____, St.)

BOARD OF HEALTH
Bureau of Vital Statistics
File No. 6461
Registered No. 451

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

Phil Brockway

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX Male 4. COLOR OR RACE White 5. SINGLE, MARRIED, WIDOWED OR DIVORCED. Married
(Write the word.)

6. DATE OF BIRTH June 4 1843
(Month) (Day) (Year)

7. AGE 70 yrs. _____ mos. _____ ds. IF LESS than 1 day how many _____ hrs. or _____ min?

8. OCCUPATION

(a) Trade, profession or particular kind of work
(b) General nature of industry business or establishment in which employed (or employer)

Farmer.
Retired.

9. BIRTHPLACE

(State or Country)

Ill.

10. NAME OF FATHER

Deceased.

11. BIRTHPLACE OF FATHER

(State or Country)

U. S.

12. MAIDEN NAME OF MOTHER

Unknown

13. BIRTHPLACE OF MOTHER

(State or Country)

U. S.

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

(Address)

J. M. Dawson

15.

Filed Dec 1 1913

Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH

Nov 12 1913
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from Nov. 9 1913, to Nov 12 1913

that I last saw him alive on Nov 9 1913

and that death occurred on the date stated above, at 5 P. M.

The CAUSE OF DEATH* was as follows:

Paralysed.

..... (Duration) 3 yrs. mos. ds.

Contributory
(Secondary)

..... (Duration) _____ yrs. mos. ds.

(Signed) O. J. Page M. D.
Nov 21 1913 (Address) Handpoint, Ida.

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place _____ In the _____
of death yrs. mos. ds. State yrs. mos. ds.

Where was disease contracted,

If not at place of death?

Former or

usual residence.

19. PLACE OF BURIAL OR REMOVAL DATE OF BURIAL

Peterson Spur 11/13 1913

20. UNDERTAKER ADDRESS

E. M. Braver S. P.

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFAADING INK—THIS IS A PERMANENT RECORD. N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

1913

No. 2-119.

Form V. S. No. 5. 12½ M. 7-24-11

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH. Registration District No. 78
County of Bonner Primary Registration District No. 2153
City of Sandpoint (No. _____, _____ St.)

File No. 646
Registered No. 252

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Mrs Minnie Kingen Nelson

If death occurred in a hospital, institution or camp give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX Female 4. COLOR OR RACE White 5. SINGLE, MARRIED, WIDOWED OR DIVORCED. Married
(Write the word.)

6. DATE OF BIRTH June 18 1851
(Month) (Day) (Year)

7. AGE 62 yrs. 3 mos. 20 ds. IF LESS than 1 day
how many _____ hrs. or _____ min?

8. OCCUPATION
(a) Trade, profession or particular kind of work. Housewife & Trained Nurse
(b) General nature of industry business or establishment in which employed (or employer)

9. BIRTHPLACE (State or Country) Denmark

10. NAME OF FATHER Christen Kingen

11. BIRTHPLACE OF FATHER (State or Country) Denmark

12. MAIDEN NAME OF MOTHER Unknown

13. BIRTHPLACE OF MOTHER (State or Country) Denmark

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) N. P. Nelson
(Address) Sandpoint

15. Filed 10/2 1913 M. M. Nelson
Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH Oct 8 1913
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from Oct 6 1913 to Oct 8 1913
that I last saw her alive on Oct 8 1913
and that death occurred on the date stated above, at 1:30 P. M.

The CAUSE OF DEATH* was as follows:
uraemia

(Duration) _____ yrs. _____ mos. 2 1/2 ds.

Contributory (Secondary) Acute nephritis

(Duration) _____ yrs. _____ mos. _____ ds.
(Signed) E. M. Patterson M. D.
Oct 9 1913 (Address) Sandpoint Ida

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death _____ yrs. _____ mos. _____ ds. In the State _____ yrs. _____ mos. _____ ds.
Where was disease contracted, _____
If not at place of death? _____
Former or usual residence _____

19. PLACE OF BURIAL OR REMOVAL Sandpoint Idaho DATE OF BURIAL 10/7 1913

20. UNDERTAKER E. M. Brown ADDRESS Sandpoint

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Form V. S. No. 5. 12½ M. 7-24-11

No. 3-120.
CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics
File No. 6469
Registered No. 453

1. PLACE OF DEATH. Registration District No. 78 Page
County of Bonner Primary Registration District No. 2155
City of Sandpoint (No. , St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

Duley E. Skaggs

If death occurred in a hospital, institution or camp give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX 4. COLOR OR RACE 5. SINGLE, MARRIED, WIDOWED OR DIVORCED.

male white single (Write the word.)

6. DATE OF BIRTH

(Month) (Day) (Year)

7. AGE

22 yrs. mos. ds.

IF LESS than 1 day
how many hrs. or min?

8. OCCUPATION

(a) Trade, profession or particular kind of work.
(b) General nature of industry business or establishment in which employed (or employer)

Thudman.
Teamster

9. BIRTHPLACE

(State or Country)

Ky.

10. NAME OF FATHER

J. H. Skaggs

11. BIRTHPLACE OF FATHER

(State or Country)

Ky.

12. MAIDEN NAME OF MOTHER

Laura Watkins

13. BIRTHPLACE OF MOTHER

(State or Country)

Ky.

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

D. M. Skaggs

(Address)

Sandpoint Ida.

15.

Filed

10/11

1913

W. McKinnis

Local Registrar

MEDICAL CERTIFICATE OF DEATH. Page

16. DATE OF DEATH

Oct 9 1913
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from

Sept 23, 1913, to Oct 9, 1913

that I last saw him alive on Oct 9, 1913

and that death occurred on the date stated above, at 11:30 P.M.

The CAUSE OF DEATH* was as follows:

Pertussis due to perforation of intestines complicated by shock
(Duration) yrs. mos. 13 ds.

Contributory
(Secondary)

(Duration) yrs. mos. ds.

(Signed)

D. J. Page M. D.
Oct 9, 1913 (Address) Sandpoint

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place In the
of death yrs. mos. ds. State yrs. mos. ds.

Where was disease contracted,

If not at place of death?

Former or

usual residence.

19. PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

Sandpoint Ida.

10/11 1913

20. UNDERTAKER

ADDRESS

Emm Brown

S.P.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Form V. S. No. 5. 12½ M. 7-24-11		No. 4- 121.		CERTIFICATE OF DEATH		State of Idaho BOARD OF HEALTH Bureau of Vital Statistics	
1. PLACE OF DEATH.		Registration District No. 78		mer		File No. 646	
County of Bonner		Primary Registration District No. 254				Registered No. 457	
City of Sandpoint (No. , St.)						If death occurred in a hospital, institution or camp give its NAME instead of street and number.	
If death occurs away from usual residence, give facts called for under special information.		2. FULL NAME Edward McWhorter.					
PERSONAL AND STATISTICAL PARTICULARS				MEDICAL CERTIFICATE OF DEATH.			
3. SEX male		4. COLOR OR RACE white		5. SINGLE, MARRIED, WIDOWED OR DIVORCED. Married (Write the word.)		16. DATE OF DEATH Oct 10 1913 (Month) (Day) (Year)	
6. DATE OF BIRTH April 11 1836 (Month) (Day) (Year)		7. AGE 77 yrs. 5 mos. 29 ds. IF LESS than 1 day how many hrs. or min?		17. I HEREBY CERTIFY, That I attended deceased from Aug 1st 1913, to Oct 5 1913 that I last saw him alive on Oct 5 1913 and that death occurred on the date stated above, at 12:49 M. The CAUSE OF DEATH* was as follows: Dephritis			
8. OCCUPATION (a) Trade, profession or particular kind of work. merchant. (b) General nature of industry business or establishment in which employed (or employer) General Country Store		9. BIRTHPLACE (State or Country) N. Y.		Contributory (Secondary) (Duration) yrs. mos. ds. (Signed) M. M. McWhorter M. D. Oct 7 1913 (Address) Sandpoint, ID.			
10. NAME OF FATHER Unknown.		11. BIRTHPLACE OF FATHER Unknown.		*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.			
12. MAIDEN NAME OF MOTHER Unknown.		13. BIRTHPLACE OF MOTHER Unknown.		18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.) At place In the of death yrs. mos. ds. State. yrs. mos. ds. Where was disease contracted, If not at place of death? Former or usual residence.			
14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE (Informant) Orris P. Osborn (Address) Sage, Idaho		15. Filed 10/11 1913 Local Registrar M. M. McWhorter		19. PLACE OF BURIAL OR REMOVAL Sage, Idaho		DATE OF BURIAL Oct 11th 1913	
				20. UNDERTAKER E. M. Brower		ADDRESS Sandpoint.	

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

No. C-125.

mch

Form V. S. No. 5. 12½ M. 7-24-11

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics
File No. 6468
Registered No. 455

1. PLACE OF DEATH. Registration District No. 78
County of Bonner Primary Registration District No. 2155
City of Sandpoint (No. , St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Mary Florence Thelan

If death occurred in a hospital, institution or camp give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX Female 4. COLOR OR RACE White 5. SINGLE, MARRIED, WIDOWED OR DIVORCED. Single
(Write the word.)

6. DATE OF BIRTH Dec. 22 1911
(Month) (Day) (Year)

7. AGE 1 yrs. 9 mos. 21 ds. IF LESS than 1 day how many hrs. or min?

8. OCCUPATION
(a) Trade, profession or particular kind of work. None
(b) General nature of industry business or establishment in which employed (or employer) None

9. BIRTHPLACE Sandpoint Idaho.
(State or Country)

10. NAME OF FATHER E. H. Thelan

11. BIRTHPLACE OF FATHER This
(State or Country)

12. MAIDEN NAME OF MOTHER Edith Hosmer.

13. BIRTHPLACE OF MOTHER Mich.
(State or Country)

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) E. Thelan.
(Address) Sandpoint.

15. Filed 07/14 1913 M. M. Kinn Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH Oct 13 1913
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from Oct 1912, to Oct 13 1913
that I last saw her alive on Oct-13 1913
and that death occurred on the date stated above, at S.P.M.

The CAUSE OF DEATH* was as follows:
Tuberculosis of mediastinal glands —
Abscess of mediastinal space.

(Duration) yrs. mos. ds.
Contributory (Secondary) Tuberculosis

(Duration) yrs. mos. ds.
(Signed) M. M. Kinn M. D.
Dec 74 1913 (Address) Sandpoint

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place In the
of death. yrs. mos. ds. State. yrs. mos. ds.
Where was disease contracted,
If not at place of death?
Former or usual residence.

19. PLACE OF BURIAL OR REMOVAL DATE OF BURIAL
Lakerien Cem. S.P. 10/15 1913
20. UNDERTAKER ADDRESS
E. M. Branner S.P.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Form V. S. No. 5. 12½ M. 7-24-11

No. 7-124

CERTIFICATE OF DEATH

State of Idaho

BOARD OF HEALTH
Bureau of Vital Statistics

File No. 6469

Registered No. #57

1. PLACE OF DEATH. Registration District No. 78
County of Bonner Primary Registration District No. 9155
City of Sandpoint (No. _____ St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

Filika Hilika

If death occurred in a hospital, institution or camp give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX Male 4. COLOR OR RACE White 5. SINGLE, MARRIED, WIDOWED OR DIVORCED. Single
(Write the word.)

6. DATE OF BIRTH unknown
(Month) (Day) (Year)

7. AGE 35 yrs. 0 mos. 0 ds. IF LESS than 1 day how many hrs. or min?

8. OCCUPATION
(a) Trade, profession or particular kind of work. Common Laborer
(b) General nature of industry business or establishment in which employed (or employer) Hands

9. BIRTHPLACE (State or Country) Finland

10. NAME OF FATHER Unknown

11. BIRTHPLACE OF FATHER (State or Country) do

12. MAIDEN NAME OF MOTHER do

13. BIRTHPLACE OF MOTHER (State or Country) do

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Th. M. Knapp
(Address) Super Ida

15. 10/15 1913 Th. M. Knapp
Filed Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH Oct 14 1913
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from 1911, to 1913

that I last saw h. alive on 1913

and that death occurred on the date stated above, at 11 M.

The CAUSE OF DEATH* was as follows:

Suicide. Hanging

(Duration) yrs. mos. ds.

Contributory (Secondary)

(Duration) yrs. mos. ds.

(Signed) Th. M. Knapp M. D. 10-15-1913 (Address) Super Ida

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place In the
of death. yrs. mos. ds. State. yrs. mos. ds.

Where was disease contracted,

If not at place of death?

Former or usual residence.

19. PLACE OF BURIAL OR REMOVAL DATE OF BURIAL

Sandpoint Ida 11/7 1913

20. UNDERTAKER ADDRESS

E. M. Brown Sandpoint

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Form V. S. No. 5. 12½M.7-24-11

No. 8-135

CERTIFICATE OF DEATH

78

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH. Registration District No. 2153

County of Bonner Primary Registration District No. 2153

City of Creston (No. St.)

File No. 6411

Registered No. 457

2. FULL NAME George H. Hood.

if death occurs away from usual residence, give facts called for under special information.

if death occurred in a hospital, institution or camp give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX Male

4. COLOR OR RACE White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED. Widowed (Write the word.)

6. DATE OF BIRTH 67 (Month) 1 (Day) 1913 (Year)

7. AGE 67 yrs. — mos. — ds. IF LESS than 1 day how many hrs. or min?

8. OCCUPATION (a) Trade, profession or particular kind of work. Farmer (b) General nature of industry business or establishment in which employed (or employer). Retired.

9. BIRTHPLACE (State or Country) N.Y.

10. NAME OF FATHER Unknown.

11. BIRTHPLACE OF FATHER So

12. MAIDEN NAME OF MOTHER So

13. BIRTHPLACE OF MOTHER So

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE (Informant) A. Hood (Address) Creston Idaho

15. Filed 10/24 1913 Local Registrar Wm. McKinnon

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH Oct 23 1913 (Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased as coroner Bonner Co that I last saw h alive on Oct 24, 1913 and that death occurred on the date stated above, at M.

The CAUSE OF DEATH* was as follows:
Valvular Heart Disease (Probably Mitral Stenosis). (Duration) Insurrection

Contributory (Secondary) (Duration) yrs. mos. ds. (Signed) Wm. McKinnon M. D. 10-24 1913 (Address) Hope Idaho

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.) At place In the of death yrs. mos. ds. State yrs. mos. ds. Where was disease contracted, If not at place of death? Former or usual residence.

19. PLACE OF BURIAL OR REMOVAL DATE OF BURIAL 10/24 1913

20. UNDERTAKER ADDRESS

Howard City Mich. E. M. Brown S.P.

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Form V. S. No. 5 20M.1-16-12 #126		9-126		State of Idaho BOARD OF HEALTH Bureau of Vital Statistics	
1. PLACE OF DEATH.		Registration District No. 78		File No. 6471	
County of <u>Banner</u>		Primary Registration District No. 2155		Registered No. 458	
City of <u>Sandpoint</u>		(No. , St.)		If death occurred in a hospital, institution or camp, give its NAME instead of street and number.	
If death occurs away from usual residence, give facts called for under special information.		2. FULL NAME <u>Clarence F. Matthews</u>			
PERSONAL AND STATISTICAL PARTICULARS					
3. SEX	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED OR DIVORCED.			
<u>Male</u>	<u>White</u>	<u>Married</u>			
6. DATE OF BIRTH					
<u>Sept 29 1886</u> (Month) (Day) (Year)					
7. AGE		IF LESS than 1 day how many hrs. or mins.?			
<u>26</u> yrs. <u>25</u> mos. <u>25</u> ds.					
8. OCCUPATION					
(a) Trade, profession or particular kind of work <u>Barber</u>					
(b) General nature of industry business, or establishment in which employed (or employer)					
9. BIRTHPLACE					
(State or Country) <u>Mo.</u>					
10. NAME OF FATHER					
<u>John H. Matthews</u>					
11. BIRTHPLACE OF FATHER					
(State or Country) <u>Unknown</u>					
12. MAIDEN NAME OF MOTHER					
<u>Do</u>					
13. BIRTHPLACE OF MOTHER					
(State or Country) <u>Do</u>					
14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE					
(Informant) <u>A. S. Matthews</u>					
(Address) <u>65277 Lincoln & Spokane</u>					
15.					
Filed <u>10/25</u> 191 <u>3</u> <u>Wm. H. H. H. H. H.</u> Local Registrar					
MEDICAL CERTIFICATE OF DEATH.					
16. DATE OF DEATH					
<u>Oct 24</u> 191 <u>3</u> (Month) (Day) (Year)					
17. I HEREBY CERTIFY, That I attended deceased from <u>Oct 24</u> 191 <u>3</u> , to <u>Oct 24</u> 191 <u>3</u> , that I last saw him alive on <u>Oct 24</u> 191 <u>3</u> , and that death occurred on the date stated above, at <u>10 P. M.</u>					
The CAUSE OF DEATH* was as follows:					
<u>Loss of both legs from being run over by train.</u>					
(Duration) <u>14 hrs.</u> yrs. mos. ds.					
Contributory (Secondary)					
(Duration) yrs. mos. ds.					
(Signed) <u>O. F. P. H. H. H. H. H.</u> M. D.					
191 <u>3</u> (Address) <u>Sandpoint, Ida.</u>					
*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.					
18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)					
At place of death yrs. mos. days. In the State yrs. mos. days.					
Where was disease contracted if not at place of death?					
Former or usual residence.					
19. PLACE OF BURIAL OR REMOVAL					
<u>La Grande, Ore.</u>					
DATE OF BURIAL <u>10/27</u> 191 <u>3</u>					
20. UNDERTAKER					
<u>C. M. Brown</u>					
ADDRESS <u>Sandpoint, Ida.</u>					

WHILE FILLING IN, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Form V. S. No. 5. 12½ M. 7-24-11

No. 10-127

CERTIFICATE OF DEATH

or C.P.S.

1. PLACE OF DEATH.

Registration District No. 78

County of Banner

Primary Registration District No. 2155

City of Sandpoint

(No. _____ St.)

State of Idaho

BOARD OF HEALTH
Bureau of Vital Statistics

File No. 6472

Registered No. 457

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

Robert Henry Emerson

If death occurred in a hospital, institution or camp give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX

male

4. COLOR OR RACE

white

5. SINGLE, MARRIED, WIDOWED OR DIVORCED.

single
(Write the word.)

6. DATE OF BIRTH

July
(Month)

10
(Day)

1883
(Year)

7. AGE

30 yrs. 3 mos. 17 ds.

IF LESS than 1 day
how many.....hrs. or
.....min?

8. OCCUPATION

(a) Trade, profession or particular kind of work.....
(b) General nature of industry business or establishment in which employed (or employer).....

Farmer

9. BIRTHPLACE

(State or Country)

Wis.

10. NAME OF FATHER

Jones. Emerson

11. BIRTHPLACE OF FATHER

(State or Country)

Unknown.

12. MAIDEN NAME OF MOTHER

Mary Jones Cloughton

13. BIRTHPLACE OF MOTHER

(State or Country)

to Ireland.

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

(Address)

R. Emerson
Davenport Wash

15.

Filed 10/29 1913

M. McKinnon
Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH

Oct.
(Month)

27
(Day)

1913
(Year)

17. I HEREBY CERTIFY, That I attended deceased from

Oct 24

1913,

to Oct 27

1913

that I last saw him alive on Oct 27 1913

and that death occurred on the date stated above, at P. M.

The CAUSE OF DEATH* was as follows:

Gunshot wound penetrating
Kidney, liver, mesentery,
and probably buried in muscle
of back.
(Duration)yrs.mos. 3 ds.

Contributory

(Secondary)

(Duration)yrs.mos.ds.

(Signed) C. P. Gracchauer M. D.

10/27 1913 (Address) Sandpoint

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place

In the

of deathyrs.mos.ds. Stateyrs.mos.ds.

Where was disease contracted,

If not at place of death?

Former or

usual residence.

19. PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

Sandpoint, Idaho

10/29 1913

20. UNDERTAKER

ADDRESS

E. M. Brown

S.P.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

No. 11-128

Form V. S. No. 5 20M.1-16-12

CERTIFICATE OF DEATH

1. PLACE OF DEATH.

County of BannerCity of KootenaiRegistration District No. 78Primary Registration District No. 2155

(No. , St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Owen WillardState of Idaho
BOARD OF HEALTH
Bureau of Vital StatisticsFile No. 6473Registered No. 460

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX

male

4. COLOR OR RACE

white

5. SINGLE, MARRIED, WIDOWED OR DIVORCED.

(Write the word.)

6. DATE OF BIRTH

Oct.251913

(Month)

(Day)

(Year)

7. AGE

..... yrs. mos. ds.

IF LESS than 1 day
how many hrs. or
..... mins.?

8. OCCUPATION

- (a) Trade, profession or particular kind of work ✓
- (b) General nature of industry business, or establishment in which employed (or employer) ✓

9. BIRTHPLACE

(State or Country)

Idaho.

10. NAME OF FATHER

Frank Willard

11. BIRTHPLACE OF FATHER

(State or Country)

Mass. U.S.A.

12. MAIDEN NAME OF MOTHER

Mable Cawkes

13. BIRTHPLACE OF MOTHER

(State or Country)

Mich. U.S.A.

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Mother(Address) Kootenai Idaho

15.

Filed

10/291913mmmmmm

Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH

Oct251913

(Month)

(Day)

(Year)

17. I HEREBY CERTIFY, That I attended deceased from

Oct 25.1913,to Oct 25.1913,that I last saw him alive on Oct 25 1913,and that death occurred on the date stated above, at 4 P.M.

The CAUSE OF DEATH* was as follows:

Premature delivery.

(Duration) yrs. mos. ds.

Contributory Period of gestation 6 mo.
(Secondary)

(Duration) yrs. mos. ds.

(Signed) Will H. Potter M. D.10/25 1913 (Address) Kootenai

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death yrs. mos. days. In the State yrs. mos. days.

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

Sandpoint Idaho10/29 1913

20. UNDERTAKER

ADDRESS

Emm BrownSandpoint.

1. PLACE OF DEATH.

Registration District No. 78County of BannerPrimary Registration District No. 2125City of Sandpoint

(No. _____, _____ St.)

File No. 6471Registered No. 261

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

C. L. Laff Shimm

If death occurred in a hospital, institution or camp give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX

Male

4. COLOR OR RACE

White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED.

Single
(Write the word.)

6. DATE OF BIRTH

(Month) (Day) (Year)

7. AGE

70 yrs. _____ mos. _____ ds.IF LESS than 1 day
how many _____ hrs. or
_____ min?

8. OCCUPATION

- (a) Trade, profession or particular kind of work.
-
- (b) General nature of industry business or establishment in which employed (or employer)

Miner
Prospecting

9. BIRTHPLACE

(State or Country)

Unknown

10. NAME OF FATHER

Lo

11. BIRTHPLACE OF FATHER

(State or Country)

Lo

12. MAIDEN NAME OF MOTHER

Lo

13. BIRTHPLACE OF MOTHER

(State or Country)

Lo

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

Emm Brown

(Address)

Sandpoint, Idaho

15.

Filed Dec 10 1913

Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH

Nov 12 1913
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from

1913 to Nov 12 1913that I last saw him alive on Nov 7 1913and that death occurred on the date stated above, at 9 P. M.

The CAUSE OF DEATH* was as follows:

Arterio-Sclerosis(Duration) chronic yrs. _____ mos. _____ ds.

Contributory (Secondary)

Liquor drinking(Duration) 10-12 yrs. _____ mos. _____ ds.

(Signed)

Rose M. Jackson M. D.12-14 1913 (Address) Sandpoint, Idaho

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place _____ yrs. _____ mos. _____ ds. In the _____ yrs. _____ mos. _____ ds.

Where was disease contracted,

If not at place of death?

Former or

usual residence.

19. PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

Sandpoint11/14 1913

20. UNDERTAKER

ADDRESS

Emm Brown Sandpoint

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Form V. S. No. 5. 12½ M. 7-24-11

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics
File No. 6472
Registered No. 462

1. PLACE OF DEATH. Registration District No. 78 Pat.
County of Blaine Primary Registration District No. 2153
City of Sandpoint (No. _____, _____ St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME A. M. Ansel C. Crozier

If death occurred in a hospital, institution or camp give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX Male 4. COLOR OR RACE White 5. SINGLE, MARRIED, WIDOWED OR DIVORCED. *Married*
(Write the word.)

6. DATE OF BIRTH Apr. 4 1845
(Month) (Day) (Year)

7. AGE 68 yrs. 7 mos. 16 ds. IF LESS than 1 day
how many hrs. or min?

8. OCCUPATION
(a) Trade, profession or particular kind of work Engineer
(b) General nature of industry Retired Stationary
business or establishment in which employed (or employer)

9. BIRTHPLACE Ill.
(State or Country)

10. NAME OF FATHER Smith Crozier

11. BIRTHPLACE OF FATHER U. S.
(State or Country)

12. MAIDEN NAME OF MOTHER — Shoemaker.

13. BIRTHPLACE OF MOTHER U. S.
(State or Country)

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) A. C. Crozier
(Address) Sandpoint

15. Filed Dec 10 1913 mmckm
Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH Nov. 20 1913
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from Nov. 12th 1913, to Nov. 20th 1913 that I last saw him alive on Nov. 20th 1913 and that death occurred on the date stated above, at 8:30 P. M.

The CAUSE OF DEATH* was as follows:

Cerebral hemorrhage

(Duration) yrs. mos. 3 — ds.
Contributory General atherosclerosis
(Secondary)

(Duration) ? yrs. mos. ds.
(Signed) J. B. Patterson M. D.
1910 1913 (Address) Sandpoint Ida.

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place In the
of death yrs. mos. ds. State yrs. mos. ds.
Where was disease contracted,
If not at place of death?
Former or
usual residence.

19. PLACE OF BURIAL OR REMOVAL DATE OF BURIAL

Sandpoint Idaho 11/27/1913

20. UNDERTAKER ADDRESS

E. M. Brower, S. P.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. PHYSICIANS—Every item of information should be carefully supplied. AGE should be stated EXACTLY. Exact statement of CAUSE OF DEATH in plain terms, so that it may be properly classified. See instructions on back of certificate.

6-135-13

Form V. S. No. 5. 12½ M. 7-24-11

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics
File No. 6478
Registered No. 463

1. PLACE OF DEATH. Registration District No. 78
County of Banner Primary Registration District No. 2155
City of Sandpoint (No. _____, _____ St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

Ard. Anderson

If death occurred in a hospital, institution or camp give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX Male 4. COLOR OR RACE White 5. SINGLE, MARRIED, WIDOWED OR DIVORCED.
(Write the word.)

6. DATE OF BIRTH

_____ 1 _____
(Month) (Day) (Year)

7. AGE

40 about.
yrs. mos. ds.

IF LESS than 1 day
how many _____ hrs. or
_____ min?

8. OCCUPATION

(a) Trade, profession or particular kind of work.
(b) General nature of industry business or establishment in which employed (or employer)

Day laborer

9. BIRTHPLACE

(State or Country) _____

10. NAME OF FATHER

11. BIRTHPLACE OF FATHER

(State or Country) _____

12. MAIDEN NAME OF MOTHER

13. BIRTHPLACE OF MOTHER

(State or Country) _____

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Emm Brown

(Address) Sandpoint

15.

Filed Dec 9 1913

M. McKeen

Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH

Nov 21 1913
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from

Nov 12 1913 to Nov 21 1913

that I last saw him alive on Nov 20 1913

and that death occurred on the date stated above, at 7 A M.

The CAUSE OF DEATH* was as follows:

Nephritis

(Duration) _____ yrs. _____ mos. _____ ds.

Contributory (Secondary)

Alcoholism

(Duration) _____ yrs. _____ mos. _____ ds.

(Signed)

D. F. Page

M. D.

Nov 21 1913 (Address) Sandpoint

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place _____ In the _____
of death _____ yrs. _____ mos. _____ ds. State _____ yrs. _____ mos. _____ ds.

Where was disease contracted,

If not at place of death? _____

Former or

usual residence. _____

19. PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

Sandpoint

Nov 25 1913

20. UNDERTAKER

ADDRESS

Emm Brown

Sandpoint

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Form V. S. No. 5. 12½ M. 7-24-11

CERTIFICATE OF DEATH

Jackson
78
2153

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics
File No. *647*
Registered No. *464*

1. PLACE OF DEATH. Registration District No. _____
County of *Bonner* Primary Registration District No. _____
City of *Sandpoint* (No. *923*, *Lake* St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

Emily Montroy

If death occurred in a hospital, institution or camp give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX 4. COLOR OR RACE 5. SINGLE, MARRIED, WIDOWED OR DIVORCED

Female *White* *Married*
(Write the word.)

6. DATE OF BIRTH

Mar *10* *1840*
(Month) (Day) (Year)

7. AGE

73 yrs. — mos. *14* ds.

IF LESS than 1 day
how many hrs. or
..... min?

8. OCCUPATION

(a) Trade, profession or particular kind of work.
(b) General nature of industry business or establishment in which employed (or employer)

Housewife

9. BIRTHPLACE

(State or Country)

Ottawa Canada

10. NAME OF FATHER

Joseph Desnoeux

11. BIRTHPLACE OF FATHER

(State or Country)

Ottawa Canada

12. MAIDEN NAME OF MOTHER

Unknown

13. BIRTHPLACE OF MOTHER

(State or Country)

Canada

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

Isaac Montroy

(Address)

Sandpoint, Id.

15.

Filed

Nov 10

191*3*

mmckinnon

Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH

Mar *24* 191*3*
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from
Nov. 7- 191*3*, to *Nov 24* 191*3*

that I last saw her alive on *Nov 18* 191*3*
and that death occurred on the date stated above, at *A. M.*

The CAUSE OF DEATH* was as follows:

Cirrhosis of Liver.

..... (Duration) *10* yrs. mos. ds.

Contributory
(Secondary)

..... (Duration) yrs. mos. ds.

(Signed) *R. H. Jackson* M. D.

11/26 19*3* (Address) *Sandpoint*

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place In the
of death yrs. mos. ds. State yrs. mos. ds.

Where was disease contracted,

If not at place of death?

Former or

usual residence.

19. PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

Sandpoint

11/26 191*3*

20. UNDERTAKER

ADDRESS

E. W. Brower

S. P.

WRITE PLAINLY, WITH UNFADEING INK—THIS IS A PERMANENT RECORD. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Form V. S. No. 5. 12½ M. 7-24-11

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics
File No. 648
Registered No. 867

1. PLACE OF DEATH. Registration District No. 78
County of Bonner Primary Registration District No. 2135
City of Hauman (No. _____, St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

Frederick Yarrow

If death occurred in a hospital, institution or camp give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX 4. COLOR OR RACE 5. SINGLE, MARRIED, WIDOWED OR DIVORCED.

male white Married
(Write the word)

6. DATE OF BIRTH

Jan 10 1882
(Month) (Day) (Year)

7. AGE

61 yrs. 10 mos. ds.

IF LESS than 1 day
how many hrs. or
..... min?

8. OCCUPATION

(a) Trade, profession or particular kind of work.
(b) General nature of industry business or establishment in which employed (or employer)

Farmer

9. BIRTHPLACE

(State or Country)

Iowa

10. NAME OF FATHER

11. BIRTHPLACE OF FATHER

(State or Country)

12. MAIDEN NAME OF MOTHER

13. BIRTHPLACE OF MOTHER

(State or Country)

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

(Address)

Ralph Gray
Landpoint

15.

Filed

Dec 10 1913

M. M. Mearns
Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH

Mar 29 1913
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from

Oct 29 1913, to Nov 20 1913
that I last saw him alive on Oct 29 1913

and that death occurred on the date stated above, at _____ M.

The CAUSE OF DEATH* was as follows:

Cerebral Haemorrhage

(Duration) yrs. mos. ds.

Contributory (Secondary)

Arterio Sclerosis

(Duration) yrs. mos. ds.

(Signed) M. M. Mearns M. D.

Nov 30 1913 (Address) Landpoint

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place In the
of death yrs. mos. ds. State yrs. mos. ds.

Where was disease contracted,

If not at place of death?

Former or

usual residence.

19. PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

Hauman

11/30 1913

20. UNDERTAKER

ADDRESS

E. M. Browne

S. C. P.

Form V. S. No. 5 20M.1-16-12

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics
File No. 26481
Registered No. 152

1. PLACE OF DEATH.

Registration District No. 2County of AdaPrimary Registration District No. 1004City of Boise(No. 318 N. 6th.

St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Charlotte Branstetter Norton

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX Female4. COLOR OR RACE White5. SINGLE, MARRIED, WIDOWED OR DIVORCED. Married
(Write the word.)6. DATE OF BIRTH October 20 1874
(Month) (Day) (Year)7. AGE 39 yrs. 19 mos. 19 ds.
IF LESS than 1 day
how many hrs. or
..... mins.?

8. OCCUPATION

(a) Trade, profession or particular kind of work No occupation

(b) General nature of industry business, or establishment in which employed (or employer)

9. BIRTHPLACE

(State or Country) Boise, Idaho10. NAME OF FATHER Henry C. Branstetter11. BIRTHPLACE OF FATHER Missouri

(State or Country)

12. MAIDEN NAME OF MOTHER Mary Jones13. BIRTHPLACE OF MOTHER Maryland

(State or Country)

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Alice Branstetter Yeomans(Address) Boise

15.

Filed Nov 10

191

W. C. Parker

Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH Nov 8 1913
(Month) (Day) (Year)17. I HEREBY CERTIFY, That I attended deceased from June 1st 1907 to Nov 8th 1913, that I last saw h.p.r. alive on Nov 8th 1913, and that death occurred on the date stated above, at 11 P.M.

The CAUSE OF DEATH* was as follows:

multiple Sclerosis of spinal cord & brain(Duration) 7 yrs. 6 mos. 19 ds.Contributory Arteriosclerosis(Secondary) Paralysis arms, legs, etc.(Duration) 10 yrs. 6 mos. 19 ds.(Signed) L. P. McCalla M. D.Nov 10 1913 (Address) Boise, Idaho

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death yrs. mos. days. In the State yrs. mos. days.

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL DATE OF BURIAL

Masonic Cemetery Nov. 11 1913

20. UNDERTAKER

ADDRESS

Schubert & Schumacher Boise

Form V. S. No. 5 20M.1-16-12

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

PLACE OF DEATH.

County of Ada
City of BoiseRegistration District No. 2
Primary Registration District No. 1004
(No. 2808 W. Jefferson St.)File No. 26482Registered No. 1

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Ada Newbanks
If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX M 4. COLOR OR RACE W 5. SINGLE, MARRIED, WIDOWED OR DIVORCED. Widower
(Write the word.)6. DATE OF BIRTH May 23rd 1845
(Month) (Day) (Year)7. AGE 68 yrs. 5 mos. 18 ds.IF LESS than 1 day
how many hrs. or
..... mins.?

8. OCCUPATION

(a) Trade, profession or particular kind of work Brickmaker

(b) General nature of industry, business, or establishment in which employed (or employer)

9. BIRTHPLACE Ohio
(State or Country)10. NAME OF FATHER Elias Newbanks11. BIRTHPLACE OF FATHER Germany
(State or Country)12. MAIDEN NAME OF MOTHER not obtainable13. BIRTHPLACE OF MOTHER not obtainable
(State or Country)

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) A. H. Douglas(Address) Boise, Ida

15.

Filed 11-13 1913 McParker

Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH Nov 11 1913
(Month) (Day) (Year)17. I HEREBY CERTIFY, That I attended deceased from Nov 4 1913, to Nov 11 1913,that I last saw him alive on Nov 10 1913, and that death occurred on the date stated above, at 8 A.M.

The CAUSE OF DEATH* was as follows:

General paresis(Duration) 2 yrs. 0 mos. 0 ds.Contributory Arteries & sclerosis
(Secondary)(Duration) ? yrs. 0 mos. 0 ds.(Signed) Maurice Henry Jackson M.D.11-13-1913 (Address) Boise, Idaho

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death yrs. mos. days. In the State yrs. mos. days.

Where was disease contracted if not at place of death?

Former or usual residence 2808 W. Jefferson Boise19. PLACE OF BURIAL OR REMOVAL Dry Creek CemeteryDATE OF BURIAL 11/14 191320. UNDERTAKER Schreiber & WidengadenADDRESS Boise, Idaho

MARGIN RESERVED FOR BINDING
WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Form V. S. No. 5 20M.1-16-12

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH.

Registration District No. 2

County of Ada

Primary Registration District No. 1004

City of Boise

(No. 411, Washington St.)

File No. 26483

Registered No. 578

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Sarah Ann McBue

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX F 4. COLOR OR RACE W 5. SINGLE, MARRIED, WIDOWED OR DIVORCED. Single
(Write the word.)

6. DATE OF BIRTH

Nov 15 1913
(Month) (Day) (Year)

7. AGE

0 yrs. 0 mos. 0 ds.

IF LESS than 1 day
how many hrs. or
mins.

8. OCCUPATION

(a) Trade, profession or particular kind of work none
(b) General nature of industry business, or establishment in which employed (or employer)

9. BIRTHPLACE

(State or Country)

Boise Idaho

10. NAME OF FATHER

J. J. McBue

11. BIRTHPLACE OF FATHER

(State or Country)

N. Y.

12. MAIDEN NAME OF MOTHER

Atella Bedard

13. BIRTHPLACE OF MOTHER

(State or Country)

Ills.

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

(Address)

J. J. McBue

15.

Filed Nov 17 1913

Max Parker

Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH

Nov 15 1913
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from

1913 to 1913

that I last saw h. alive on 1913

and that death occurred on the date stated above, at 10 P. M.

The CAUSE OF DEATH* was as follows:

Maternal Abnormalities

(Duration) 6 yrs. mos. ds.

Contributory
(Secondary)

(Duration) yrs. mos. ds.

(Signed) L. B. Brown M. D.

19 (Address) City

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death St. Alphonsus Hosp In the State Idaho yrs. mos. days.

Where was disease contracted if not at place of death?

Former or usual residence 18x Ada Boise Idaho

19. PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

St. Johns Cemetery 11/16 1913

20. UNDERTAKER

ADDRESS

Schreiber & Sidewaden Boise, Ida

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Form V. S. No. 5 20M.1-16-12

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics
File No. 276484

1. PLACE OF DEATH.

Registration District No. 2

County of Ada

Primary Registration District No. 2004

City of Boise

(No. 433 So 9th St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

Sylvian E. Eckert

Registered No. _____

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX M

4. COLOR OR RACE White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED. Single
(Write the word.)

6. DATE OF BIRTH

June 11th 1891
(Month) (Day) (Year)

7. AGE

22 yrs. 5 mos. 5 ds.

IF LESS than 1 day
how many hrs. or
..... mins.?

8. OCCUPATION

(a) Trade, profession or particular kind of work

Carpenter

(b) General nature of industry business, or establishment in which employed (or employer)

9. BIRTHPLACE

(State or Country)

Linn Co. Oregon

10. NAME OF FATHER

Edward Eckert

11. BIRTHPLACE OF FATHER

(State or Country)

Butte Co. Cal.

12. MAIDEN NAME OF MOTHER

Mary Luella Cory

13. BIRTHPLACE OF MOTHER

(State or Country)

Butte Co. Cal.

14. THE ABOVE IS TO THE BEST OF MY KNOWLEDGE

(Informant)

Jack Gilmore

(Address)

15.

Filed 11-17 1913

M. S. Parker

Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH

Nov 16th 1913
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from

Nov 13 1913 to Nov 16 1913

that I last saw him alive on Nov 16 1913

and that death occurred on the date stated above, at 11:30 M.

The CAUSE OF DEATH* was as follows:

Dysphoid

(Duration) yrs. mos. 6 weeks

Contributory (Secondary)

Hemorrhage

(Duration) yrs. mos. ds.

(Signed)

M. S. Parker M. D.

11/17 1913 (Address) Boise, Ida.

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death yrs. mos. days. In the State yrs. mos. days.

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

Harris Hill Cemetery 11/18 1913

20. UNDERTAKER

ADDRESS

Schreiber & Sidenfaden Boise, Idaho

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Form V. S. No. 5 20M.1-16-12

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics
File No. 276485
Registered _____

1. PLACE OF DEATH. Registration District No. 2
County of Ada Primary Registration District No. 1004
City of Boise (No. 112 E. Bannock St.)
If death occurs away from usual residence, give facts called for under special information. 2. FULL NAME Luther Snyder

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX M. 4. COLOR OR RACE W. 5. SINGLE, MARRIED, WIDOWED OR DIVORCED. Married
(Write the word.)

6. DATE OF BIRTH July 30 1855
(Month) (Day) (Year)

7. AGE 58 yrs. 3 mos. 17 ds. IF LESS than 1 day how many hrs. or mins.?

8. OCCUPATION
(a) Trade, profession or particular kind of work Rancher
(b) General nature of industry business, or establishment in which employed (or employer)

9. BIRTHPLACE Kansas
(State or Country)

10. NAME OF FATHER not obtainable

11. BIRTHPLACE OF FATHER not obtainable
(State or Country)

12. MAIDEN NAME OF MOTHER not obtainable

13. BIRTHPLACE OF MOTHER not obtainable
(State or Country)

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Wm. H. Ashbrook
(Address)

15. Filed Nov 18 1913 W. S. Parker
Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH Nov 17 1913
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from Feb 1913, to Nov 17 1913, that I last saw him alive on Nov 17 1913, and that death occurred on the date stated above, at 9 P. M.
The CAUSE OF DEATH* was as follows:
Empyema
(Duration) yrs. mos. ds.
Contributory (Secondary)
(Duration) yrs. mos. ds.
(Signed) W. S. Parker D.
1118. 19. 13 (Address) Boise, Ida

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death St Lukes Hospital In the State Idaho
yrs. mos. days. yrs. mos. days.

Where was disease contracted if not at place of death?

Former or usual residence Meridian Idaho

19. PLACE OF BURIAL OR REMOVAL DATE OF BURIAL
Meridian Cemetery 11/19/13

20. UNDERTAKER ADDRESS
Schreiber & Sidenfaden Boise, Idaho

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Form V. S. No. 5 20M.1-16-12

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics
File No. 2116480
Registered No. 1716

1. PLACE OF DEATH.

Registration District No. 2County of AdaPrimary Registration District No. 1004City of Boise(No. 1716, Franklin St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Mr. Harmon

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX

Male

4. COLOR OR RACE

White5. SINGLE, MARRIED, WID-
OWED OR DIVORCED.Married
(Write the word.)

6. DATE OF BIRTH

Jan 23 1834
Month Day Year

7. AGE

79 yrs. 9 mos. 24 ds.

IF LESS than 1 day
how many hrs. or
..... mins.?

8. OCCUPATION

- (a) Trade, profession or particular kind of work
(b) General nature of industry, business, or establishment in which employed (or employer)

Retired

9. BIRTHPLACE

(State or Country)

Ohio

10. NAME OF FATHER

John Kent Harmon

11. BIRTHPLACE OF FATHER

(State or Country)

Am.

12. MAIDEN NAME OF MOTHER

Harrington Hendrix

13. BIRTHPLACE OF MOTHER

(State or Country)

Am.

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

Mary E. Harmon

(Address)

15.

Filed Nov 18 1913M. S. Parker

Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH

Nov 17 1913
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from Nov 15 1913 to Nov 18 1913,
that I last saw him alive on Nov 15 1913

and that death occurred on the date stated above, at 11:30 AM.

The CAUSE OF DEATH* was as follows:

Senility with
depression of brain
causing apoplexy & emphysema
(Duration) yrs. mos. ds.

Contributory
(Secondary)

(Duration) yrs. mos. ds.

(Signed)

John B. Boeck M. D.
Nov 18 1913 (Address) Boise, Ida

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death yrs. mos. days. In the State yrs. mos. days.

Where was disease contracted if not at place of death?.....

Former or usual residence.....

19. PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

Marries Hill Cemetery 11/19 1913

20. UNDERTAKER

ADDRESS

Schreiber & Sidenfader Boise, Idaho

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Form V. S. No. 5 20M.1-16-12

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics
File No. 282 6188
Registered No. 282

1. PLACE OF DEATH.

Registration District No. 2

County of Ada

Primary Registration District No. 1004

City of Boise

(No. 112, E. Bayne St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Grayce Ingraham

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX

F

4. COLOR OR RACE

W.

5. SINGLE, MARRIED, WIDOWED OR DIVORCED.

Married
(Write the word.)

6. DATE OF BIRTH

April 20 1897
(Month) (Day) (Year)

7. AGE

36 yrs. 7 mos. 0 ds.

IF LESS than 1 day
how many hrs. or
..... mins.

8. OCCUPATION

(a) Trade, profession or particular kind of work

Housekeeper

(b) General nature of industry business, or establishment in which employed (or employer)

9. BIRTHPLACE

(State or Country)

Nebraska

10. NAME OF FATHER

Wm. W. Wheeler

11. BIRTHPLACE OF FATHER

(State or Country)

American

12. MAIDEN NAME OF MOTHER

Susan Wilcox

13. BIRTHPLACE OF MOTHER

(State or Country)

American

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) L. S. Ingraham

(Address) 30 Boise

15.

Filed 11-21 1913

W. S. Parker

Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH

Nov 20 1913
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from Nov 18 1913, to Nov 20 1913, that I last saw her alive on Nov 20 1913

and that death occurred on the date stated above, at 11 P.M.

The CAUSE OF DEATH* was as follows:

Ememia

(Duration) yrs. mos. ds.

Contributory
(Secondary)

(Duration) yrs. mos. ds.

(Signed)

11/21/1913 (Address) Boise, Ida.

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death St. Luke's Hospital yrs. mos. 2 days. State Idaho yrs. mos. days.

Where was disease contracted if not at place of death?

Former or usual residence Boise Idaho

19. PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

Morris Hill Cemetery 11/22 1913

20. UNDERTAKER

ADDRESS

Schreibers Undertakers Boise

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Form V. S. No. 5 20M.1-16-12

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics
File No. 26489
Registered No. 1004

1. PLACE OF DEATH

Registration District No. 2

County of Ada

Primary Registration District No. 1004

City of Boise

(No. St. Luke's Hospital)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

E. Lighth & Ethel

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX

4. COLOR OR RACE

5. SINGLE, MARRIED, WIDOWED OR DIVORCED.

Female White

Single (Write the word.)

6. DATE OF BIRTH

July 5, 1857 (Month) (Day) (Year)

7. AGE

56 yrs. 4 mos. 18 ds.

IF LESS than 1 day how many hrs. or mins.

8. OCCUPATION

(a) Trade, profession or particular kind of work

(b) General nature of industry business, or establishment in which employed (or employer)

Housewife

9. BIRTHPLACE

(State or Country)

Iowa

10. NAME OF FATHER

Sanford R. Ethel

11. BIRTHPLACE OF FATHER

(State or Country)

Mo.

12. MAIDEN NAME OF MOTHER

Katherine Evans

13. BIRTHPLACE OF MOTHER

(State or Country)

Indiana

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

(Address)

Boysie Blackwell
Boise, Idaho

15.

Filed 11-24-1913

M. Parker
Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH

Nov 21, 1913 (Month) (Day) (Year)

I HEREBY CERTIFY, That I attended deceased from Nov 21, 1913, to Nov 23, 1913, that I last saw her alive on Nov 23, 1913, and that death occurred on the date stated above, at 7 P.M.

The CAUSE OF DEATH* was as follows:

Cardiac Obstruction with gangrene

(Duration) yrs. mos. ds.

Contributory (Secondary)

(Duration) yrs. mos. ds.

(Signed)

11/24/1913 (Address) Boise

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death. yrs. mos. days. In the State. yrs. mos. days.

Where was disease contracted if not at place of death?

Former or usual residence.

19. PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

Glenns Ferry Id. Nov 25, 1913

20. UNDERTAKER

ADDRESS

Jay Summers Boise Id.

Form V. S. No. 5 20M.1-16-12

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics
File No. 6492 6000
Registered No. 284

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

1. PLACE OF DEATH.

Registration District No. 2County of AdaPrimary Registration District No. 1004City of Boise(No. 710, North 21st St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME John W. Body

PERSONAL AND STATISTICAL PARTICULARS

3. SEX

Male

4. COLOR OR RACE

White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED.

Married
(Write the word.)

6. DATE OF BIRTH

Dec.31875

(Month)

(Day)

(Year)

7. AGE

38 yrs. 11 mos. 11 ds.

IF LESS than 1 day
how many hrs. or
..... mins.?

8. OCCUPATION

(a) Trade, profession or particular kind of work

Contractor

(b) General nature of industry business, or establishment in which employed (or employer)

9. BIRTHPLACE

(State or Country)

St Louis Mo.

10. NAME OF FATHER

Thomas Body

11. BIRTHPLACE OF FATHER

(State or Country)

Wales

12. MAIDEN NAME OF MOTHER

Not obtainable

13. BIRTHPLACE OF MOTHER

(State or Country)

English

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Mrs. J. W. Body(Address) Boise

15.

Filed 11-281913M. J. Parker

Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH

Nov.241913

(Month)

(Day)

(Year)

17. I HEREBY CERTIFY, That I attended deceased from

Nov 11913, toNov 241913,that I last saw him alive on Nov 23 1913and that death occurred on the date stated above, at 24 M.

The CAUSE OF DEATH* was as follows:

Pulmonary Tuberculosisabout3 yrs.

mos.

ds.

Contributory
(Secondary)

(Duration)

yrs.

mos.

ds.

(Signed) J. W. Forney M. D.11/28 1913(Address) Boise

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place

of death yrs. mos. days.

In the

State yrs. mos. days.

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

Morris Hill CemeteryNov. 30 1913

20. UNDERTAKER

ADDRESS

Schreiber & WidemeyerBoise

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Form V. S. No. 5 20M.1-16-12

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics
File No. 8491

1. PLACE OF DEATH.

Registration District No. 2

County of Ida

Primary Registration District No. 1004

City of Boise

(No. 222 1/2 Main St.)

Registered No. 1004

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME File Hawkins

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX Male

4. COLOR OR RACE White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED. Single

(Write the word.)

6. DATE OF BIRTH Not attainable

(Month)

(Day)

(Year)

7. AGE About 30 years

..... yrs. mos. ds.

IF LESS than 1 day
how many hrs. or
..... mins.?

8. OCCUPATION

(a) Trade, profession or particular kind of work Unknown

(b) General nature of industry, business, or establishment in which employed (or employer) Unknown

9. BIRTHPLACE

(State or Country) Unknown

10. NAME OF FATHER Not obtainable

11. BIRTHPLACE OF FATHER

(State or Country) Unknown

12. MAIDEN NAME OF MOTHER Unknown

13. BIRTHPLACE OF MOTHER

(State or Country) Unknown

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Adolph Schreiber

(Address) Boise

15.

Filed 11-28 1913

McParker

Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH Nov 24 1913

(Month)

(Day)

(Year)

17. I HEREBY CERTIFY, That I attended deceased from Nov 24 1913, to Nov 24 1913

that I last saw him alive on Nov 24 1913

and that death occurred on the date stated above, at 5 P. M.

The CAUSE OF DEATH* was as follows:

Pneumonia (Bronchitis)
tuberculosis

(Duration)

yrs.

mos.

ds.

Contributory (Secondary) Pulmonary Tuberculosis

(Duration)

yrs.

mos.

ds.

(Signed) Frank A. Houghton M. D.

19

(Address)

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place Offord Hotel In the
of death yrs. mos. days. State yrs. mos. days.

Where was disease contracted if not at place of death? Supposed to be Mackay Hotel

Former or usual residence Supposed to be Mackay Hotel

19. PLACE OF BURIAL OR REMOVAL Morris & Co. Mortuary

DATE OF BURIAL 11/28 1913

Ada Co. Plat

20. UNDERTAKER Schreiber & Houghton

ADDRESS Boise Idaho

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Form V. S. No. 5 20M.1-16-12

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH.

Registration District No. 2County of AdaPrimary Registration District No. 1004City of Bosse(No. Soldiers Home St.)File No. 286 6492

Registered No. _____

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

John M. Herman

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX

4. COLOR OR RACE

5. SINGLE, MARRIED, WID-
OWED OR DIVORCED.Male WhiteMarried
(Write the words)

6. DATE OF BIRTH

Not obtainable 1845
(Month) (Day) (Year)

7. AGE

68 yrs. — mos. — ds.IF LESS than 1 day
how many hrs. or
..... mins.?

8. OCCUPATION

(a) Trade, profession or
particular kind of work.Veteran Civil War(b) General nature of industry
business, or establishment in
which employed (or employer)

9. BIRTHPLACE

(State or Country)

Not obtainable10. NAME OF
FATHERNot obtainable11. BIRTHPLACE
OF FATHER

(State or Country)

Not obtainable12. MAIDEN NAME
OF MOTHERNot obtainable13. BIRTHPLACE
OF MOTHER

(State or Country)

Not obtainable

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

L. G. Burnett

(Address)

Soldiers Home

15.

Filed Nov. 29th, 1913

M. B. [Signature]
Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH

11 28 1913
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from

11/14 1913, to 11/28 1913that I last saw him alive on 11/27 1913and that death occurred on the date stated above, at 7 A.M.

The CAUSE OF DEATH* was as follows:

Stroke
Apoplexy

(Duration) yrs. mos. ds.

Contributory
(Secondary)Arterio Sclerosis

(Duration) yrs. mos. ds.

(Signed) Fred A. [Signature] M. D.

19 (Address)

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions,
Transients or Recent Residents.)

At place of death yrs. mos. days. In the State yrs. mos. days.

Where was disease contracted
if not at place of death?Former or
usual residence

19. PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

Weslow IdgDec 2 1913

20. UNDERTAKER

ADDRESS

Fry SummersBosse Idg

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY.
CIVILIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Extension of OCCUPATION is very important. See instructions on back of certificate.

Form V. S. No. 5 20M.1-16-12

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics
File No. **6493**

PLACE OF DEATH

Registration District No. 8

County of Ada
City of near Ustick

Primary Registration District No. 2004
(No. near Ustick St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Ethel Louisa Waits

Registered No. 19
If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX F. 4. COLOR OR RACE W. 5. SINGLE, MARRIED, WIDOWED OR DIVORCED Married
(Write the word.)

6. DATE OF BIRTH Feb 28 - 1888
(Month) (Day) (Year)

7. AGE 32 yrs. 8 mos. 7 ds.
IF LESS than 1 day how many hrs. or mins.?

8. OCCUPATION
(a) Trade, profession or particular kind of work Housekeeper
(b) General nature of industry, business, or establishment in which employed (or employer)

9. BIRTHPLACE Sack City Iowa
(State or Country)

10. NAME OF FATHER Geo. R. Rasmussen

11. BIRTHPLACE OF FATHER Penn
(State or Country)

12. MAIDEN NAME OF MOTHER Emma Gamble

13. BIRTHPLACE OF MOTHER Ills.
(State or Country)

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Ralph Waits
(Address) Ustick Ida

15. Filed 11 - 6 1913 228 Park
Local Registrar D. H. Brown

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH Nov 4 - 1913
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from 10 - 29 - 1913, to Nov 4 - 1913, that I last saw her alive on Nov 4 - 1913, and that death occurred on the date stated above, at 2 P.M.

The CAUSE OF DEATH* was as follows:
Pneumo-pneumonia

(Duration) yrs. mos. 10 ds.

Contributory (Secondary)

(Duration) yrs. mos. ds.

(Signed) J. E. Froger M. D.
11 - 6 1913 (Address) Boise Idaho

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death yrs. mos. days. In the State yrs. mos. days.

Where was disease contracted if not at place of death?

Former or usual residence Ustick, Idaho

19. PLACE OF BURIAL OR REMOVAL Morris Hill Cemetery DATE OF BURIAL 11/8 1913

20. UNDERTAKER Schreiber & Vidupaden ADDRESS Boise

MARGIN RESERVED FOR BINDING
WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Form V. S. No. 5 20M.1-16-12

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics
File No. **6494**
Registered No. **21**

1. PLACE OF DEATH.

Registration District No. **8**

County of **Ada**

Primary Registration District No. **2004**

City of **near Boise**

(No. **near Boise** St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

Myra Louise Montuth

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX

Female

4. COLOR OR RACE

white

5. SINGLE, MARRIED, WIDOWED OR DIVORCED.

Single
(Write the word.)

6. DATE OF BIRTH

Nov

17

1913

(Month)

(Day)

(Year)

7. AGE

etc.

1 yrs. **1** mos. **1** ds.

IF LESS than 1 day
how many hrs. or mins.

8. OCCUPATION

(a) Trade, profession or particular kind of work

(b) General nature of industry business, or establishment in which employed (or employer)

At home

9. BIRTHPLACE

(State or Country)

Boise Id.

10. NAME OF FATHER

O G Montuth

11. BIRTHPLACE OF FATHER

(State or Country)

Nebraska

12. MAIDEN NAME OF MOTHER

Myra Potter

13. BIRTHPLACE OF MOTHER

(State or Country)

Mich.

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

O A. Montuth

(Address)

Boise Idaho

15.

Filed **11-18**

1913

M. S. Parker

Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

Nov. -

18th

1913

(Month)

(Day)

(Year)

17. I HEREBY CERTIFY, That I attended deceased from

Nov. 17

1913

to **Nov. 18**

1913

that I last saw her alive on **Nov. 17** **1913**

and that death occurred on the date stated above, at **7 A.M.**

The CAUSE OF DEATH* was as follows:

Atelectasis (Solidification of lung) -

(Duration) yrs. mos. ds.

Contributory **Mucous Contained in**

(Secondary)

respiratory passages

(Duration) yrs. mos. ds.

(Signed)

E. L. Dutton

M. D.

Nov 19 1913 (Address) **Meridian Id.**

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place

of death yrs. mos. days.

In the

State yrs. mos. days.

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

Morris Hill Cemetery, Nov 19 1913

20. UNDERTAKER

ADDRESS

J. J. Summers

Boise Id.

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Form V. S. No. 5 20M.1-16-12

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

PLACE OF DEATH.

Registration District No. 2

County of Gada
City of Bose

Primary Registration District No. 1004

File No. 0495

(No. St. Alphonsus Hospital)

Registered No. _____

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

Rena Myrtle Campbell

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX

F

4. COLOR OR RACE

White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED.

married
(Write the words)

6. DATE OF BIRTH

Sept 2 1871
(Month) (Day) (Year)

7. AGE

42 yrs. 1 mos. 15 ds.

IF LESS than 1 day
how many hrs. or
..... mins.?

8. OCCUPATION

(a) Trade, profession or particular kind of work

Housewife

(b) General nature of industry, business, or establishment in which employed (or employer)

9. BIRTHPLACE

(State or Country)

West Virginia

10. NAME OF FATHER

Wesley Brown

11. BIRTHPLACE OF FATHER

(State or Country)

Va

12. MAIDEN NAME OF MOTHER

Mary Heatherly

13. BIRTHPLACE OF MOTHER

(State or Country)

Va

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Mrs. R. E. Bradley

(Address) King Hill, Idaho

15.

Filed 11-1 1913

W. S. Parker
Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH

Oct 31 1913
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That, I attended deceased from Aug 25 1913, to Oct 31 1913, that I last saw her alive on Oct 31 1913, and that death occurred on the date stated above, at 10 M.

The CAUSE OF DEATH* was as follows:

Carcinoma of Breast

(Duration) yrs. mos. ds.

Contributory (Secondary)

(Duration) yrs. mos. ds.

(Signed)

11/1 1913 (Address) Bose, Idaho

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death yrs. mos. days. In the State yrs. mos. days.

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL DATE OF BURIAL

Morris Hill Cemetery Nov 1 1913

20. UNDERTAKER

ADDRESS

V. J. & L. Summer Bose, Idaho

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Form V. S. No. 5 20M.1-16-12

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH

Registration District No. 2

County of Ada

Primary Registration District No. 1004

File No. 263 6496

City of Bain

(No. 410, State Idaho St.)

Registered No. _____

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Milton George Nebeker

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX

4. COLOR OR RACE

5. SINGLE, MARRIED, WID-
OWED OR DIVORCED.

M

W.

Single
(Write the word.)

6. DATE OF BIRTH

Feb 23rd 1912
(Month) (Day) (Year)

7. AGE

9 yrs. 8 mos. 8 ds.

IF LESS than 1 day
how many hrs. or
..... mins.?

8. OCCUPATION

(a) Trade, profession or
particular kind of work

(b) General nature of industry
business, or establishment in
which employed (or employer)

none

9. BIRTHPLACE

(State or Country)

Marley, Idaho

10. NAME OF
FATHER

Geo Nebeker

11. BIRTHPLACE
OF FATHER

(State or Country)

Laketon, Utah

12. MAIDEN NAME
OF MOTHER

Jenny Johnson

13. BIRTHPLACE
OF MOTHER

(State or Country)

Utah

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

Geo Nebeker

(Address)

Marley, Idaho

15.

Filed Nov. 2nd, 1913

M. G. Nebeker
Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH

Nov. 2 1913
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from
Nov. 1 1913, to Nov. 2 1913,
that I last saw him alive on Nov. 2 1913

and that death occurred on the date stated above, at 10 A.M.

The CAUSE OF DEATH* was as follows:

Fracture of Skull, with
Concussion of Brain

(Duration) yrs. mos. / ds.

Contributory
(Secondary)

(Duration) yrs. mos. ds.

(Signed) Chas F. Zeller M. D.

19 (Address) Shoshone, Idaho

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions,
Transients or Recent Residents.)

At place of death yrs. mos. days. State Idaho yrs. mos. days.

Where was disease contracted
if not at place of death?

Former or
usual residence Shoshone, Idaho

19. PLACE OF BIRTH OR REMOVAL

DATE OF BURIAL

Paris, Idaho

11/2 1913

20. UNDERTAKER

ADDRESS

Schreiber & Sibley

Bain, Id.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Form V. S. No. 5 20M.1-16-12

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH

Registration District No. 2County of AdaPrimary Registration District No. 1904City of Boise(No. St. Lukes Hospital St.)File No. 26849Registered No. 550

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

Frank Lee Lemmon

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX

4. COLOR OR RACE

5. SINGLE, MARRIED, WIDOWED OR DIVORCED

Male WhiteMarried
(Write the word.)

6. DATE OF BIRTH

Dec 24 1862
(Month) (Day) (Year)

7. AGE

50 yrs. 10 mos. 9 ds.IF LESS than 1 day
how many hrs. or
..... mins.?

8. OCCUPATION

- (a) Trade, profession or particular kind of work
(b) General nature of industry business, or establishment in which employed (or employer)

Building Contractor

9. BIRTHPLACE

(State or Country)

Iowa

10. NAME OF FATHER

James H. Lemmon

11. BIRTHPLACE OF FATHER

(State or Country)

Wis

12. MAIDEN NAME OF MOTHER

Adeline Kater

13. BIRTHPLACE OF MOTHER

(State or Country)

Madison

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

Gayle H. V. Lemmon

(Address)

15.

Filed

Nov. 41913Mc Parker

Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH

4 2 1913
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from

11/1 1913 to 11/2 1913that I last saw him alive on 11/2 1913and that death occurred on the date stated above, at 5/4 M.

The CAUSE OF DEATH* was as follows:

Accidental
Killed by Mule

(Duration) yrs. mos. ds.

Contributory

(Secondary)

(Duration) yrs. mos. ds.

(Signed)

F. A. Pittenger

M. D.

11/3 1913 (Address) Black

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death yrs. mos. days. In the State yrs. mos. days.

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

Altoona IowaNov. 9 1913

20. UNDERTAKER

ADDRESS

Fry & SummersBoise Id

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Form V. S. No. 5 20M.1-16-12

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics
File No. 2649
Registered No. 15

1. PLACE OF DEATH.

Registration District No. 2
County of Ada
Primary Registration District No. 1004
City of Boise
(No. 1213 20. 13 St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Geneva Smart

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX Female 4. COLOR OR RACE white american 5. SINGLE, MARRIED, WIDOWED OR DIVORCED. single
(Write the word.)

6. DATE OF BIRTH

(Month) (Day) (Year)

7. AGE

.....yrs. 13 mos.ds.

IF LESS than 1 day
how manyhrs. or
.....mins.?

8. OCCUPATION

(a) Trade, profession or particular kind of work none
(b) General nature of industry, business, or establishment in which employed (or employer)

9. BIRTHPLACE

(State or Country) Boise Ida

10. NAME OF FATHER

H. G. Smart

11. BIRTHPLACE OF FATHER

(State or Country) Kansas

12. MAIDEN NAME OF MOTHER

Myrtle May High

13. BIRTHPLACE OF MOTHER

(State or Country) Kansas

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Dr. E. High

(Address)

15.

Filed Nov 4 1913 W. S. Parker

Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH

November 3 1913
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from Oct 22 1913, to Nov 3 1913,

that I last saw her alive on Nov 3 1913,

and that death occurred on the date stated above, at 5 P.M.

The CAUSE OF DEATH* was as follows:

Enteritis

(Duration)yrs.mos. 13 ds.

Contributory malnutrition
(Secondary)

(Duration)yrs.mos.ds.

(Signed) R. L. Sene M. D.
11/4 1913 (Address) Boise

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of deathyrs.mos.days. In the Stateyrs.mos.days.

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL

Mountain Hill Cem Nov. 5 1913

20. UNDERTAKER

Fry & Summers Boise

ADDRESS

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Form V. S. No. 5 20M.1-16-12

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics
File No. 26,6499
Registered No. 1

1. PLACE OF DEATH.

Registration District No. 2

County of Ada

Primary Registration District No. 1004

City of Boise

(No. 807 N. 25 St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Ida Fuller Chambers.

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX Female

4. COLOR OR RACE White

5. SINGLE, MARRIED, WID-
OWED OR DIVORCED.
Married
(Write the word)

6. DATE OF BIRTH

Jan — 8 1865
(Month) (Day) (Year)

7. AGE

48 yrs. 8 mos. 27 ds.

IF LESS than 1 day
how many hrs. or
..... mins.

8. OCCUPATION

(a) Trade, profession or
particular kind of work Housewife
(b) General nature of industry
business, or establishment in
which employed (or employer)

9. BIRTHPLACE

(State or Country) Proctor, Iowa

10. NAME OF
FATHER Constance Fuller

11. BIRTHPLACE
OF FATHER Germany

(State or Country)

12. MAIDEN NAME
OF MOTHER Catherine Byers

13. BIRTHPLACE
OF MOTHER Germany

(State or Country)

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) J. H. Chambers.

(Address) 807 N. 25

15.

Filed Nov 4 1913

W. B. Parker
Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH

Nov 4 1913
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from

July 15 1913, to Nov 4 1913,
that I last saw her alive on Oct. 4 1913,

and that death occurred on the date stated above, at 6 A. M.

The CAUSE OF DEATH* was as follows:

Carcinoma of right breast.

(Duration) 1 yrs. 3 mos. ds.

Contributory
(Secondary)

(Duration) yrs. mos. ds.

(Signed) L. B. McCall M. D.

19 (Address) Boise Idaho

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death yrs. mos. days. In the State yrs. mos. days.

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

Morris Hill 11/5 1913

20. UNDERTAKER

ADDRESS

Schreiber & Siderfaden
Boise

MARGIN RESERVED FOR BINDING
WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Form V. S. No. 5 20M.1-16-12

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH.

Registration District No. 2

County of Ada

Primary Registration District No. 1004

City of Boise

(No. 410, State Idaho St.)

File No. 3650

Registered No. 1004

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

Louise Lee Shan

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX

M

4. COLOR OR RACE

Yellow

5. SINGLE, MARRIED, WIDOWED OR DIVORCED.

Married
(Write the word.)

6. DATE OF BIRTH

1858
(Month) (Day) (Year)

7. AGE

55 yrs. mos. ds.

IF LESS than 1 day
how many hrs. or mins.?

8. OCCUPATION

(a) Trade, profession or particular kind of work

Laundryman

(b) General nature of industry business, or establishment in which employed (or employer)

9. BIRTHPLACE

(State or Country)

China

10. NAME OF FATHER

not obtainable

11. BIRTHPLACE OF FATHER

(State or Country)

Not obtainable

12. MAIDEN NAME OF MOTHER

not obtainable

13. BIRTHPLACE OF MOTHER

(State or Country)

not obtainable

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

Louise Lee

(Address)

Boise Idaho.

15.

Filed

Nov 5

191

M. Parker
Local Registrar

Dr. Collister

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

Nov 4 1913
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from

191, to 191,

that I last saw him alive on Nov 2 1913,

and that death occurred on the date stated above, at M.

The CAUSE OF DEATH* was as follows:

Cancer of Stomach

(Duration) yrs. mos. ds.

Contributory
(Secondary)

(Duration) yrs. mos. ds.

(Signed)

Geo. C. Smith M. D.

19 (Address)

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death yrs. mos. days. In the State yrs. mos. days.

Where was disease contracted if not at place of death?

Former or usual residence.

19. PLACE OF BURIAL OR REMOVAL DATE OF BURIAL

Chinese Cemetery 11/5 1913

20. UNDERTAKER

ADDRESS

Schreiber Hidenfaden

Boise,

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Form V. S. No. 5 20M.1-16-12

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics
File No. **6501**

1. PLACE OF DEATH.

Registration District No. 5

County of Bear Lake

Primary Registration District No. 2134

City of Pegram

(No. _____, St.)

Registered No. _____

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

Grace Grundy

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX

Female

4. COLOR OR RACE

White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED.

Single
(Write the word.)

6. DATE OF BIRTH

Dec 27th 1913
(Month) (Day) (Year)

7. AGE

2 yrs. 2 mos. 2 ds.

IF LESS than 1 day
how many _____ hrs. or
_____ mins.

8. OCCUPATION

(a) Trade, profession or particular kind of work
(b) General nature of industry business, or establishment in which employed (or employer)

None

9. BIRTHPLACE

(State or Country)

Pegram Ida.

10. NAME OF FATHER

Chas Grundy

11. BIRTHPLACE OF FATHER

(State or Country)

Utah

12. MAIDEN NAME OF MOTHER

Grace Davidson

13. BIRTHPLACE OF MOTHER

(State or Country)

Wyoming

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

Chas Grundy

(Address)

Pegram Ida

15.

Filed

12/30/13

1913

St. H. King

Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH

Dec 29th 1913
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from Dec 27th 1913 to Dec 29 1913

that I last saw her alive on Dec 29 1913

and that death occurred on the date stated above, at 12-M.

The CAUSE OF DEATH* was as follows:

Unknown - Premature Birth at 6 mos. Gestation

(Duration) _____ yrs. _____ mos. _____ ds.

Contributory (Secondary)

(Duration) _____ yrs. _____ mos. _____ ds.

(Signed)

St. H. King M. D.

12/29/13 (Address) Montpelier Ida.

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death _____ yrs. _____ mos. 2 days. In the State _____ yrs. _____ mos. 2 days.

Where was disease contracted if not at place of death?

Former or usual residence

Idaho

19. PLACE OF BURIAL OR REMOVAL

Pegram Ida

DATE OF BURIAL

12/30/13 1913

20. UNDERTAKER

None

ADDRESS

Form V. S. No. 5. 12½ M. 7-1-11

CERTIFICATE OF DEATH

1. PLACE OF DEATH. Registration District No. 104
 County of Idaho Primary Registration District No. 2182
 City of Joseph (No. _____, _____ St.)

State of Idaho
 BOARD OF HEALTH
 Bureau of Vital Statistics
 File No. 6502
 Registered No. _____

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Andrew Jackson Campbell

If death occurred in a hospital, institution or camp give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX Male 4. COLOR OR RACE White 5. SINGLE, MARRIED, WIDOWED OR DIVORCED. married
 (Write the word.)

6. DATE OF BIRTH Mar 13 1886
 (Month) (Day) (Year)

7. AGE 28 yrs. 9 mos. 6 ds. IF LESS than 1 day
 how many hrs. or
 min?

8. OCCUPATION

(a) Trade, profession or particular kind of work. Rancher
 (b) General nature of industry business or establishment in which employed (or employer)

9. BIRTHPLACE North Carolina
 (State or Country)

10. NAME OF FATHER James M Campbell

11. BIRTHPLACE OF FATHER North Carolina
 (State or Country)

12. MAIDEN NAME OF MOTHER Elizabeth Carol

13. BIRTHPLACE OF MOTHER North Carolina
 (State or Country)

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
 (Informant) C B Campbell
 (Address) Joseph Ida

15. W A Fiskett
 Local Registrar

Filed 191

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH December 19 1913
 (Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from Dec 1913, to Dec 1913
 that I last saw him alive on Mar 1912
 and that death occurred on the date stated above, at _____ M.

The CAUSE OF DEATH* was as follows:

Heart trouble
Mitral regurgitation

(Duration) 2 yrs. 7 mos. 1 ds.
 Contributory (Secondary) Dropsy & Paralysis

(Duration) _____ yrs. _____ mos. _____ ds.
 (Signed) W A Fiskett M. D.
Dec 23 1913 (Address) Whitebird

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place _____ In the _____
 of death yrs. mos. ds. State yrs. mos. ds.
 Where was disease contracted,
 If not at place of death?
 Former or
 usual residence.

19. PLACE OF BURIAL OR REMOVAL DATE OF BURIAL

Donneog Dec 21 1913
 20. UNDERTAKER ADDRESS

Graham Grangeville

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Form V. S. No. 5 20M.1-16-12

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH

Registration District No. 98

County of _____

Primary Registration District No. 2176

City of _____

(No. _____)

St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

David Henry Browning

File No. 6505

Registered No. 24

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX

Male

4. COLOR OR RACE

White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED.

Married
(Write the word.)

6. DATE OF BIRTH

Mar. 16 1835
(Month) (Day) (Year)

7. AGE

78 yrs. 9 mos. 15 ds.

IF LESS than 1 day
how many _____ hrs. or
_____ mins.?

8. OCCUPATION

(a) Trade, profession or particular kind of work

Farming

(b) General nature of industry business, or establishment in which employed (or employer)

9. BIRTHPLACE

(State or Country)

Ill.

10. NAME OF FATHER

James Green Browning

11. BIRTHPLACE OF FATHER

(State or Country)

Penn.

12. MAIDEN NAME OF MOTHER

Mary Ann Neal

13. BIRTHPLACE OF MOTHER

(State or Country)

Penn.

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

D. H. Browning

(Address)

15.

Filed

Jan 10 1914 Ray H. Hibbs
Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

Dec 31 1913
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from Dec 31 1913, to Dec 31 1913

that I last saw him alive on Dec 31 1913

and that death occurred on the date stated above, at 1:30 P. M.

The CAUSE OF DEATH* was as follows:

Pneumonia

(Duration) _____ yrs. _____ mos. 2 ds.

Contributory (Secondary)

Senility

(Duration) _____ yrs. _____ mos. _____ ds.

(Signed)

Ray H. Hibbs M. D.

(Address) Rigby, Ida.

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death _____ yrs. _____ mos. _____ days. In the State _____ yrs. _____ mos. _____ days.

Where was disease contracted, if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

Annies Cemetery 1-3-1914

20. UNDERTAKER

ADDRESS

B. Edinwoodey Idaho Falls

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Form V. S. No. 5 20M.1-16-12

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH. Registration District No. 69
County of Brigham Primary Registration District No. 2147
City of Shelley (No. _____ St.)

File No. 6507
Registered No. _____

If death occurs away from usual residence, give facts called for under special information.

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Infant

PERSONAL AND STATISTICAL PARTICULARS

3. SEX Girl 4. COLOR OR RACE W 5. SINGLE, MARRIED, WIDOWED OR DIVORCED. Infant
(Write the word.)

6. DATE OF BIRTH Sept 18 1913
(Month) (Day) (Year)

7. AGE _____ yrs. _____ mos. 10 ds.
IF LESS than 1 day how many _____ hrs. or _____ mins.?

8. OCCUPATION

(a) Trade, profession or particular kind of work
(b) General nature of industry, business, or establishment in which employed (or employer)

Infant

9. BIRTHPLACE

(State or Country)

Brigham Co. Idaho

10. NAME OF FATHER

Wm. T. Wornack

11. BIRTHPLACE OF FATHER

(State or Country)

Idaho

12. MAIDEN NAME OF MOTHER

Edna May Craft

13. BIRTHPLACE OF MOTHER

(State or Country)

Idaho

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

H. J. Crofts
Shelley, Idaho

(Address)

15.

Filed 14 1914 Edwin C. Crites
Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH Sept 29 1913
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from Sept 28 1913, to Sept 29 1913, that I last saw her alive on Sept 29 1913, and that death occurred on the date stated above, at 4 P M.

The CAUSE OF DEATH* was as follows:

Baby was always very weak - died sudden
no diagnosis of cause
(Duration) _____ yrs. _____ mos. _____ ds.

Contributory (Secondary)

(Duration) _____ yrs. _____ mos. _____ ds.
(Signed) F. M. Crofts M. D.

Jan 14 1914 (Address) Shelley, Idaho

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death _____ yrs. _____ mos. _____ days. In the State _____ yrs. _____ mos. _____ days.

Where was disease contracted if not at place of death?

Former or usual residence.

19. PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

Shelley 9-30 1913
20. UNDERTAKER _____ ADDRESS _____

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Form V. S. No. 5 20M.1-16-12

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH

Registration District No. 69

County of Bingham

Primary Registration District No. 2147

City of Idaho Falls

(No. _____ St.)

File No. 6508

Registered No. _____

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME William Harmon

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX Male 4. COLOR OR RACE White 5. SINGLE, MARRIED, WIDOWED OR DIVORCED Married
(Write the word.)

6. DATE OF BIRTH Sept 25 1982
(Month) (Day) (Year)

7. AGE 31 yrs. 2 mos. 23 ds.
IF LESS than 1 day how many hrs. or mins.?

8. OCCUPATION
(a) Trade, profession or particular kind of work Farmer
(b) General nature of industry, business, or establishment in which employed (or employer)

9. BIRTHPLACE (State or Country) Connell Iowa

10. NAME OF FATHER John Harmon

11. BIRTHPLACE OF FATHER (State or Country) Idaho

12. MAIDEN NAME OF MOTHER Marcy Thomas

13. BIRTHPLACE OF MOTHER (State or Country) Idaho

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Flornice M. Harmon
(Address) Shelley, Ida.

15. Filed 12-21-1913 Edwin Cutler
Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH Dec 18 1913
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from Dec 18 1913 to Dec 18 1913, that I last saw him alive on Dec 18 1913, and that death occurred on the date stated above, at 10 P.M.
The CAUSE OF DEATH* was as follows:

Diabetic's Mel
about 2 yrs. mos. ds.
(Duration)

Contributory (Secondary) ✓
(Duration) 2 yrs. mos. ds.
(Signed) Dr. Robert M. D.
Dec 20 1913 (Address) Shelley Idaho

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death 2 yrs. mos. days. In the State 2 yrs. mos. days.
Where was disease contracted if not at place of death?
Former or usual residence _____

19. PLACE OF BURIAL OR REMOVAL Idaho Falls. DATE OF BURIAL 12-21-1913

20. UNDERTAKER Ed Hunt ADDRESS Idaho Falls

Form V. S. No. 5 20M.1-16-12

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH

Registration District No. 69

County of Blaine

Primary Registration District No. 2147

City of Shelley

(No.)

(St.)

File No. 6509

Registered No.

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

Maudie E. Rice

PERSONAL AND STATISTICAL PARTICULARS

3. SEX

4. COLOR OR RACE

5. SINGLE, MARRIED, WIDOWED OR DIVORCED.

6. DATE OF BIRTH

Oct. 23 1866

(Month)

(Day)

(Year)

7. AGE

47 yrs. 1 mos. 10 ds.

IF LESS than 1 day
how many hrs. or
..... mins.?

8. OCCUPATION

(a) Trade, profession or particular kind of work

House wife

(b) General nature of industry business, or establishment in which employed (or employer)

9. BIRTHPLACE

(State or Country)

Ind.

10. NAME OF FATHER

William Strickland

11. BIRTHPLACE OF FATHER

(State or Country)

Ind.

12. MAIDEN NAME OF MOTHER

Mary E. Pratt

13. BIRTHPLACE OF MOTHER

(State or Country)

Ind.

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

Fred Rice

(Address)

Shelley Idaho

15.

Filed

12-3-1913

Ed. Custer M.D.

Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH

Dec. 3

(Month)

(Day)

1913 (Year)

17. I HEREBY CERTIFY, That I attended deceased from

Oct. 21 1913, to Dec. 3 1913

that I last saw her alive on Oct. 30 1913

and that death occurred on the date stated above, at 6:20 P.M.

The CAUSE OF DEATH* was as follows:

Obstruction of Lf. maxillary

(Duration) 18 yrs. mos. ds.

Contributory

(Secondary)

(Duration) 7 yrs. mos. ds.

(Signed)

F. J. Roberts M. D.

Dec. 3 1913 (Address) Shelley Idaho

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL OR HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place

of death yrs. mos. days.

In the

State yrs. mos. days.

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

Goshute

12-4-1913

20. UNDERTAKER

ADDRESS

M. D.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Form V. S. No. 5 20M.1-16-12

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH.

Registration District No.

County of Bingham

Primary Registration District No.

City of Shelley

(No., St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

Dural Wayne WeedingFile No. 6510

Registered No.

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX

Male

4. COLOR OR RACE

White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED.

Single
(Write the word.)

6. DATE OF BIRTH

9

(Month)

25

(Day)

1913

(Year)

7. AGE

32ds.

IF LESS than 1 day
how many hrs. or
..... mins.

8. OCCUPATION

(a) Trade, profession or particular kind of work

A babe

(b) General nature of industry, business, or establishment in which employed (or employer)

9. BIRTHPLACE

(State or Country)

Firth Idaho

10. NAME OF FATHER

Chas. G. Weeding

11. BIRTHPLACE OF FATHER

(State or Country)

Utah

12. MAIDEN NAME OF MOTHER

Mauda H. Salverson

13. BIRTHPLACE OF MOTHER

(State or Country)

Hyrum Utah

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

Caroline Hansen

(Address)

Firth Idaho

15.

Filed 12-28th1913Edwin Corder

Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH

12

(Month)

27

(Day)

1913

(Year)

17. I HEREBY CERTIFY, That I attended deceased from

191

to

191

that I last saw h. alive on

191

and that death occurred on the date stated above, at

M.

The CAUSE OF DEATH* was as follows:

Indigestion

(Duration) yrs. mos. ds.

Contributory

(Secondary)

(Duration) yrs. mos. ds.

(Signed)

Dr. Physician

M. D.

19. (Address) Employed

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL OR HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death yrs. mos. days. In the State yrs. mos. days.

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

Firth12-28 1913

20. UNDERTAKER

ADDRESS

None employed

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Form V. S. No. 5 20M.1-16-12

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH.

Registration District No. 69County of BinghamPrimary Registration District No. 2147City of Blackfoot

(No. _____)

St.)

File No. 6511

Registered No. _____

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

Eli Lyon

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX

m.

4. COLOR OR RACE

white

5. SINGLE, MARRIED, WIDOWED OR DIVORCED.

single
(Write the word.)

6. DATE OF BIRTH

11 - 23 - 1913
(Month) (Day) (Year)

7. AGE

____ yrs. ____ mos. ____ ds.

IF LESS than 1 day
how many 10 hrs. or
____ mins.

8. OCCUPATION

(a) Trade, profession or particular kind of work

None (at home)

(b) General nature of industry business, or establishment in which employed (or employer)

9. BIRTHPLACE

(State or Country)

Basalt Idaho

10. NAME OF FATHER

J J Lyons

11. BIRTHPLACE OF FATHER

(State or Country)

Idaho

12. MAIDEN NAME OF MOTHER

Helen H. Singleton

13. BIRTHPLACE OF MOTHER

(State or Country)

S. L. City Utah

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

J J Lyons

(Address)

208 S. Shelly

15.

Filed 11 - 24 - 1913Edwin Cook
Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH

11 - 23 - 1913
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from

1913, to 1913,
that I last saw him alive on 1913,

and that death occurred on the date stated above, at 1 P.M.

The CAUSE OF DEATH* was as follows:

Convulsions

(Duration) ____ yrs. ____ mos. ____ ds.

Contributory
(Secondary)Prenatal birth

(Duration) ____ yrs. ____ mos. ____ ds.

(Signed)

Alvin Benson M.D.19 (Address) Shelly R.D. #1

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death ____ yrs. ____ mos. ____ days. In the State ____ yrs. ____ mos. ____ days.

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

Basalt - Ida11 - 24 1913

20. UNDERTAKER

ADDRESS

None

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Form V. S. No. 5 20M.1-16-12

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH.

Registration District No. 69County of BinghamPrimary Registration District No. 2147City of Shelley

(No. _____, St.)

File No. 6512

Registered No. _____

If death occurs away from usual residence, give facts called for under special information.

FULL NAME

Richard James Maguire

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX

4. COLOR OR RACE

5. SINGLE, MARRIED, WIDOWED OR DIVORCED

MaleWhiteMarried
(Write the word.)

6. DATE OF BIRTH

Nov.
(Month)4th
(Day)1881
(Year)

7. AGE

32 yrs. - mos. 24 ds.IF LESS than 1 day
how many hrs. or
..... mins.?

8. OCCUPATION

(a) Trade, profession or particular kind of work

Druggist

(b) General nature of industry business, or establishment in which employed (or employer)

9. BIRTHPLACE

(State or Country)

Nebraska

10. NAME OF FATHER

Martin J. Maguire

11. BIRTHPLACE OF FATHER

(State or Country)

Sharon N. York

12. MAIDEN NAME OF MOTHER

Johanna McVey

13. BIRTHPLACE OF MOTHER

(State or Country)

Ireland

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

J. R. J. Maguire

(Address)

Heon, Idaho

15.

Filed 11-30-1913Edwin C. Hunter
Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH

Nov.291913

(Month)

(Day)

(Year)

17. I HEREBY CERTIFY, That I attended deceased from

191311-291913that I last saw him alive on 11-28 1913and that death occurred on the date stated above, at 2 A.M.

The CAUSE OF DEATH* was as follows:

Apoplexy

(Duration)

yrs.

mos.

ds.

Contributory
(Secondary)Overwork

(Duration)

yrs.

mos.

ds.

(Signed)

Edwin C. Hunter M. D.

(Address)

Shelley, Idaho

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place

of death

yrs.

mos.

days

In the

State

yrs.

mos.

days

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

Idaho Falls12-2-1913

20. UNDERTAKER

ADDRESS

G. H. HuntIdaho Falls

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Form V. S. No. 5 20M.1-16-12

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH.

Registration District No.

County of Bingham

Primary Registration District No.

City of Basalt

(No., St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

Mary Ann Johnson

File No. 6513

Registered No.

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX

F

4. COLOR OR RACE

W.

5. SINGLE, MARRIED, WIDOWED OR DIVORCED

Married
(Write the word.)

6. DATE OF BIRTH

July 24 - 1857
(Month) (Day) (Year)

7. AGE

56 yrs. 5 mos. 3 ds.

IF LESS than 1 day
how many hrs. or
..... min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work

Laundry Keeper

(b) General nature of industry business, or establishment in which employed (or employer)

9. BIRTHPLACE

(State or Country)

Denmark

10. NAME OF FATHER

Nels. Sorenson

11. BIRTHPLACE OF FATHER

(State or Country)

Denmark

12. MAIDEN NAME OF MOTHER

Christine ?

13. BIRTHPLACE OF MOTHER

(State or Country)

Denmark

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

John Johnson
Basalt, Idaho

15.

Filed 11-28- 1913

Edwin Cullen

Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

11 - 27 - 1913
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from

11-20- 1913, to 11-27- 1913,

that I last saw her alive on 11-25- 1913,

and that death occurred on the date stated above, at 6 A. M.

The CAUSE OF DEATH was as follows:

Sp. poplexy

(Duration) yrs. mos. 7 - ds.

Contributory (Secondary)

Nephritis

(Duration) 3 yrs. mos. ds.

(Signed)

Edwin Cullen M. D.

11-28 1913 (Address) Shelley Idaho

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death yrs. mos. days. In the State yrs. mos. days.

Where was disease contracted if not at place of death?

John Johnson

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

Basalt

11-30 1913

20. UNDERTAKER

ADDRESS

none

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Form V. S. No. 5 20M.1-16-12

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics
File No. **6514**
Registered No. _____

1. PLACE OF DEATH.

Registration District No. _____

County of Bingham

Primary Registration District No. _____

City of Shelley

(No. _____ St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

Sarah Porter

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX

Female

4. COLOR OR RACE

White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED.

Married
(Write the word.)

6. DATE OF BIRTH

Sept 25 1884
(Month) (Day) (Year)

7. AGE

66 yrs. 1 mos. 25 ds.

IF LESS than 1 day
how many hrs. or
..... mins.?

8. OCCUPATION

- (a) Trade, profession or particular kind of work
(b) General nature of industry business, or establishment in which employed (or employer)

Housewife

9. BIRTHPLACE

(State or Country)

Iowa

10. NAME OF FATHER

William Ferguson

11. BIRTHPLACE OF FATHER

(State or Country)

Iowa

12. MAIDEN NAME OF MOTHER

Mary Henderson

13. BIRTHPLACE OF MOTHER

(State or Country)

Iowa

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

S. Porter

(Address)

Shelley Idaho

15.

Filed 11-21 1913

Edwin Cullen
Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH

Nov 20 1913
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from Nov 13 1913 to Nov 20 1913

that I last saw her alive on Nov 20 1913

and that death occurred on the date stated above, at 6:24 M.

The CAUSE OF DEATH* was as follows:

Paroxysms of Right
kidney
most persistent mos. ds.

Contributory old age and
(Secondary) original periton.
(Duration) yrs. mos. ds.

(Signed) J. W. Roberts M. D.
Nov 20 1913 (Address) Shelley Idaho

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death yrs. mos. 2 days. In the State yrs. mos. 11 days.

Where was disease contracted if not at place of death? ✓

Former or usual residence Granby Iowa

19. PLACE OF BURIAL OR REMOVAL

Granby Iowa

DATE OF BURIAL

Shipped 1913

20. UNDERTAKER

G. H. Hunt

ADDRESS

Idaho Falls

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Form V. S. No. 5. 10M. 6-20-11.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics
File No. 6516

1. PLACE OF DEATH.
County of Ada
City of Meridian
If death occurs away from usual residence, give facts called for under special information.

Registration District No. 1
Primary Registration District No. 2083
(No. , St.)

2. FULL NAME
No Arthur Ballard
If death occurred in a hospital, institution or camp give its NAME instead of street and number.

Registered No.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX male
4. COLOR OR RACE white
5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.)

6. DATE OF BIRTH April 20 1913
(Month) (Day) (Year)

7. AGE 8 yrs. 10 mos. 10 ds.
IF LESS than 1 day how many hrs. or min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work
(b) General nature of industry business or establishment in which employed (or employer)

9. BIRTHPLACE Meridian Idaho
(State or Country)

10. NAME OF FATHER Arthur R Ballard

11. BIRTHPLACE OF FATHER Ill.
(State or Country)

12. MAIDEN NAME OF MOTHER Nellie Henry

13. BIRTHPLACE OF MOTHER Mo
(State or Country)

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) H. F. Neal
(Address) Meridian Idaho

15. Filed Jan 1 1914
Q. L. Outton
Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH Dec 31 1913
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from 191 to Dec 31 1913
that I last saw him alive on Dec 31 1913
and that death occurred on the date stated above, at 9 P. M.
The CAUSE OF DEATH was as follows:
Cholera Infantum
(Duration) yrs. mos. ds.
Contributory (Secondary)
(Duration) yrs. mos. ds.
(Signed) H. F. Neal, M. D.
Jan 1 1914 (Address) Meridian Idaho
*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.
18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death. yrs. mos. ds. State. yrs. mos. ds.
Where was disease contracted.
If not at place of death?
Former or usual residence.

19. PLACE OF BURIAL OR REMOVAL Meridian Cemetery
DATE OF BURIAL Jan 1 1914

20. UNDERTAKER J. M. Anderson
ADDRESS Acting.

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Form V. S. No. 5 20M.1-16-12

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH. Registration District No. 1085.
County of Twins Falls Primary Registration District No. _____
City of " " (No. " " St.)

File No. 6517
Registered No. _____

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Thomas Cooney Jr.

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX Male 4. COLOR OR RACE white 5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.)

6. DATE OF BIRTH Dec. 28 1913
(Month) (Day) (Year)

7. AGE _____ yrs. _____ mos. _____ ds. IF LESS than 1 day how many _____ hrs. or _____ mins.

8. OCCUPATION

- (a) Trade, profession or particular kind of work
(b) General nature of industry, business, or establishment in which employed (or employer)

9. BIRTHPLACE Idaho.
(State or Country)

10. NAME OF FATHER Thomas Cooney

11. BIRTHPLACE OF FATHER Colorado.
(State or Country)

12. MAIDEN NAME OF MOTHER Katherine O'Donnell

13. BIRTHPLACE OF MOTHER Ireland
(State or Country)

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Thomas Cooney

(Address) Twins Falls,

15. Filed 12-29 1914 John H. Hughes
Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH Dec 28 1913
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from Dec 28 1913, to Dec 28 1913, that I last saw him alive on Dec 28 1913, and that death occurred on the date stated above, at 11 A.M.

The CAUSE OF DEATH* was as follows:

Premature Birth

(Duration) _____ yrs. _____ mos. _____ ds.
Contributory (Secondary) _____

(Duration) _____ yrs. _____ mos. _____ ds.
(Signed) Dr. M. C. Alexander M. D.
Dec 28 1913 (Address) Twins Falls, Idaho

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death _____ yrs. _____ mos. _____ days. In the State _____ yrs. _____ mos. _____ days.

Where was disease contracted if not at place of death? _____

Former or usual residence _____

19. PLACE OF BURIAL OR REMOVAL Twins Falls DATE OF BURIAL Dec 29 1913

20. UNDERTAKER John H. Hughes ADDRESS Twins Falls

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Form V. S. No. 5 20M.1-16-12

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics
File No. **6518**

1. PLACE OF DEATH
County of **Twin Falls** Registration District No. **1085**
City of **Idaho Falls** (No. _____ St.)
Primary Registration District No. _____

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME **Marion Albert Estling**

Registered No. _____
If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX **Male** 4. COLOR OR RACE **White** 5. SINGLE, MARRIED, WIDOWED OR DIVORCED. **Single**

6. DATE OF BIRTH **May 10 1913**
(Month) (Day) (Year)

7. AGE **7 yrs. 7 mos. 8 ds.**
IF LESS than 1 day how many hrs. or mins.?

8. OCCUPATION
(a) Trade, profession or particular kind of work **Carpenter**
(b) General nature of industry, business, or establishment in which employed (or employer)

9. BIRTHPLACE **Idaho**
(State or Country)

10. NAME OF FATHER **Albert Estling**

11. BIRTHPLACE OF FATHER **Wis.**
(State or Country)

12. MAIDEN NAME OF MOTHER **Mary Burgin**

13. BIRTHPLACE OF MOTHER **Iowa**
(State or Country)

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) **Albert Estling**
(Address) **Twin Falls**

15. Filed **12-24** 191**4** **John H. Engelder**
Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH **Dec. 23 1913**
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from **Dec. 22 1913**, to **Dec. 23 1913**
that I last saw him alive on **Dec. 23 1913**
and that death occurred on the date stated above, at **10 A.M.**

The CAUSE OF DEATH* was as follows:
Intestinal obstruction

(Duration) yrs. mos. **3** ds.
Contributory (Secondary)

(Duration) yrs. mos. ds.
(Signed) **W. H. C. M. D.**

Dec. 18 1913 (Address) **Twin Falls, Idaho**

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death yrs. mos. days. In the State yrs. mos. days.

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL **Twin Falls, Ida** DATE OF BURIAL **Dec 24 1913**

20. UNDERTAKER **J. J. Grosman** ADDRESS **717**

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Form V. S. No. 5 20M.1-16-12

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH

Registration District No. 1085

County of Twin Falls

Primary Registration District No.

File No. 6519

City of

(No. St.)

Registered No.

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

George W. Nipper

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX

4. COLOR OR RACE

5. SINGLE, MARRIED, WIDOWED OR DIVORCED

Male

White

Single (Use word.)

6. DATE OF BIRTH

Jan. 13

(Month)

1913

(Day)

(Year)

7. AGE

yrs. 11 mos. 3 ds.

IF LESS than 1 day
how many hrs. or
..... mins.?

8. OCCUPATION

- (a) Trade, profession or particular kind of work
(b) General nature of industry business, or establishment in which employed (or employer)

9. BIRTHPLACE

(State or Country)

Idaho

10. NAME OF FATHER

G. W. Nipper

11. BIRTHPLACE OF FATHER

(State or Country)

Idaho

12. MAIDEN NAME OF MOTHER

Pearl Cronbey

13. BIRTHPLACE OF MOTHER

(State or Country)

Idaho

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

(Address)

G. W. Nipper
Twin Falls, Idaho

15.

Filed

2-17

1913

J. W. Beglar
Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

Dec. 16

(Month)

(Day)

1913

(Year)

17. I HEREBY CERTIFY, That I attended deceased from

Dec. 16

1913

to Dec. 16

1913

that I last saw him alive on Dec. 16 1913

and that death occurred on the date stated above, at M.

The CAUSE OF DEATH* was as follows:

Strangulation - due to apple
in the neck

(Duration) Immediate mos. ds.

Contributory
(Secondary)

(Duration) yrs. mos. ds.

(Signed) J. W. Beglar M. D.

Dec. 16 1913 (Address)

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death yrs. mos. days. In the State yrs. mos. days.

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

Twin Falls

Dec. 18 1913

20. UNDERTAKER

ADDRESS

J. F. Grossman Twin Falls

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Form V. S. No. 5. 12½ M. 7-24-11

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics
File No. 6520
Registered No. _____

1. PLACE OF DEATH. Registration District No. 185
County of Twins Falls Primary Registration District No. _____
City of Twins Falls (No. _____, St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

Gordon Ray Rasmussen

If death occurred in a hospital, institution or camp give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX M 4. COLOR OR RACE W 5. SINGLE, MARRIED, WIDOWED OR DIVORCED. Single
(Write the word.)

6. DATE OF BIRTH Sept 20 1908
(Month) (Day) (Year)

7. AGE 5 yrs. 2 mos. 3 ds. IF LESS than 1 day
how many _____ hrs. or _____ min?

8. OCCUPATION

- (a) Trade, profession or particular kind of work.
(b) General nature of industry business or establishment in which employed (or employer)

9. BIRTHPLACE
(State or Country) Utah

10. NAME OF FATHER Jac. H. Rasmussen

11. BIRTHPLACE OF FATHER
(State or Country) Denmark

12. MAIDEN NAME OF MOTHER Beatrice Casper

13. BIRTHPLACE OF MOTHER
(State or Country) Utah

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Jac. H. Rasmussen
(Address) Burley

15. Filed 12-2 1913 John D. Hughes
Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH Dec. 1st 1913
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from Nov. 31 1913, to Dec. 1st 1913
that I last saw him alive on Dec. 1st 1913
and that death occurred on the date stated above, at 1:30 P. M.
The CAUSE OF DEATH* was as follows:
Guns shot.

(Duration) _____ yrs. _____ mos. 1 ds.
Contributory (Secondary) _____
(Duration) _____ yrs. _____ mos. _____ ds.
(Signed) R. A. Stoen M. D.
_____ 19 _____ (Address) Burley

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place _____ In the _____
of death _____ yrs. _____ mos. _____ ds. State _____ yrs. _____ mos. _____ ds.
Where was disease contracted,
If not at place of death? _____
Former or
usual residence. _____

19. PLACE OF BURIAL OR REMOVAL DATE OF BURIAL

Burley Dec 4 1913
20. UNDERTAKER J. J. Groenewald ADDRESS Twins Falls

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Form V. S. No. 5 20M.1-16-12

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH

Registration District No. 1085

County of

Primary Registration District No.

File No. 6521

City of

(No. , St.)

Registered No.

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX

4. COLOR OR RACE

5. SINGLE, MARRIED, WIDOWED OR DIVORCED

6. DATE OF BIRTH

7. AGE

IF LESS than 1 day
how many hrs. or
..... mins.

8. OCCUPATION

(a) Trade, profession or particular kind of work

(b) General nature of industry, business, or establishment in which employed (or employer)

9. BIRTHPLACE

(State or Country)

10. NAME OF FATHER

11. BIRTHPLACE OF FATHER

(State or Country)

12. MAIDEN NAME OF MOTHER

13. BIRTHPLACE OF MOTHER

(State or Country)

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

(Address)

15.

Filed

2-23

1913

Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

Dec. 21 1913
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from Dec 15 1913, to Dec 21 1913,

that I last saw him alive on Dec 21 1913,

and that death occurred on the date stated above, at 3 P. M.

The CAUSE OF DEATH* was as follows:

Pneumonia (Catarrhal)

(Duration) yrs. mos. 12 ds.

Contributory
(Secondary)

(Duration) yrs. mos. ds.

(Signed) H. W. Wilson M. D.

Dec 19 1913 (Address) Twin Falls, Idaho

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death. yrs. mos. days. In the State. yrs. mos. days.

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

Twin Falls

Dec. 23 1913

20. UNDERTAKER

ADDRESS

H. P. Groverman Twin Falls

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Form V. S. No. 5 20M.1-16-12

CERTIFICATE OF DEATH

1. PLACE OF DEATH _____ Registration District No. 1085
County of Twiss Falls Primary Registration District No. _____
City of " " (No. _____ St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME John V. Delaney

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics
File No. 6522
Registered No. _____

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX Male 4. COLOR OR RACE white 5. SINGLE, MARRIED, WIDOWED OR DIVORCED. Married

6. DATE OF BIRTH March 16 1860
(Month) (Day) (Year)

7. AGE 53 yrs. 9 mos. 4 ds.
IF LESS than 1 day how many hrs. or mins.?

8. OCCUPATION
(a) Trade, profession or particular kind of work Laborer
(b) General nature of industry, business, or establishment in which employed (or employer) Farm

9. BIRTHPLACE New York
(State or Country)

10. NAME OF FATHER William Delaney

11. BIRTHPLACE OF FATHER Ireland
(State or Country)

12. MAIDEN NAME OF MOTHER Bridget Caswell

13. BIRTHPLACE OF MOTHER Ireland
(State or Country)

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) James B. Delaney
(Address) Saratoga, Wyoming

15. Filed 12-23 1913 John C. Bunker
Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH Dec 21 1913
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from Dec. 8 - 1913, to Dec 21 - 1913, that I last saw him alive on Dec 21 - 1913, and that death occurred on the date stated above, at 7:45 A.M.
The CAUSE OF DEATH* was as follows:

Bronchial pneumonia
(Duration) yrs. mos. 8 ds.

Contributory Arterio-sclerosis
(Secondary)
(Duration) 10 yrs. mos. ds.
(Signed) D. L. Alexander M. D.
Dec 22 1913 (Address) Twiss Falls Idaho

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death yrs. mos. days. In the State yrs. mos. days.

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL Twiss Falls DATE OF BURIAL Dec 22 1913
20. UNDERTAKER J. J. Foxman ADDRESS Twiss Falls

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Form V. S. No. 5 20M.1-16-12

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH.

Registration District No. 1085

County of Twin Falls

Primary Registration District No. _____

City of Twin Falls

(No. _____, St.)

File No. 11-6523

Registered No. _____

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Mrs Martha Wall Carver

PERSONAL AND STATISTICAL PARTICULARS

3. SEX

Female

4. COLOR OR RACE

White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED.

Widowed

6. DATE OF BIRTH

July 3^d 1895
(Month) (Day) (Year)

7. AGE

78 yrs. 5 mos. 9 ds.

IF LESS than 1 day
how many _____ hrs. or
_____ mins.?

8. OCCUPATION

- (a) Trade, profession or particular kind of work
(b) General nature of industry, business, or establishment in which employed (or employer)

9. BIRTHPLACE

(State or Country)

Columbus, Ohio

10. NAME OF FATHER

Henry B. Carver

11. BIRTHPLACE OF FATHER

(State or Country)

New York

12. MAIDEN NAME OF MOTHER

Rebecca Harold

13. BIRTHPLACE OF MOTHER

(State or Country)

Idaho

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

Leroy G. Hagan

(Address)

Twin Falls, Ida

15.

Filed 12-13 1913

3

John C. Hagan
Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

December 12 1913
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from Dec 5 1913, to Dec 12 1913, that I last saw him alive on Dec 12 1913, and that death occurred on the date stated above, at 10:30 AM.

The CAUSE OF DEATH was as follows:

Broncho pneumonia

(Duration) _____ yrs. _____ mos. 7 ds.

Contributory Chronic bronchitis
(Secondary)

(Duration) 10 yrs. _____ mos. _____ ds.

(Signed) D. L. Alexander M. D.

Dec 13 1913. (Address) Twin Falls, Idaho

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death _____ yrs. _____ mos. _____ days. In the State _____ yrs. _____ mos. _____ days.

Where was disease contracted if not at place of death?

Former or usual residence _____

19. PLACE OF BURIAL OR REMOVAL

Twin Falls

DATE OF BURIAL

12-14 1913

20. UNDERTAKER

C. J. Hagan

ADDRESS

Twin Falls

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Form V. S. No. 5 20M.1-16-12

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH. Registration District No. 7085
County of Lewis Falls Primary Registration District No. _____
City of Hausen (No. _____, St.) _____

File No. 6524
Registered No. _____

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Elmer Van Horn Calhoun

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX M 4. COLOR OR RACE white 5. SINGLE, MARRIED, WIDOWED OR DIVORCED. single

6. DATE OF BIRTH Dec 19 1917
(Month) (Day) (Year)

7. AGE 12 yrs. 11 mos. 17 ds.
IF LESS than 1 day how many hrs. or mins.?

8. OCCUPATION
(a) Trade, profession or particular kind of work School boy
(b) General nature of industry, business, or establishment in which employed (or employer) four

9. BIRTHPLACE
(State or Country) Colorado

10. NAME OF FATHER Walter J. Calhoun

11. BIRTHPLACE OF FATHER
(State or Country) Iowa

12. MAIDEN NAME OF MOTHER Hannetta Barnes

13. BIRTHPLACE OF MOTHER
(State or Country) Iowa

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) W. J. Calhoun
(Address) Hausen Ida

15. Filed 12-8 1913 John H. Engler
Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH Dec 8 1913
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from Nov 15 1913 to Dec 8 1913, that I last saw him alive on Dec 6 1913, and that death occurred on the date stated above, at 3 PM.

The CAUSE OF DEATH* was as follows:

typhoid
(Duration) yrs. mos. ds.
Contributory (Secondary)
(Duration) yrs. mos. ds.
(Signed) H. Groves D.
19 (Address) Lewis Falls, Idaho

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death yrs. mos. days. In the State yrs. mos. days.

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL Lewis Falls DATE OF BURIAL Dec 9 1913

20. UNDERTAKER H. Groves ADDRESS Lewis Falls

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Form V. S. No. 5 20M.1-16-12

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH
County of *Twin Falls*
City of _____

Registration District No. *2085*
Primary Registration District No. _____
(No. _____ St.)

File No. *6525*
Registered No. _____

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME *No Name*

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX *Female* 4. COLOR OR RACE *White* 5. SINGLE, MARRIED, WIDOWED OR DIVORCED. *(Write the word.)*

6. DATE OF BIRTH *Dec 19* 1913
(Month) (Day) (Year)

7. AGE *X* yrs. *X* mos. *7* ds. IF LESS than 1 day how many *48* hrs. or *mins.*

8. OCCUPATION
(a) Trade, profession or particular kind of work _____
(b) General nature of industry business, or establishment in which employed (or employer) _____

9. BIRTHPLACE *Twin Falls County*
(State or Country)

10. NAME OF FATHER *Carl Nelson*

11. BIRTHPLACE OF FATHER *Sweden*
(State or Country)

12. MAIDEN NAME OF MOTHER *Rueie Boehen*

13. BIRTHPLACE OF MOTHER *Ill*
(State or Country)

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) *Carl Nelson*
(Address) *Twin Falls P.O. # 1*

15. Filed *12-23* 1913 *John Hughes*
Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH *Dec 21* 1913
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from *Dec 19* 1913, to *Dec 21* 1913, that I last saw her alive on *Dec 21* 1913, and that death occurred on the date stated above, at *5 P.M.*

The CAUSE OF DEATH* was as follows:
Premature babe

(Duration) _____ yrs. _____ mos. _____ ds.
Contributory (Secondary) _____

(Duration) _____ yrs. _____ mos. _____ ds.
(Signed) *J. R. Morgan* M. D.
Dec 21, 1913. (Address) *Twin Falls, Ide.*

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death _____ yrs. _____ mos. _____ days. In the State _____ yrs. _____ mos. _____ days.
Where was disease contracted if not at place of death? _____
Former or usual residence _____

19. PLACE OF BURIAL OR REMOVAL *Twin Falls* DATE OF BURIAL *Dec 23* 1913

20. UNDERTAKER *C. Kroachy* ADDRESS *Twin Falls*

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Form V. S. No. 5 20M.1-16-12

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics
File No. **5-6526**
Registered No. _____

1. PLACE OF DEATH.

Registration District No. **2**

County of **Ada**

Primary Registration District No. **1004**

City of **Boise**

(No. **2nd Lincoln** St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME, **Annie J. Foster**

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX **Female**

4. COLOR OR RACE **White**

5. SINGLE, MARRIED, WIDOWED OR DIVORCED. **Married**
(Write the word.)

6. DATE OF BIRTH **March 28 1856**
(Month) (Day) (Year)

7. AGE **57 yrs. 2 mos. 2 ds.**

IF LESS than 1 day
how many hrs. or
..... mins.

8. OCCUPATION

(a) Trade, profession or particular kind of work **Housewife**

(b) General nature of industry, business, or establishment in which employed (or employer)

9. BIRTHPLACE **Ind.**
(State or Country)

10. NAME OF FATHER **Chas. Biggs**

11. BIRTHPLACE OF FATHER **Am.**
(State or Country)

12. MAIDEN NAME OF MOTHER **M. Bennett**

13. BIRTHPLACE OF MOTHER **Am.**
(State or Country)

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) **J. T. Foster**

(Address) **Bo Boise**

15.

Filed **Nov 6 1913**

M. Parker

Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH **Nov. 4 1913**
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from **Oct 30 1913**, to **Nov. 4 1913**, that I last saw her alive on **Nov 4 1913**, and that death occurred on the date stated above, at **8 P. M.**

The CAUSE OF DEATH* was as follows:

Peritonitis - Appendicitis - Int.

(Duration) yrs. mos. **6** ds.

Contributory (Secondary)

(Duration) yrs. mos. ds.

(Signed) **William H. Vukobrat**

Nov 5 1913

(Address) **Boise Ida**

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death yrs. mos. days. In the State yrs. mos. days.

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL, DATE OF BURIAL **Harris Hill Cemetery 11/6 1913**

20. UNDERTAKER **Schreiber & Videngaden**

ADDRESS **Boise**

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH.
County of Ada
City of Boise

Registration District No. 2
Primary Registration District No. 1004
(No. 815 Reseque St.)

File No. 270
Registered No. 6527

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME William Richardson

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX M 4. COLOR OR RACE W 5. SINGLE, MARRIED, WIDOWED OR DIVORCED. Married
(Write the word.)

6. DATE OF BIRTH Mar 16 1913
(Month) (Day) (Year)

7. AGE 74 yrs. 7 mos. 19 ds.
IF LESS than 1 day how many hrs. or mins.?

8. OCCUPATION
(a) Trade, profession or particular kind of work Teamster
(b) General nature of industry business, or establishment in which employed (or employer)

9. BIRTHPLACE Ills.
(State or Country)

10. NAME OF FATHER James Richardson

11. BIRTHPLACE OF FATHER Scotland
(State or Country)

12. MAIDEN NAME OF MOTHER Jane Miller

13. BIRTHPLACE OF MOTHER Scotland
(State or Country)

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Mrs. Mary Richardson
(Address)

15. Filed 11-7 1913 M. S. Parker
Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH Nov 6 1913
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from Sept. 6 1913, to Nov. 6 1913, that I last saw him alive on Nov. 3 1913, and that death occurred on the date stated above, at M.

The CAUSE OF DEATH* was as follows:
Chronic pyelonephritis
Nephritis

(Duration) 50 yrs. — mos. — ds.
Contributory (Secondary)
(Duration) Wm. Turkey yrs. — mos. — ds.
(Signed) Wm. Turkey M. D.
Nov 6 1913 (Address) Boise Idaho

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death... yrs... mos... days. In the State... yrs... mos... days.
Where was disease contracted if not at place of death?
Former or usual residence 815 Reseque St.

19. PLACE OF BURIAL OR REMOVAL Morris Hill Cemetery DATE OF BURIAL 11/7 1913

20. UNDERTAKER Schreiber & Sidney ADDRESS Boise

Turkey.

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Form V. S. No. 5 20M.1-16-12

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics
File No. **6528**
Registered No. _____

1. PLACE OF DEATH. Registration District No. _____
County of Ada Primary Registration District No. 1004
City of Boise (No. 110, East Boise St.)
If death occurs away from usual residence, give facts called for under special information. 2. FULL NAME L. W. Patterson

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX Male 4. COLOR OR RACE White 5. SINGLE, MARRIED, WIDOWED OR DIVORCED. Not obtainable
(Write the word.)

6. DATE OF BIRTH Not obtainable
(Month) (Day) (Year)

7. AGE 62 yrs. _____ mos. _____ ds. IF LESS than 1 day how many _____ hrs. or _____ mins.?

8. OCCUPATION
(a) Trade, profession or particular kind of work Labrador
(b) General nature of industry business, or establishment in which employed (or employer) _____

9. BIRTHPLACE Kansas
(State or Country)

10. NAME OF FATHER Not obtainable

11. BIRTHPLACE OF FATHER "
(State or Country)

12. MAIDEN NAME OF MOTHER "

13. BIRTHPLACE OF MOTHER "
(State or Country)

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Adolph Schreiber
(Address) Boise

15. Filed Nov 8 1913 Mc. Parker
Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH Nov 3rd 1913
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from June 1st 1913, to Nov 3rd 1913, that I last saw him alive on 2nd Nov 1913, and that death occurred on the date stated above, at 7 AM.
The CAUSE OF DEATH* was as follows:

Carcinoma Liver

(Duration) 1 yrs. _____ mos. _____ ds.
Contributory Pneumonia
(Secondary)

(Duration) 15 yrs. _____ mos. _____ ds.
(Signed) R. E. S. Hurst M. D.
19 _____ (Address) Boise Ida

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death _____ yrs. _____ mos. _____ days. In the State _____ yrs. _____ mos. _____ days.

Where was disease contracted if not at place of death? _____

Former or usual residence _____

19. PLACE OF BURIAL OR REMOVAL DATE OF BURIAL
Morris Hill Ada Co. Id. Nov 8 1913

20. UNDERTAKER Schreiber & Hiden ADDRESS Boise

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Form V. S. No. 5 20M.1-16-12

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics
File No. **6530**
Registered No. **20**

1. PLACE OF DEATH.

Registration District No. **41**County of **Senili**Primary Registration District No. **2116**City of **Salmon**

(No. _____ St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

William Stethem

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX

Male

4. COLOR OR RACE

White5. ~~STATUS~~ **WIDOWED****Widowed**
(Write the word.)

6. DATE OF BIRTH

Do not know what month 1850
(Month) (Day) (Year)

7. AGE

63 yrs. mos. ds.IF LESS than 1 day
how many hrs. or mins.?

8. OCCUPATION

(a) Trade, profession or particular kind of work

Quartz Miner

(b) General nature of industry, business, or establishment in which employed (or employer)

9. BIRTHPLACE

(State or Country)

Ireland

10. NAME OF FATHER

Do not know

11. BIRTHPLACE OF FATHER

(State or Country)

Ireland

12. MAIDEN NAME OF MOTHER

Do not know

13. BIRTHPLACE OF MOTHER

(State or Country)

Ireland

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

E. K. Abbott

(Address)

Salmon Ida.

15.

Filed

12-29

1913

W. L. Smith

Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH

December 21
(Month) (Day) (Year)17. I HEREBY CERTIFY, That I attended deceased from **Dec 19** 1913, to **Dec 21** 1913,that I last saw him alive on **Dec 21** 1913, and that death occurred on the date stated above, at **10 P.M.**

The CAUSE OF DEATH* was as follows:

Coronal Hemorrhage(Duration) yrs. mos. **3** ds.

Contributory (Secondary)

Had valve replacement

(Duration) yrs. mos. ds.

(Signed)

J. S. Wright

M. D.

Dec 23 1913

(Address)

Salmon

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death.....yrs.....mos.....days. In the State.....yrs.....mos.....days.

Where was disease contracted if not at place of death?.....

Former or usual residence.....

19. PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

Salmon Cemetery**Dec-23** 1913

20. UNDERTAKER

ADDRESS

W. C. Daehler**Salmon****Idaho**

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Form V. S. No. 5 20M.1-16-12

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH

Registration District No. 41County of LemhiPrimary Registration District No. 2116City of Salmon

(No. _____ St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

Joseph P. WardFile No. 6531Registered No. 21

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX

Male

4. COLOR OR RACE

White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED

Married
(Write the word.)

6. DATE OF BIRTH

June 17th 1887
(Month) (Day) (Year)

7. AGE

56 yrs. 6 mos. _____ ds.

IF LESS than 1 day
how many _____ hrs. or
_____ mins.?

8. OCCUPATION

(a) Trade, profession or particular kind of work

Saloon keeper

(b) General nature of industry business, or establishment in which employed (or employer)

9. BIRTHPLACE

(State or Country)

Wisconsin

10. NAME OF FATHER

James Ward

11. BIRTHPLACE OF FATHER

(State or Country)

Ireland

12. MAIDEN NAME OF MOTHER

Mary Burke

13. BIRTHPLACE OF MOTHER

(State or Country)

Ireland

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

Emerson Hill

(Address)

Salmon Ida

15.

Filed

December 6, 1913W. C. Smith
Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

Dec 25 1913
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from

Dec 23 1913, to Dec 25 1913,

that I last saw him alive on Dec 25 1913,

and that death occurred on the date stated above, at 11 P.M.

The CAUSE OF DEATH* was as follows:

atrophic cirrhosis
of the liver

about 6 yrs. _____ mos. _____ ds.

Contributory (Secondary)

Edema of lungs(Duration) about 2 yrs. _____ mos. _____ ds.

(Signed)

Chas. F. Hume, M.D.12-26-1913(Address) Salmon, Idaho

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place

of death _____ yrs. _____ mos. _____ days.

In the

State _____ yrs. _____ mos. _____ days.

Where was disease contracted
if not at place of death?

Former or
usual residence

19. PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

Dillon Montana Dec 29 1913

20. UNDERTAKER

ADDRESS

W. C. Hoebe Salmon
Ida

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Form V, S. No. 5. 12½ M. 7-24-11

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics
File No. 6534
Registered No. _____

1. PLACE OF DEATH. Registration District No. 122
County of Shoshone Primary Registration District No. 2200
City of Mullan (No. _____, St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

Agnes Burke

If death occurred in a hospital, institution or camp give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX girl 4. COLOR OR RACE white 5. SINGLE, MARRIED, WIDOWED OR DIVORCED. infant
(Write the word.)

6. DATE OF BIRTH Dec 13 1913
(Month) (Day) (Year)

7. AGE 7 yrs. mos. ds. IF LESS than 1 day how many 9 hrs. or min.

8. OCCUPATION

(a) Trade, profession or particular kind of work
(b) General nature of industry business or establishment in which employed (or employer)

Infant

9. BIRTHPLACE Mullan Idaho
(State or Country)

10. NAME OF FATHER Thomas Burke

11. BIRTHPLACE OF FATHER Ireland
(State or Country)

12. MAIDEN NAME OF MOTHER Winifred McDonnell

13. BIRTHPLACE OF MOTHER Ireland
(State or Country)

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) John Thomas Burke
(Address) Mullan Ida

15. Jan 21 1914 W. M. Mowery
Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH Dec 13 1913
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from Dec 13 1913, to Dec 13 1913
that I last saw her alive on Dec 13 13am 1913
and that death occurred on the date stated above, at 10 A.M.
The CAUSE OF DEATH* was as follows:

Blue Room Heart Failure
The Foreman's valve failed to close

(Duration) 7 hrs. ds.

Contributory (Secondary)

(Duration) 7 yrs. mos. ds.

(Signed) F. W. Rolf M. D.
Dec 13 1913 (Address) Mullan Ida

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place In the
of death 7 yrs. mos. ds. State 7 yrs. mos. ds.
Where was disease contracted,
If not at place of death?
Former or usual residence

19. PLACE OF BURIAL OR REMOVAL Mullan Ida DATE OF BURIAL Dec 13 1913

20. UNDERTAKER ADDRESS

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Form V. S. No. 5. 12½ M. 7-24-11

CERTIFICATE OF DEATH

1. PLACE OF DEATH.

Registration District No. 122

County of Shoshone

Primary Registration District No. 2208

City of Mullan

(No. , St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

Viola Oja

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

File No. 6535

Registered No.

If death occurred in a hospital, institution or camp give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX

F

4. COLOR OR RACE

W

5. SINGLE, MARRIED, WIDOWED OR DIVORCED.

Single

(Write the word.)

6. DATE OF BIRTH

Oct

25

1913

(Month)

(Day)

(Year)

7. AGE

1 yrs. 22 mos. 22 ds.

IF LESS than 1 day
how many hrs. or min?

8. OCCUPATION

- (a) Trade, profession or particular kind of work.
(b) General nature of industry business or establishment in which employed (or employer)

9. BIRTHPLACE

(State or Country)

Mullan Ida.

10. NAME OF FATHER

Victor Oja

11. BIRTHPLACE OF FATHER

(State or Country)

Finland.

12. MAIDEN NAME OF MOTHER

Eva Ojala

13. BIRTHPLACE OF MOTHER

(State or Country)

Finland

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

Mr. Eva Oja

(Address)

Mullan Ida

15.

Filed

1913

Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH

Dec

17

1913

(Month)

(Day)

(Year)

17. I HEREBY CERTIFY, That I attended deceased from

191

to

191

that I last saw h. alive on 191

and that death occurred on the date stated above, at M.

The CAUSE OF DEATH was as follows

Cholera Infantum

(Duration)

yrs.

mos.

ds.

Contributory (Secondary)

(Duration)

yrs.

mos.

ds.

(Signed)

F. W. Polk

M. D.

19

(Address)

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place

In the

of death. yrs. mos. ds. State. yrs. mos. ds.

Where was disease contracted,

If not at place of death?

Former or

usual residence.

19. PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

Mullan Ida

Dec 17

1913

20. UNDERTAKER

ADDRESS

None

WHITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. CLAIMS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. ment of OCCUPATION is very important. See instructions on back of certificate.

Form V, S. No. 5. 12½M.7-24-11

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH.
County of Shoshone
City of Mullan

Registration District No. 122
Primary Registration District No. 2202
(No. _____, _____ St.)

File No. 6536
Registered No.

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Martha U. Apelma

If death occurred in a hospital, institution or camp give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX Female	4. COLOR OR RACE White	5. SINGLE, MARRIED, WID OWED OR DIVORCED. Divorced (Write the word.)
------------------	---------------------------	---

6. DATE OF BIRTH April 15 1856
(Month) (Day) (Year)

7. AGE 3 yrs. 7 mos. 1 ds. IF LESS than 1 day
how many.....hrs. or
min)

8. OCCUPATION

(a) Trade, profession or particular kind of work.....
(b) General nature of industry business or establishment in which employed (or employer)

9. BIRTHPLACE *Torrington Conn*
(State or Country)

10. NAME OF FATHER *Sollman*

11. BIRTHPLACE
OF FATHER *Germany*
(State or Country)

12. MAIDEN NAME
OF MOTHER

13. BIRTHPLACE
OF MOTHER
(State or Country) *Germany*

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Mrs. Ethel Dalton
(Address) Millan Ida

15. *1914* *1* *1914*
Filed *1914* 191 *1* *1914*
Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH Dec 16 1913
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from May 1913, to Dec 16 1913
that I last saw her alive on Dec 16 1913
and that death occurred on the date stated above, at 10 A.M.

The CAUSE OF DEATH* was as follows:

CAUSE OF DEATH - was as follows:
Pleurisy with Pericarditis

..... (Duration) 0 yrs. 9 mos. 14 ds.
Contributory (Secondary) Bright's Disease

..... (Duration) yrs. 8 mos. ds.
(Signed) F. W. Rolfe M. D.
Dec 17 1913 (Address) Mulliken St.

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death.....yrs.....mos.....ds. In the State.....yrs.....mos.....ds.

Where was disease contracted,
If not at place of death?.....

Former or
usual residence.....

19. PLACE OF BURIAL OR REMOVAL	DATE OF BURIAL
Mountain View. Crest Mullen.	Dec 18 1913

20. UNDERTAKER	ADDRESS
Ward's Undertaking Co	Wallace Ave

MARGIN RESERVED FOR BINDING
WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
Item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICAL state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact state-
UPATION is very important. See instructions on back of certificate.

Form V. S. No. 5 20M.1-16-12

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics
File No. 6537

1. PLACE OF DEATH

Registration District No. 123

County of Shoshone

Primary Registration District No. 2202

City of Seeley

(No. 7)

St.)

Registered No. _____

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Josephine Veduck

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX F

4. COLOR OR RACE W.

5. SINGLE, MARRIED, WID-
OWED OR DIVORCED.

married
(Write the word.)

6. DATE OF BIRTH Oct 20 1890

(Month)

(Day)

(Year)

7. AGE 27 yrs. 9 mos. 3 ds.

IF LESS than 1 day
how many hrs. or
..... mins.

8. OCCUPATION

- (a) Trade, profession or particular kind of work
(b) General nature of industry business, or establishment in which employed (or employer)

Housewife

9. BIRTHPLACE

(State or Country)

Austria

10. NAME OF FATHER

Frank Glass

11. BIRTHPLACE OF FATHER

(State or Country)

Austria

12. MAIDEN NAME OF MOTHER

Agnes Jurkovic

13. BIRTHPLACE OF MOTHER

(State or Country)

Bohemia

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

Widuck

Geo. S. Lasher
Deed. Dec 27, 1913

Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH August 13 1913

(Month)

(Day)

(Year)

17. I HEREBY CERTIFY, That I attended deceased from

191... to 191...

that I last saw h... alive on 191...

and that death occurred on the date stated above, at M.

The CAUSE OF DEATH* was as follows:

Consumption

(Duration)

yrs.

mos.

ds.

Contributory
(Secondary)

(Duration)

yrs.

mos.

ds.

(Signed)

M. D.

19

(Address)

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death

.....yrs.mos.days.

In the

State.....yrs.mos.days.

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

Greenwood

Aug. 16 1913

20. UNDERTAKER

ADDRESS

E. B. Kurhille

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Form V. S. No. 5, 10M. 6-20-11.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics
File No. 246538
Registered No. _____

1. PLACE OF DEATH.

Registration District No. 123County of ShoshonePrimary Registration District No. 2202City of Kellogg

(No. _____ St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

Elzior Mycalf

If death occurred in a hospital, institution or camp give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX

M

4. COLOR OR RACE 5. SINGLE, MARRIED, WIDOWED OR DIVORCED.

W.single
(Write the word.)

6. DATE OF BIRTH

Jan
(Month)24
(Day)1910
(Year)

7. AGE

3 yrs. 7 mos. 15 ds.

IF LESS than 1 day
how many _____ hrs. or
_____ min.?

8. OCCUPATION

- (a) Trade, profession or particular kind of work.
(b) General nature of industry business or establishment in which employed (or employer)

9. BIRTHPLACE

(State or Country)

Kellogg, Idaho

10. NAME OF FATHER

La Mycalf

11. BIRTHPLACE OF FATHER

(State or Country)

Michigan

12. MAIDEN NAME OF MOTHER

Georgia Behan

13. BIRTHPLACE OF MOTHER

(State or Country)

Canada

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

(Address)

Kellogg, Idaho

15.

Filed

Aug 9 1913

Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

Sept.
(Month)7
(Day)1913
(Year)

17. I HEREBY CERTIFY, That I attended deceased from

191, to 191that I last saw him alive on Sept. 7 1913,and that death occurred on the date stated above, at M.

The CAUSE OF DEATH* was as follows:

Enteritis

(Duration) _____ yrs. _____ mos. _____ ds.

Contributory
(Secondary)

(Duration) _____ yrs. _____ mos. _____ ds.

(Signed) J. R. Wilson M. D.12/24 1913 (Address) Kellogg

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and 2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place _____ yrs. _____ mos. _____ ds. In the _____ yrs. _____ mos. _____ ds.

Where was disease contracted,

If not at place of death?

Former or

usual residence.

19. PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

GreenwoodSept. 9 1913

20. UNDERTAKER

ADDRESS

W. B. ShanklinKellogg, Ida.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Form V. S. No. 5. 12½ M. 7-24-11

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics
File No. 4 6540
Registered No. _____

1. PLACE OF DEATH. Registration District No. 123
County of Shoshone Primary Registration District No. 2202
City of Keelogg (No. _____, _____ St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Mary Lulu Oresnick

If death occurred in a hospital, institution or camp give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX F 4. COLOR OR RACE White 5. SINGLE, MARRIED, WIDOWED OR DIVORCED. Single
(Write the word.)

6. DATE OF BIRTH July 4 1913
(Month) (Day) (Year)

7. AGE 4 yrs. 19 mos. 19 ds. IF LESS than 1 day how many _____ hrs. or _____ min?

8. OCCUPATION

- (a) Trade, profession or particular kind of work _____
(b) General nature of industry business or establishment in which employed (or employer) _____

9. BIRTHPLACE

(State or Country) Keelogg, Ida.

10. NAME OF FATHER

Joe Oresnick

11. BIRTHPLACE OF FATHER

(State or Country) Austria

12. MAIDEN NAME OF MOTHER

Louise Maunz

13. BIRTHPLACE OF MOTHER

(State or Country) Austria

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) _____
(Address) _____

15. Filed Dec 29 1913 Geo. J. Lecher
Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH Nov 25 1913
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from Nov 24 1913, to Nov 25 1913, that I last saw her alive on Nov 24 1913, and that death occurred on the date stated above, at _____ M.

THE CAUSE OF DEATH* was as follows:

Inflammation of bowels

_____ (Duration) _____ yrs. _____ mos. _____ ds.

Contributory (Secondary)

_____ (Duration) _____ yrs. _____ mos. _____ ds.
(Signed) J. R. Mason M. D.
Nov 25 1913 (Address) Keelogg, Ida.

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place _____ In the _____
of death _____ yrs. _____ mos. _____ ds. State _____ yrs. _____ mos. _____ ds.
Where was disease contracted, _____
If not at place of death? _____
Former or _____
usual residence _____

19. PLACE OF BURIAL OR REMOVAL DATE OF BURIAL

Greenwood Nov. 27 1913

20. UNDERTAKER ADDRESS

E. B. Shanklin Keelogg, Ida.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Form V. S. No. 5 10M. 6-20-11.

1. PLACE OF DEATH.

County of Shoshone

City of Wadsworth

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

Registration District No. 123

Primary Registration District No. 2214

(No. _____ St.)

William Charles Melhorns

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics
File No. 76541

Registered No. _____

If death occurred in a hospital, institution or camp give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX

M

4. COLOR OR RACE

7

5. SINGLE, MARRIED, WIDOWED OR DIVORCED.

married
(Write the word.)

6. DATE OF BIRTH

Aug 15 1847
(Month) (Day) (Year)

7. AGE

66 yrs. 4 mos. 11 ds.

IF LESS than 1 day
how many _____ hrs. or
_____ min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work
(b) General nature of industry business or establishment in which employed (or employer)

Miner

9. BIRTHPLACE

(State or Country)

England

10. NAME OF FATHER

Joseph Melhorns

11. BIRTHPLACE OF FATHER

(State or Country)

England

12. MAIDEN NAME OF MOTHER

Miss Betsey Kern

13. BIRTHPLACE OF MOTHER

(State or Country)

England

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Charles W. Melhorns
(Address) Greenwood

15.

Filed 12/29 1913 Geo. S. Leaker
Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

Dec 26 1913
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from

Dec 18 1913, to Dec 18 1913

that I last saw him alive on Dec 18 1913,

and that death occurred on the date stated above, at _____ M.

The CAUSE OF DEATH* was as follows:

Stroke
(Duration) _____ yrs. _____ mos. _____ ds.

Contributory
(Secondary)

(Duration) _____ yrs. _____ mos. _____ ds.

(Signed) J. R. Nelson M. D.

12/29 1913 (Address) Idaho

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place _____ In the _____
of death _____ yrs. _____ mos. _____ ds. State _____ yrs. _____ mos. _____ ds.
Where was disease contracted,
If not at place of death?
Former or
usual residence _____

19. PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

Greenwood Dec 29 1913

20. UNDERTAKER

ADDRESS

Chas. W. Melhorns Idaho

RECORDING—THIS IS A PERMANENT RECORD. PHYSI-
cally supplied. AGE should be stated EXACTLY. PHYSI-
cal state-
in plain terms, so that it may be properly classified. Exact state-
is very important. See instructions on back of certificate.

Form V. S. No. 5. 10M. 6-20-11.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH
County of Shoshone
City of Keeloc

Registration District No. 123
Primary Registration District No. 2202
(No. _____ St.)

File No. 6542
Registered No. _____

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Benjamin Harrison Corbus

If death occurred in a hospital, institution or camp give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX M 4. COLOR OR RACE W 5. SINGLE, MARRIED, WID-
OWED OR DIVORCED. married
(Write the word.)

6. DATE OF BIRTH March 27 1889
(Month) (Day) (Year)

7. AGE 24 yrs. 8 mos. ds. IF LESS than 1 day
how many hrs. or
min.?

8. OCCUPATION miner
(a) Trade, profession or particular kind of work
(b) General nature of industry business or establishment in which employed (or employer)

9. BIRTHPLACE Oregon
(State or Country)

10. NAME OF FATHER Eugene Merrill Corbus

11. BIRTHPLACE OF FATHER Indiana
(State or Country)

12. MAIDEN NAME OF MOTHER Elizabeth Walsh

13. BIRTHPLACE OF MOTHER Ontario, Canada
(State or Country)

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Elizabeth Corbus
(Address) Three Turps Wash

15. Filed 12/29 1913 Geo. J. Lasher
Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH Dec 20 1913
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from Dec 3 1913, to Dec 20 1913,
that I last saw him alive on Dec 20 1913,
and that death occurred on the date stated above, at 1:30 A.M.

The CAUSE OF DEATH* was as follows:

Typhoid fever
(Duration) yrs. mos. ds.

Contributory (Secondary)
(Duration) yrs. mos. ds.
(Signed) J. R. Mason M. D.
Dec 23 1913 (Address) Keeloc, Idaho

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place In the
of death yrs. mos. ds. State yrs. mos. ds.
Where was disease contracted,
If not at place of death?
Former or
usual residence.

19. PLACE OF BURIAL OR REMOVAL Greenwood DATE OF BURIAL Dec 22 1913

20. UNDERTAKER Ed Shanklin ADDRESS Keeloc, Ida.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Form V. S. No. 5. 12-14 M. 7-24-11

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics
File No. 6543

1. PLACE OF DEATH
County of Shoshone
City of Wardner

Registration District No. 123
Primary Registration District No. 2202
(No. _____ St.)

Registered No. _____

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

John Burbrick

If death occurred in a hospital, institution or camp give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX m 4. COLOR OR RACE W 5. SINGLE, MARRIED, WIDOWED OR DIVORCED.
Married
(Write the word)

6. DATE OF BIRTH March 1869
(Month) (Day) (Year)

7. AGE 54 yrs. _____ mos. _____ ds. IF LESS than 1 day
how many _____ hrs. or _____ min?

8. OCCUPATION

(a) Trade, profession or particular kind of work Miner
(b) General nature of industry business or establishment in which employed (or employer)

9. BIRTHPLACE

(State or Country)

Minnesota

10. NAME OF FATHER

Mr. Berbrick

11. BIRTHPLACE OF FATHER

(State or Country)

Don't Know

12. MAIDEN NAME OF MOTHER

Don't Know

13. BIRTHPLACE OF MOTHER

(State or Country)

Idaho

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

(Address)

15.

Filed Dec 29 1913 Geo. D. Lester
Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

Dec 15 1913
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from 2nd 1913, to Dec 15 1913

that I last saw him alive on Dec 15 1913
and that death occurred on the date stated above, at 8 P.M.

The CAUSE OF DEATH* was as follows:

Consumption

(Duration) _____ yrs. _____ mos. _____ ds.

Contributory
(Secondary)

(Duration) _____ yrs. _____ mos. _____ ds.

(Signed) J. R. Mason M. D.

Dec 23 1913 (Address) Kelly

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place _____ In the _____
of death _____ yrs. _____ mos. _____ ds. State _____ yrs. _____ mos. _____ ds.

Where was disease contracted,

If not at place of death?

Former or

usual residence.

19. PLACE OF BURIAL OR REMOVAL DATE OF BURIAL

Greenwood

Dec 18 1913

20. UNDERTAKER

ADDRESS

E. B. Hankin

Kelly

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Form V. S. No. 5. 10M. 6-20-11.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics
File No. 2 6545
Registered No. _____

1. PLACE OF DEATH. Registration District No. 123
County of Blaine Primary Registration District No. 2202
City of Booth (No. _____ St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

Mrs. Bernice M. Gail

If death occurred in a hospital, institution or camp give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX F 4. COLOR OR RACE W. 5. SINGLE, MARRIED, WIDOWED OR DIVORCED. Married
(Write the word.)

6. DATE OF BIRTH

_____. 1. _____
(Month) (Day) (Year)

7. AGE

_____. yrs. _____. mos. _____. ds. IF LESS than 1 day
how many _____ hrs. or
_____ min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work Known
(b) General nature of industry business or establishment in which employed (or employer) nothing & age

9. BIRTHPLACE

(State or Country)

10. NAME OF FATHER

11. BIRTHPLACE OF FATHER

(State or Country)

12. MAIDEN NAME OF MOTHER

13. BIRTHPLACE OF MOTHER

(State or Country)

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) _____

(Address) _____

15.

Filed Jan 10 1914 Geo. J. Leeper

Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

October 24 1913
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from

Oct 12 1913, to Oct 24 1913

that I last saw her alive on Oct 24 1913

and that death occurred on the date stated above, at 4 A. M.

The CAUSE OF DEATH* was as follows:

Pulmonary Tuberculosis

(Duration) _____ yrs. 6 mos. _____ ds.

Contributory (Secondary)

Chronic alcoholism

(Duration) ? yrs. ? mos. ? ds.

(Signed) Alex. S. McCrackin M. D.

Nov 1 1913 (Address) Kellogg, Ida

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and 2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death _____ yrs. _____ mos. 13 In the _____ State 2 yrs. ? mos. ? ds.

Where was disease contracted, _____?

If not at place of death? _____?

Former or

usual residence _____?

19. PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

Greenwood

Oct 25th 1913

20. UNDERTAKER

ADDRESS

E. B. Thowhill

Kellogg

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. PHYSICIAN'S NAME—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIAN'S CLANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Form V. S. No. 5. 10M. 6-20-11.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics
File No. 10 6546

1. PLACE OF DEATH.

Registration District No. 123County of ShoshonePrimary Registration District No. 2202City of Keelogg

(No. _____ St.)

Registered No. _____

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

David Jones

If death occurred in a hospital, institution or camp give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX

M

4. COLOR OR RACE

W.

5. SINGLE, MARRIED, WIDOWED OR DIVORCED.

Single
(Write the word.)

6. DATE OF BIRTH

Do not know

(Month)

(Day)

(Year)

7. AGE

Do not know

yrs.

mos.

ds.

IF LESS than 1 day
how many hrs. or
..... min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work

Miner

(b) General nature of industry business or establishment in which employed (or employer)

9. BIRTHPLACE

(State or Country)

Do not know

10. NAME OF FATHER

Do not know

11. BIRTHPLACE OF FATHER

(State or Country)

Do not know

12. MAIDEN NAME OF MOTHER

Do not know

13. BIRTHPLACE OF MOTHER

(State or Country)

Do not know

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

(Address)

15.

Filed Jan 10 1914 Geo. J. Lecher
Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

December

(Month)

20

(Day)

1913

(Year)

17. I HEREBY CERTIFY, That I attended deceased from

Dec 19 1913, to Dec 20 1913that I last saw him alive on Dec 19 1913,and that death occurred on the date stated above, at 1 A.M.

The CAUSE OF DEATH* was as follows:

Fat embolism - following
compound fracture of right
femur - (accidental) (mine)

(Duration) yrs. mos. 2 ds.

Contributory (Secondary)

Compound fracture of right femur(Duration) yrs. mos. 2 ds.(Signed) Alex. T. M. Frachin M. D.Jan 5 1914 (Address) Keelogg, Idaho

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and 2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death yrs. mos. 2 ds. In the 6 yrs. mos. ds. State

Where was disease contracted,

If not at place of death?

Former or

usual residence.

19. PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

GreenwoodDec 22 1913

20. UNDERTAKER

ADDRESS

E. B. ThornhillKeelogg

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Form V. S. No. 5. 12½ M. 7-24-11

CERTIFICATE OF DEATH

1. PLACE OF DEATH.
County of Shoshone
City of Mullan

Registration District No. 122
Primary Registration District No. 220
(No. 52, _____ St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Hjalmer Wilson

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

File No. 6547
Registered No. _____

If death occurred in a hospital, institution or camp give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX M. 4. COLOR OR RACE W 5. SINGLE, MARRIED, WIDOWED OR DIVORCED. Single
(Write the word.)

6. DATE OF BIRTH Aug 28 1
(Month) (Day) (Year)

7. AGE 30 yrs. _____ mos. _____ ds. IF LESS than 1 day
how many _____ hrs. or _____ min?

8. OCCUPATION

- (a) Trade, profession or particular kind of work.....
(b) General nature of industry business or establishment in which employed (or employer).....

Mining

9. BIRTHPLACE Bienberg Lakatrach
(State or Country) Sweden

10. NAME OF FATHER John Anton Wilson

11. BIRTHPLACE OF FATHER Sweden
(State or Country)

12. MAIDEN NAME OF MOTHER

13. BIRTHPLACE OF MOTHER Sweden
(State or Country)

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) _____

(Address) _____

15. 20 1913 W. H. Nowary
Filed _____ Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH Aug 28 1913
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from _____
_____ 191____, to _____ 191____

that I last saw him alive on _____ 191____

and that death occurred on the date stated above, at 7 A. M.

The CAUSE OF DEATH* was as follows:

Heart accident
Caught in mine cave &
body not recovered till Oct 1

(Duration) _____ yrs. _____ mos. _____ ds.

Contributory (Secondary) Reported by
James F. Bean

(Signed) W. H. Nowary _____
10/4 1913 (Address) Wallace Idaho

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place _____ In the _____
of death _____ yrs. _____ mos. _____ ds. State _____ yrs. _____ mos. _____ ds.

Where was disease contracted,
If not at place of death? _____

Former or
usual residence _____

19. PLACE OF BURIAL OR REMOVAL DATE OF BURIAL

Mullan Idaho Oct 4 1913

20. UNDERTAKER ADDRESS

Ward Wallace Idaho

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Form V. S. No. 5 20M.1-16-12

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH.
County of *Shoshone*
City of *Mullan*

Registration District No. *122*
Primary Registration District No. *2207*
(No. _____ St.)

File No. *6548*
Registered No. _____

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME *Kenneth Lewis*

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX *male* 4. COLOR OR RACE *white* 5. SINGLE, MARRIED, WIDOWED OR DIVORCED.
single
(Write the word.)

6. DATE OF BIRTH
5 (Month) *1* (Day) *1913* (Year)

7. AGE *5* yrs. *5* mos. *1* ds. IF LESS than 1 day how many hrs. or mins.)

8. OCCUPATION
(a) Trade, profession or particular kind of work *none*
(b) General nature of industry, business, or establishment in which employed (or employer)

9. BIRTHPLACE
(State or Country) *Meyers Falls*

10. NAME OF FATHER *C. W. Aris*

11. BIRTHPLACE OF FATHER
(State or Country) *New York*

12. MAIDEN NAME OF MOTHER *Martha Kanisch*

13. BIRTHPLACE OF MOTHER
(State or Country) *Paris*

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) *C. W. Aris*
(Address) *Mullan Ida*

15. Filed *20* 191*3* *H. Mowary*
Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH *Oct 30* 191*3*
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from *1913* to *1913* that I last saw *him* alive on *30* 191*3* and that death occurred on the date stated above, at *8:30* P.M.

The CAUSE OF DEATH* was as follows:
convulsion

(Duration) yrs. mos. *2 2 hrs.*

Contributory (Secondary)
(Duration) yrs. mos. ds.
(Signed) *Dr. F. W. Roll*
Oct 31 1913 (Address) *Mullan Ida*

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death.....yrs.....mos.....days. State.....yrs.....mos.....days.
Where was disease contracted if not at place of death?
Former or usual residence.....

19. PLACE OF BURIAL OR REMOVAL *Wallace* DATE OF BURIAL *1913*

20. UNDERTAKER *Ward Undertaking & Wallace* ADDRESS

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Form V. S. No. 5. 12½ M. 7-24-11

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH

Registration District No.

County of *Shoshone*

Primary Registration District No.

City of *Mullan*

(No.

St.)

File No.

6549

Registered No.

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

Emily Kittler

If death occurred in a hospital, institution or camp give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX

4. COLOR OR RACE

5. SINGLE, MARRIED, WIDOWED OR DIVORCED.

Female

White

Single
(Write the word.)

6. DATE OF BIRTH

July

13

1912

(Month)

(Day)

(Year)

7. AGE

1 yrs. *7* mos. *3* ds.

IF LESS than 1 day
how many..... hrs. or
..... min?

8. OCCUPATION

(a) Trade, profession or particular kind of work.

None

(b) General nature of industry business or establishment in which employed (or employer)

9. BIRTHPLACE

(State or Country)

Mullan

10. NAME OF FATHER

Arro Kittler

11. BIRTHPLACE OF FATHER

(State or Country)

Indiana

12. MAIDEN NAME OF MOTHER

Emma Posonen

13. BIRTHPLACE OF MOTHER

(State or Country)

Finland

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

(Address)

Thomas Mearns
Mullan Ida

15.

Filed *Aug 20* 191*3*

H. F. Mowery
Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH

September

16

191*3*

(Month)

(Day)

(Year)

17. I HEREBY CERTIFY, That I attended deceased from

Sept 9 191*3*, to *Sept 16* 191*3*

that I last saw her alive on *Sept 16* 191*3*

and that death occurred on the date stated above, at *9 A*. M.

The CAUSE OF DEATH* was as follows:

Cholera Infantum

(Duration)

yrs.

mos.

15 ds.

Contributory

(Secondary)

(Duration)

yrs.

mos.

ds.

(Signed)

James R. Bear M. D.

9/16

191*3*

(Address) *Mullan Ida*

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; (2) whether ACCIDENTAL, SUICIDAL OR HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place

In the

of death..... yrs..... mos..... ds. State..... yrs..... mos..... ds.

Where was disease contracted,

If not at place of death?.....

Former or

usual residence.....

19. PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

Mt View Cemetery

9/17

191*3*

20. UNDERTAKER

ADDRESS

None

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Form V. S. No. 5. 12½M.7-24-11

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

File No. 6550
Registered No.

If death occurred in a hospital, institution or camp give its name instead of street and number.

1. PLACE OF DEATH. Registration District No. 122
County of Shoshone Primary Registration District No. 2200
City of Malheur (No. , St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Thos. G. Kennedy

PERSONAL AND STATISTICAL PARTICULARS

3. SEX 4. COLOR OR RACE 5. SINGLE, MARRIED, WIDOWED OR DIVORCED.

male white (Write the word.)

6. DATE OF BIRTH

(Month) (Day) (Year)

7. AGE

48

yrs. mos. ds.

IF LESS than 1 day
how many hrs. or min?

8. OCCUPATION

(a) Trade, profession or particular kind of work.
(b) General nature of industry, business or establishment in which employed (or employer)

Justice of Peace

9. BIRTHPLACE

(State or Country)

USA

10. NAME OF FATHER

11. BIRTHPLACE OF FATHER

(State or Country)

12. MAIDEN NAME OF MOTHER

13. BIRTHPLACE OF MOTHER

(State or Country)

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) (Address)

15.

Filed Nov 20 1913

Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH

Sept

23 1913

(Month)

(Day)

17. I HEREBY CERTIFY, That I attended deceased

Sept 5 1913

to Sept 23 1913

that I last saw him alive on Sept 22 1913

and that death occurred on the date stated above, at 5:20 PM

The CAUSE OF DEATH* was as follows:

Typhoid Fever

(Duration) yrs. mos.

Contributory (Secondary)

(Duration) yrs. mos.

(Signed)

James R. Bear

Sept 23 1913 (Address) Mullan

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, MEANS OF INJURY; (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions or Recent Residents.)

At place In the

of death yrs. mos. ds. State yrs. mos.

Where was disease contracted,

If not at place of death?

Former or

usual residence.

19. PLACE OF BURIAL OR REMOVAL DATE OF BURIAL

Mullan Ida

Sept 25 1913

20. UNDERTAKER

ADDRESS

Ward Co.

Malheur

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Form V. S. No. 5 20M.1-16-12

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH.

Registration District No. 70

County of Shoshone

Primary Registration District No. 1411

City of Malheur

(No. 1411 St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME J. B. Olson

File No. 6551

Registered No. 93

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX Male 4. COLOR OR RACE White 5. SINGLE, MARRIED, WIDOWED OR DIVORCED. not known (Write the word.)

6. DATE OF BIRTH (Month) (Day) (Year)

7. AGE 67 yrs. — mos. — ds. IF LESS than 1 day how many hrs. or mins.?

8. OCCUPATION (a) Trade, profession or particular kind of work Miner - Rancher (b) General nature of industry business, or establishment in which employed (or employer)

9. BIRTHPLACE (State or Country) Sweden

10. NAME OF FATHER Unknown

11. BIRTHPLACE OF FATHER Unknown (State or Country)

12. MAIDEN NAME OF MOTHER Unknown

13. BIRTHPLACE OF MOTHER Unknown (State or Country)

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE (Informant) Harry Thompson (Address) Wallace Idaho

15. Filed Dec 1 1913 J. B. Cooney Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH Nov 30 1913 (Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from June 18 1913 to Nov 30 1913 that I last saw him alive on Nov 30 1913 and that death occurred on the date stated above, at 9 A.M.

The CAUSE OF DEATH* was as follows: Pernicious Anaemia

(Duration) yrs. 6 mos. ds. Contributory (Secondary) Exposure

(Duration) yrs. mos. ds. (Signed) Dr. J. B. Cooney

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.) 22 days At place of death yrs. mos. days. State yrs. mos. days.

Where was disease contracted if not at place of death? Former or usual residence

19. PLACE OF BURIAL OR REMOVAL Wallace Idaho DATE OF BURIAL Dec 2 1913

20. UNDERTAKER Mrs. J. B. Cooney ADDRESS Wallace

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Form V. S. No. 5 20M.1-16-12

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH.

Registration District No. 70

County of Shoshone

Primary Registration District No. 1011

City of Wallace

(No. _____, St.)

File No. 6552

Registered No. 94

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Fred Bergman

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX

4. COLOR OR RACE

5. SINGLE, MARRIED, WID-
OWED OR DIVORCED.

male white

single
(Write the word.)

6. DATE OF BIRTH

_____. 1. _____
(Month) (Day) (Year)

7. AGE

54 yrs. ____ mos. ____ ds.

IF LESS than 1 day
how many ____ hrs. or
____ mins.?

8. OCCUPATION

(a) Trade, profession or
particular kind of work
(b) General nature of industry
business, or establishment in
which employed (or employer)

laborer

9. BIRTHPLACE

(State or Country)

Germany

10. NAME OF
FATHER

unknown

11. BIRTHPLACE
OF FATHER

(State or Country)

12. MAIDEN NAME
OF MOTHER

13. BIRTHPLACE
OF MOTHER

(State or Country)

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Harry Thompson

(Address) Wallace Ida

15.

Filed Dec 1 1913

St. Leo Implet

Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH

Nov 29 1913
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from

_____. 191____, to _____ 191____
that I last saw him alive on Nov 29 1913

and that death occurred on the date stated above, at 6 P. M.

The CAUSE OF DEATH* was as follows:

Acute dilatation
of heart

(Duration) ____ yrs. ____ mos. ____ ds.

Contributory Chronic myocarditis
(Secondary)

(Duration) ____ yrs. ____ mos. ____ ds.

(Signed) Dr. H. H. Thompson

(Address) Wallace Ida

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death ____ yrs. ____ mos. ____ days. State ____ yrs. ____ mos. ____ days.

Where was disease contracted if not at place of death? _____

Former or usual residence _____

19. PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

Wallace

Dec 3 1913

20. UNDERTAKER

ADDRESS

Hard Undertaking Co Wallace Ida

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH.

Registration District No. 70

County of Shoshone

Primary Registration District No. 1011

City of Wallace,

(No. 118 Cedar St., St.)

File No. 6553

Registered No. 90-

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Nellie M. Lockhart,

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX female 4. COLOR OR RACE white 5. SINGLE, MARRIED, WIDOWED OR DIVORCED. married
(Write the word.)

6. DATE OF BIRTH

(Month) (Day) (Year)

7. AGE

40

yrs. mos. ds.

IF LESS than 1 day
how many hrs. or
mins.?

8. OCCUPATION

(a) Trade, profession or particular kind of work none
(b) General nature of industry business, or establishment in which employed (or employer)

9. BIRTHPLACE

(State or Country) Grangeville, Idaho.

10. NAME OF FATHER

James Crooks

11. BIRTHPLACE OF FATHER

not given

(State or Country)

12. MAIDEN NAME OF MOTHER

"

13. BIRTHPLACE OF MOTHER

"

(State or Country)

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

Mr. B. G. Lockhart

(Address)

Wallace, Idaho

15.

Filed Dec. 3,

1913

J. L. Leary

Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH

Dec 15

2

1913

(Month)

(Day)

(Year)

I HEREBY CERTIFY, That I attended deceased from Dec 15, 1913, to Dec 2, 1913,

that I last saw her alive on Dec 2, 1913, and that death occurred on the date stated above, at 8:00 P.M.

The CAUSE OF DEATH* was as follows:

Aortic regurgitation with aortic stenosis

(Duration) 3

yrs.

mos.

ds.

Contributory

(Secondary)

(Duration)

yrs.

mos.

ds.

(Signed)

Dec 3, 1913

(Address)

Mrs. M. W. Wallace

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place

of death

yrs. mos. days.

In the

State

yrs. mos. days.

Where was disease contracted if not at place of death?

Former or usual residence.

19. PLACE OF BURIAL OR REMOVAL

Grangeville, Idaho.

DATE OF BURIAL

Dec. 4 1913

20. UNDERTAKER

Anna L. Wooten

ADDRESS

Wallace, Id.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Form V. S. No. 5 20M.1-16-12

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH.

Registration District No. 70County of ShoshonePrimary Registration District No. 1011City of Wallace(No. Providence Hospital St.)File No. 6554Registered No. 96

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

Magnus Palmquist

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX

male

4. COLOR OR RACE

white

5. SINGLE, MARRIED, WIDOWED OR DIVORCED.
single
(Write the word.)

6. DATE OF BIRTH

(Month)

(Day)

(Year)

7. AGE

27

yrs. -- mos. -- ds.

IF LESS than 1 day
how many hrs. or
mins.?

8. OCCUPATION

(a) Trade, profession or
particular kind of work

carpenter

(b) General nature of industry
business, or establishment in
which employed (or employer)

9. BIRTHPLACE

(State or Country)

Sweden

10. NAME OF
FATHER

not given

11. BIRTHPLACE
OF FATHER

(State or Country)

Sweden

12. MAIDEN NAME
OF MOTHER

not given

13. BIRTHPLACE
OF MOTHER

(State or Country)

Sweden

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

(Address)

Wallace, Idaho

15.

Filed

Dec 61913H. L. Lingle

Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH

Dec31913

(Month)

(Day)

(Year)

17. I HEREBY CERTIFY, That I attended deceased from

Nov 22 1913 to Dec 3 1913,that I last saw him alive on Dec 3 1913,and that death occurred on the date stated above, at 10 AM

The CAUSE OF DEATH* was as follows:

Perforation of bowel
Prod. Typhoid fever

(Duration)

yrs.

mos.

ds.

Contributory
(Secondary)

(Duration)

yrs.

mos.

ds.

(Signed)

Dec 6 1913 Dr. Mowbray M.D.
(Address) Wallace, Ida

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place

of death.....yrs.....mos.....days.

In the

State.....yrs.....mos.....days.

Where was disease contracted
if not at place of death?Former or
usual residence

19. PLACE OF BURIAL OR REMOVAL

Wallace, Idaho

DATE OF BURIAL

Dec. 7 1913.

20. UNDERTAKER

Quincy Martell

ADDRESS

Wallace, Id.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Form V. S. No. 5 20M.1-16-12

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH.

Registration District No. 70County of ShoshonePrimary Registration District No. 1011City of Wallace

(No. _____, St.)

File No. 6555Registered No. 97

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

Eliza Heller

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX

Female

4. COLOR OR RACE

white

5. SINGLE, MARRIED, WIDOWED OR DIVORCED.

Married
(Write the word.)

6. DATE OF BIRTH

(Month)

(Day)

(Year)

7. AGE

64 yrs. — mos. — ds.

IF LESS than 1 day
how many hrs. or
mins.?

8. OCCUPATION

(a) Trade, profession or particular kind of work
(b) General nature of industry business, or establishment in which employed (or employer)

housewife

9. BIRTHPLACE

(State or Country)

Germany

10. NAME OF FATHER

Herman Roth

11. BIRTHPLACE OF FATHER

(State or Country)

Germany

12. MAIDEN NAME OF MOTHER

unknown

13. BIRTHPLACE OF MOTHER

(State or Country)

Germany

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

Geo H Heller

(Address)

Wallace Ida

15.

Filed Dec. 151913Geo H Heller

Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH

Dec141913

(Month)

(Day)

(Year)

17. I HEREBY CERTIFY, That I attended deceased from

Sept 211913to Dec 141913that I last saw her alive on Dec 14 1913and that death occurred on the date stated above, at 7:15 M.

The CAUSE OF DEATH* was as follows:

Carcinoma of uterus(Duration) 1 yrs. — mos. — ds.

Contributory

(Secondary)

(Duration) — yrs. — mos. — ds.

(Signed)

May 15 M. D.12-14 1913 (Address) Wallace Ida

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death — yrs. — mos. — days. In the State — yrs. — mos. — days.

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

Shoshone WashDec. 14 1913

20. UNDERTAKER

ADDRESS

Hard Undertaking Co. Wallace Ida

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Form V. S. No. 5 20M.1-16-12

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH.

Registration District No. 70

County of Shoshone

Primary Registration District No. 1011

City of Wallace

(No. _____, St.)

File No. 6556

Registered No. 98

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

Doc Davis

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX

4. COLOR OR RACE

5. SINGLE, MARRIED, WIDOWED OR DIVORCED.

Male

White

(Write the word.)

6. DATE OF BIRTH

(Month)

(Day)

(Year)

7. AGE

about
20 yrs. mos. ds.

IF LESS than 1 day
how many hrs. or
mins.

8. OCCUPATION

(a) Trade, profession or particular kind of work

Miner

(b) General nature of industry business, or establishment in which employed (or employer)

9. BIRTHPLACE

(State or Country)

10. NAME OF FATHER

Theodore P. Davis

11. BIRTHPLACE OF FATHER

(State or Country)

Unknown

12. MAIDEN NAME OF MOTHER

"

13. BIRTHPLACE OF MOTHER

(State or Country)

"

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

(Address)

Narry Thompson

Wallace Idaho

15.

Filed

191

St. Leo Quigley
Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH

Dec

16

1913

(Month)

(Day)

(Year)

17. I HEREBY CERTIFY, That I attended deceased from

Dec 13 1913 to Dec 16 1913

that I last saw him alive on Dec 16 1913

and that death occurred on the date stated above, at 4 AM

The CAUSE OF DEATH* was as follows:

Lobar Pneumonia

(Duration)

yrs.

mos.

ds.

Contributory
(Secondary)

(Duration)

yrs.

mos.

ds.

(Signed)

Max Runk

M. D.

12/21 1913 (Address) Wallace Idaho

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death yrs. mos. days.

In the State yrs. mos. days.

Where was disease contracted if not at place of death?

Former or usual residence.

19. PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

Wallace, Idaho

12/22 1913

20. UNDERTAKER

ADDRESS

Wards Undertaking Co.

Wallace Ida

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Form V. S. No. 5 20M.1-16-12

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics
File No. **6554**

1. PLACE OF DEATH.

Registration District No. **70**County of **Shoshone**Primary Registration District No. **1011**City of **Wallace**

(No. _____, _____ St.)

Registered No. **99**

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME **George Allen Duncan**

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX

Male

4. COLOR OR RACE

White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED.

single
(Write the word.)

6. DATE OF BIRTH

Sept 28 - 1913
(Month) (Day) (Year)

7. AGE

2 yrs. 2 mos. 23 ds.

IF LESS than 1 day
how many _____ hrs. or
_____ mins.

8. OCCUPATION

(a) Trade, profession or particular kind of work
(b) General nature of industry business, or establishment in which employed (or employer)

none

9. BIRTHPLACE

(State or Country)

Wallace - Idaho

10. NAME OF FATHER

Charles A. Duncan

11. BIRTHPLACE OF FATHER

(State or Country)

Detroit, Michigan

12. MAIDEN NAME OF MOTHER

Katherine Harvey

13. BIRTHPLACE OF MOTHER

(State or Country)

Ossian - Iowa

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) **Charles A. Duncan**(Address) **176 King St. Wallace, Ida.**

15.

Filed **12/21**191**3****Dr. Leo Zinsler**

Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH

Dec 21 1913
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from

Dec 20 1913 to **Dec 21 1913**

that I last saw him alive on **Dec 20 1913**

and that death occurred on the date stated above, at **12:20 AM**

The CAUSE OF DEATH was as follows:

Acute lobar pneumonia(Duration) yrs. mos. **3** ds.

Contributory (Secondary)

exposure

(Duration) yrs. mos. ds.

(Signed)

Dr. Mowbray M. D.**Dec 21 1913** (Address) **Wallace, Ida**

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death. _____ yrs. _____ mos. _____ days. In the State. _____ yrs. _____ mos. _____ days.

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL

Mullan Ida

DATE OF BURIAL

12/22 1913

20. UNDERTAKER

Hard Undertaking Co Wallace Ida

ADDRESS

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Form V. S. No. 5 20M.1-16-12

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH. Registration District No. 70
County of Shoshone Primary Registration District No. 1111
City of Wallace (No. _____ St.)

File No. 6558
Registered No. 100

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Harry Fehling

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX male 4. COLOR OR RACE white 5. SINGLE, MARRIED, WIDOWED OR DIVORCED. single
(Write the word.)

6. DATE OF BIRTH _____
(Month) (Day) (Year)

7. AGE 60 yrs. _____ mos. _____ ds.
IF LESS than 1 day how many _____ hrs. or _____ mins.?

8. OCCUPATION
(a) Trade, profession or particular kind of work mines
(b) General nature of industry, business, or establishment in which employed (or employer)

9. BIRTHPLACE Germany
(State or Country)

10. NAME OF FATHER _____

11. BIRTHPLACE OF FATHER _____
(State or Country)

12. MAIDEN NAME OF MOTHER _____

13. BIRTHPLACE OF MOTHER _____
(State or Country)

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Harry Thompson
(Address) Wallace Ida

15. Filed Dec. 24 1913 F. Leo Gingles
Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH Dec 19 1913
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from _____ 191____, to _____ 191____,
that I last saw h_____ alive on _____ 191____,
and that death occurred on the date stated above, at _____ M.

The CAUSE OF DEATH* was as follows:
Chloroform poisoning
Self administered suicidal
(Duration) _____ yrs. _____ mos. _____ ds.

Contributory (Secondary) _____
(Duration) _____ yrs. _____ mos. _____ ds.
(Signed) Chas. R. Hower M. D.
Wallace 1913 (Address)

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death _____ yrs. _____ mos. _____ days. In the State _____ yrs. _____ mos. _____ days.

Where was disease contracted if not at place of death? _____

Former or usual residence _____

19. PLACE OF BURIAL OR REMOVAL Wallace Ida DATE OF BURIAL Dec 24 1913

20. UNDERTAKER Hard Undertaking ADDRESS Wallace Ida

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Form V. S. No. 5 20M.1-16-12

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH

Registration District No.

County of

Primary Registration District No.

City of

(No.

File No.

Registered No.

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX

4. COLOR OR RACE

5. SINGLE, MARRIED, WIDOWED OR DIVORCED.

6. DATE OF BIRTH

7. AGE

IF LESS than 1 day
how many hrs. or
mins.?

8. OCCUPATION

(a) Trade, profession or
particular kind of work(b) General nature of industry
business, or establishment in
which employed (or employer)

9. BIRTHPLACE

(State or Country)

10. NAME OF
FATHER11. BIRTHPLACE
OF FATHER

(State or Country)

12. MAIDEN NAME
OF MOTHER13. BIRTHPLACE
OF MOTHER

(State or Country)

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

(Address)

15.

Filed

191

Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

17. I HEREBY CERTIFY, That I attended deceased from

that I last saw him alive on

and that death occurred on the date stated above, at

The CAUSE OF DEATH* was as follows:

Contributory
(Secondary)

(Signed)

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions,
Transients or Recent Residents.)

At place of death... yrs... mos... days. In the State... yrs... mos... days.

Where was disease contracted
if not at place of death?Former or
usual residence

19. PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

20. UNDERTAKER

ADDRESS

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Form V. S. No. 5 20M.1-16-12

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH.

Registration District No. 70County of ShoshonePrimary Registration District No. 1011City of Wallace(No. 21, Bank St.)File No. 6560Registered No. 108

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Pho Koontz White

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX

Male

4. COLOR OR RACE

White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED.

Married
(Write the word.)

6. DATE OF BIRTH

Sept 1 1860
(Month) (Day) (Year)

7. AGE

53 yrs. 3 mos. 24 ds.

IF LESS than 1 day
how many hrs. or
..... mins.?

8. OCCUPATION

(a) Trade, profession or particular kind of work

(b) General nature of industry business, or establishment in which employed (or employer)

Traveling Salesman

9. BIRTHPLACE

(State or Country)

Lancaster Ohio

10. NAME OF FATHER

Pho White

11. BIRTHPLACE OF FATHER

(State or Country)

Pho White

12. MAIDEN NAME OF MOTHER

Koontz

13. BIRTHPLACE OF MOTHER

(State or Country)

Lancaster Ohio

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Mrs. Minnie K. White(Address) Wallace Ida

15.

Filed Dec 25 1911 H. Leo Quinby

Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH

Dec 24 1913
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from Oct 1913 to Dec 24 1913
that I last saw him alive on Dec 24 1913
and that death occurred on the date stated above, at 11 P.M.

The CAUSE OF DEATH* was as follows:

Angina Pectoris(Duration) 1 1/2 yrs. mos. ds.Contributory
(Secondary)(Duration) Chas. R. Mowery yrs. mos. ds.(Signed) Dec 25 1913 (Address) Wallace Ida

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death yrs. mos. days. In the State yrs. mos. days.

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

Omaha KansasDec 26 1913

20. UNDERTAKER

ADDRESS

Bruce G. Mowery Wallace

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Form V. S. No. 5 20M.1-16-12

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH.

Registration District No. 15

County of Baine

Primary Registration District No. _____

City of McCabe

(No. _____, St.)

File No. 6561

Registered No. _____

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Marli Cale

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX Male 4. COLOR OR RACE white 5. SINGLE, MARRIED, WIDOWED OR DIVORCED. widowed
(Write the word.)

6. DATE OF BIRTH

May 12 1848
(Month) (Day) (Year)

7. AGE

65 yrs. 7 mos. 11 ds.

IF LESS than 1 day
how many hrs. or
..... mins.?

8. OCCUPATION

(a) Trade, profession or particular kind of work former retired agent
(b) General nature of industry, business, or establishment in which employed (or employer)

9. BIRTHPLACE

(State or Country) Ill.

10. NAME OF FATHER

11. BIRTHPLACE OF FATHER

(State or Country)

12. MAIDEN NAME OF MOTHER

13. BIRTHPLACE OF MOTHER

(State or Country)

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) E. A. Cale

(Address) Lardo Idaho

15.

Filed Jan 10 1914 G. H. Compton
Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH

Dec. 23 1913
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from

Dec. 11 1913, to Dec. 23 1913,
that I last saw him alive on Dec. 23 1913.

and that death occurred on the date stated above, at 1:15 A.M.

The CAUSE OF DEATH* was as follows:

Acute Dilatation of heart.

(Duration) yrs. mos. ds.

Contributory myocarditis.
(Secondary)

(Duration) yrs. mos. ds.

(Signed) Frank E. Brown M. D.

19 (Address) Council, Idaho.

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL OR HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death yrs. mos. days. In the State yrs. mos. days.

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL DATE OF BURIAL

Holmes Cemetery Dec. 24 1913

20. UNDERTAKER ADDRESS

Brown

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Form V. S. No. 5. 12½ M. 7-24-11

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH. Registration District No. 78 Page 78
County of Bonner Primary Registration District No. 2155
City of Sandpoint (No. _____, _____ St.)

File No. 6562
Registered No. 468

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

Ernest — Neyman

If death occurred in a hospital, institution or camp give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX Male 4. COLOR OR RACE White 5. SINGLE, MARRIED, WIDOWED OR DIVORCED. Single
(Write the word.)

6. DATE OF BIRTH _____
(Month) (Day) (Year)

7. AGE 26 yrs. — mos. — ds. IF LESS than 1 day how many _____ hrs. or _____ min?

8. OCCUPATION

- (a) Trade, profession or particular kind of work.
(b) General nature of industry, business or establishment in which employed (or employer)

Brakeman
Logging train

9. BIRTHPLACE

(State or Country)

Michigan

10. NAME OF FATHER

Andrew Newman

11. BIRTHPLACE OF FATHER

(State or Country)

U. S.

12. MAIDEN NAME OF MOTHER

Unknown

13. BIRTHPLACE OF MOTHER

(State or Country)

U. S.

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

Elmer Jacobson

(Address)

Cedar River Mich

15.

Filed

Jan 6

1914

M. Muckelion

Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH

Nov 12 1913
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from Oct 19 1913, to Nov 12 1913 that I last saw h. unalive on Nov 12 1913 and that death occurred on the date stated above, at 12 M.

The CAUSE OF DEATH* was as follows:

Heart failure due to the
admission of an anesthetic

(Duration) _____ yrs. _____ mos. _____ ds.
Contributory Alcoholism
(Secondary) Myocarditis lower leg aet
of RA accident (Duration) _____ yrs. _____ mos. 24 ds.
(Signed) O. J. Payne M. D.
Oct 13 1913 (Address) Sandpoint Ida

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place _____ In the _____
of death _____ yrs. _____ mos. _____ ds. State _____ yrs. _____ mos. _____ ds.
Where was disease contracted, _____
If not at place of death? _____
Former or _____
usual residence _____

19. PLACE OF BURIAL OR REMOVAL DATE OF BURIAL

Cedar River Mich 11/14 1913

20. UNDERTAKER

ADDRESS

E. M. Brower S.P.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Form V. S. No. 5. 12½ M. 7-24-11

CERTIFICATE OF DEATH

State of Idaho

BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH.

Registration District No. 78

County of Bonner

Primary Registration District No. 2/55

City of Sandpoint

(No. _____, _____ St.)

File No. 6563

Registered No. 469

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

Cora May Billings Pilling

If death occurred in a hospital, institution or camp give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX

Female

4. COLOR OR RACE

5. SINGLE, MARRIED, WIDOWED OR DIVORCED.

MARRIED
(Write the word.)

6. DATE OF BIRTH

May 31 1862
(Month) (Day) (Year)

7. AGE

57 yrs. 5 mos. 16 ds.

IF LESS than 1 day
how many _____ hrs. or
_____ min?

8. OCCUPATION

(a) Trade, profession or particular kind of work.

Housewife

(b) General nature of industry business or establishment in which employed (or employer)

9. BIRTHPLACE

(State or Country)

Minn.

10. NAME OF FATHER

Wm. Hunt

11. BIRTHPLACE OF FATHER

(State or Country)

M. S.

12. MAIDEN NAME OF MOTHER

May Ette

13. BIRTHPLACE OF MOTHER

(State or Country)

U. S.

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

(Address)

15.

Filed Jan 6 1913

Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH

Mar. 17 1913
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from

Nov 10 1913, to Nov 17 1913

that I last saw her alive on Nov 17 1913

and that death occurred on the date stated above, at 5 AM

The CAUSE OF DEATH* was as follows:

Hyper Emesis following operati
removal of large ovarian tumor
& appendectomy

(Duration) _____ yrs. _____ mos. _____ ds.

Contributory Eth - anaesthesia
(Secondary)

(Duration) _____ yrs. _____ mos. _____ ds.

(Signed) M. M. McCallister M. D.

Nov 18 1913. (Address) Sandpoint

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place _____ In the _____
of death _____ yrs. _____ mos. _____ ds. State _____ yrs. _____ mos. _____ ds.

Where was disease contracted,

If not at place of death?

Former or

usual residence.

19. PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

Idaho 11/19 1913

20. UNDERTAKER

ADDRESS

E. M. Brown

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Expect statement of OCCUPATION is very important. See instructions on back of certificate.

Form V. S. No. 5 20M.1-16-12

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH

Registration District No. 78

County of Bonner

Primary Registration District No. 2153

City of Sandpoint

(No. _____ St.)

File No. 6564

Registered No. _____

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

James Smith

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX

4. COLOR OR RACE

5. SINGLE, MARRIED, WIDOWED OR DIVORCED.

Male White

Single
(Write the word.)

6. DATE OF BIRTH

(Month) (Day) (Year)

7. AGE

20 yrs. mos. ds.

IF LESS than 1 day
how many hrs. or
mins?

8. OCCUPATION

(a) Trade, profession or particular kind of work
(b) General nature of industry, business, or establishment in which employed (as employer)

Unknown

9. BIRTHPLACE

(State or Country)

Ido

10. NAME OF FATHER

Ido

11. BIRTHPLACE OF FATHER

(State or Country)

Ido

12. MAIDEN NAME OF MOTHER

Ido

13. BIRTHPLACE OF MOTHER

(State or Country)

Ido

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

Ernest Brown

(Address)

15.

Filed

12/10

1913

W. M. Kinnison
Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

Dec 10 1913
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from

1913, to Dec 10 1913

that I last saw him alive on Dec 10 1913

and that death occurred on the date stated above, at 4.9 M.

The CAUSE OF DEATH* was as follows:

R.R. Accident. run over and arm & leg crushed & scalp lacerated

(Duration) yrs. mos. 7/2 ds.

Contributory Shiner
(Secondary)

(Duration) yrs. mos. ds.

(Signed) R. J. Jackson M. D.

12/12 1913 (Address)

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death yrs. mos. days. In the State yrs. mos. days.

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

Sandpoint

12/13 1913

20. UNDERTAKER

ADDRESS

E. M. Brown

S.P.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Form V. S. No. 5. 12½ M. 7-24-11

CERTIFICATE OF DEATH

1. PLACE OF DEATH. Registration District No. 78
County of Bonner Primary Registration District No. 2153
City of Sandpoint (No. _____, St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

Chas. Marty

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics
File No. 6565
Registered No. 471

If death occurred in a hospital, institution or camp give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX 4. COLOR OR RACE 5. SINGLE, MARRIED, WIDOWED OR DIVORCED.

Male White Single
(Write the word.)

6. DATE OF BIRTH

_____. 1. _____
(Month) (Day) (Year)

7. AGE

45 yrs. _____ mos. _____ ds.
IF LESS than 1 day
how many _____ hrs. or
_____ min?

8. OCCUPATION

- (a) Trade, profession or particular kind of work.
(b) General nature of industry business or establishment in which employed (or employer)

Woodsman
Chute tender

9. BIRTHPLACE

(State or Country)

Stortz Island

10. NAME OF FATHER

Unknown

11. BIRTHPLACE OF FATHER

(State or Country)

Id

12. MAIDEN NAME OF MOTHER

Id

13. BIRTHPLACE OF MOTHER

(State or Country)

Id

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

(Address)

E. M. Brower
Sandpoint Ida.

15.

Filed 12/17 1913

M. McKenyon
Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH

Dec 17 1913
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from _____ 191____, to _____ 191____

that I last saw h. _____ alive on _____ 191____

and that death occurred on the date stated above, at _____ M.

The CAUSE OF DEATH* was as follows:

Struck on chest by
log coming down chute
instantly killed
_____ (Duration) _____ yrs. _____ mos. _____ ds.

Contributory
(Secondary)

_____ (Duration) _____ yrs. _____ mos. _____ ds.

(Signed)

W. M. McKenyon
12/17 1913 (Address) Idaho

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place _____ In the _____
of death _____ yrs. _____ mos. _____ ds. State _____ yrs. _____ mos. _____ ds.

Where was disease contracted,

If not at place of death?

Former or

usual residence.

19. PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

Sandpoint Ida 12/18 1913

20. UNDERTAKER

ADDRESS

E. M. Brower Sandpoint

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Form V. S. No. 5. 12½ M. 7-24-11

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH.

Registration District No. 78

County of Banner

Primary Registration District No. 2155

City of Elmira

(No. _____)

St. _____

File No. 6566

Registered No. 472

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

Frank Ludwick

If death occurred in a hospital, institution or camp give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX

4. COLOR OR RACE

5. SINGLE, MARRIED, WIDOWED OR DIVORCED.

man

white

married
(Write the word.)

6. DATE OF BIRTH

July 24

(Month)

(Day)

1857
(Year)

7. AGE

56 yrs. 4 mos. 24 ds.

IF LESS than 1 day
how many _____ hrs. or
_____ min?

8. OCCUPATION

(a) Trade, profession or particular kind of work.
(b) General nature of industry business or establishment in which employed (or employer)

Rancher

9. BIRTHPLACE

(State or Country)

Born Quoten Denmark

10. NAME OF FATHER

Unknown

11. BIRTHPLACE OF FATHER

(State or Country)

Ido.

12. MAIDEN NAME OF MOTHER

Ido.

13. BIRTHPLACE OF MOTHER

(State or Country)

Ido.

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

M. Bennett

(Address)

Elmira Idaho

15.

Filed 12/18 1913

M. Bennett
Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH

Dec 18
(Month)

18
(Day)

1913
(Year)

17. I HEREBY CERTIFY, That I attended deceased from Aug 15 1913, to Oct 7 1913

that I last saw him alive on Oct 1 1913

and that death occurred on the date stated above, at 1 A. M.

The CAUSE OF DEATH* was as follows:

Carcinoma of stomach

(Duration) _____ yrs. _____ mos. _____ ds.

Contributory (Secondary)

(Duration) _____ yrs. _____ mos. _____ ds.

(Signed) M. Bennett M. D.

Dec 19 1913 (Address) Sandpoint

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place _____ In the _____
of death _____ yrs. _____ mos. _____ ds. State _____ yrs. _____ mos. _____ ds.

Where was disease contracted,

If not at place of death?

Former or

usual residence.

19. PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

Sandpoint 2da.

12/20 1913

20. UNDERTAKER

ADDRESS

E. M. Brown

Sandpoint

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Form V, S. No. 5. 12½ M. 7-24-11

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics
File No. 6587
Registered No. 473

1. PLACE OF DEATH.

Registration District No. 78 Pitter.County of BonnePrimary Registration District No. 2158City of Kootenai

(No., St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

Margaret Schneider

If death occurred in a hospital, institution or camp give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX

4. COLOR OR RACE

5. SINGLE, MARRIED, WIDOWED OR DIVORCED.

FemaleWhiteSingle
(Write the word.)

6. DATE OF BIRTH

..... 1
(Month) (Day) (Year)

7. AGE

3 yrs. 1 mos. ds.

IF LESS than 1 day
how many hrs. or
..... min?

8. OCCUPATION

(a) Trade, profession or particular kind of work.
(b) General nature of industry business or establishment in which employed (or employer)

None

9. BIRTHPLACE

(State or Country)

Winn

10. NAME OF FATHER

George Schneider

11. BIRTHPLACE OF FATHER

(State or Country)

Hungary

12. MAIDEN NAME OF MOTHER

Therese Franz Dossia

13. BIRTHPLACE OF MOTHER

(State or Country)

Hungary Dossia

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

(Address)

Leo Schneider
Kootenai Idaho

15.

Filed

12/23 1913M. M. Schumir
Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH

Dec. 22 1913
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from

Dec - 17 1913, to Dec 22 1913that I last saw her alive on Dec 22 1913and that death occurred on the date stated above, at 4:30 P.M.

The CAUSE OF DEATH* was as follows:

Gastro Enteritis (acute)..... (Duration) 4 yrs. mos. ds.Contributory
(Secondary)

..... (Duration) yrs. mos. ds.

(Signed) Will St. Paul M. D.12/22 1913 (Address) Kootenai

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place In the
of death yrs. mos. ds. State yrs. mos. ds.

Where was disease contracted,

If not at place of death?

Former or

usual residence.

19. PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

Lakerew Em.12/24 1913

20. UNDERTAKER

ADDRESS

E. W. Brower Sandpoint

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Form V. S. No. 5. 12½ M. 7-24-11

CERTIFICATE OF DEATH

1. PLACE OF DEATH. Registration District No. 78
 County of Bonner Primary Registration District No. 2155
 City of Juliette Id. (No. _____, _____ St.)

State of Idaho
 BOARD OF HEALTH
 Bureau of Vital Statistics
 File No. 6568
 Registered No. 774

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME John M. Mays

If death occurred in a hospital, institution or camp give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX male 4. COLOR OR RACE white 5. SINGLE, MARRIED, WIDOWED OR DIVORCED. single
 (Write the word.)

6. DATE OF BIRTH _____
 (Month) (Day) (Year)

7. AGE 76 yrs. _____ mos. _____ ds. IF LESS than 1 day how many _____ hrs. or _____ min?

8. OCCUPATION
 (a) Trade, profession or particular kind of work. Rancher
 (b) General nature of industry business or establishment in which employed (or employer) _____

9. BIRTHPLACE Vermont
 (State or Country)

10. NAME OF FATHER _____

11. BIRTHPLACE OF FATHER _____
 (State or Country)

12. MAIDEN NAME OF MOTHER _____

13. BIRTHPLACE OF MOTHER _____
 (State or Country)

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
 (Informant) E. A. Shuman
 (Address) Bureau Idaho

15. 12/28 1914 W. M. Shuman
 Filed _____ Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH Dec 28 1913
 (Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from Dec 25 1913, to Dec 28 1913, that I last saw him alive on Dec 28 1913, and that death occurred on the date stated above, at 10 A.M. The CAUSE OF DEATH* was as follows:
Fracture of skull
Due to a fall (accidental)

_____ (Duration) _____ yrs. _____ mos. 4 ds.

Contributory (Secondary) _____

_____ (Duration) _____ yrs. _____ mos. _____ ds.
 (Signed), E. P. Blackhouse M. D.
12/30 1913 (Address) Idaho

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place _____ In the _____
 of death _____ yrs. _____ mos. _____ ds. State _____ yrs. _____ mos. _____ ds.
 Where was disease contracted, _____
 If not at place of death? _____
 Former or _____
 usual residence. _____

19. PLACE OF BURIAL OR REMOVAL Idaho DATE OF BURIAL Dec 31, 1913

20. UNDERTAKER E. M. Brower ADDRESS Idaho

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Form V. S. No. 5. 12½ M. 7-24-11

CERTIFICATE OF DEATH

Stack

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics
File No. 6569
Registered No. 470

1. PLACE OF DEATH. Registration District No. 78
County of Bonner Primary Registration District No. 2155
City of Sandpoint (No. , St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Mary Williams

If death occurred in a hospital, institution or camp give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX Female 4. COLOR OR RACE White 5. SINGLE, MARRIED, WIDOWED OR DIVORCED. Widow
(Write the word.)

6. DATE OF BIRTH Unknown
(Month) (Day) (Year)

7. AGE 56 yrs. mos. ds. IF LESS than 1 day how many hrs. or min?

8. OCCUPATION (a) Trade, profession or particular kind of work. Housewife (b) General nature of industry business or establishment in which employed (or employer) Retired

9. BIRTHPLACE Ill.
(State or Country)

10. NAME OF FATHER Joseph Gibbard.

11. BIRTHPLACE OF FATHER Unknown.
(State or Country)

12. MAIDEN NAME OF MOTHER L. Loo

13. BIRTHPLACE OF MOTHER Loo
(State or Country)

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) H. E. Bertram
(Address) City

15. Filed 12/31/1913 M. M. McQueen
Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH Dec 30 1913.
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from Dec 30 1913, to Dec 30 1913 that I last saw her alive on Dec 30 1913 and that death occurred on the date stated above, at 7:30 PM.

The CAUSE OF DEATH* was as follows:
Cerebral Hemorrhage.

(Duration) yrs. mos. ds. 2 hours

Contributory (Secondary)

(Duration) yrs. mos. ds.
(Signed) C. P. Stackhouse M. D.
Dec 31 1913 (Address) Sandpoint.

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place In the
of death yrs. mos. ds. State yrs. mos. ds.
Where was disease contracted,
If not at place of death?
Former or
usual residence.

19. PLACE OF BURIAL OR REMOVAL DATE OF BURIAL

Butte Mont Jan 1 1913

20. UNDERTAKER. ADDRESS

E. M. Bauer S. P.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Form V, S. No. 5. 12½ M. 7-24-11

CERTIFICATE OF DEATH

State of Idaho

BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH. Registration District No. 78 me
County of Bonner Primary Registration District No. 2157
City of Sandpoint (No. 2. 3rd St.)

File No. 6570
Registered No. 476

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

Thomas Thomanon

If death occurred in a hospital, institution or camp give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX male 4. COLOR OR RACE White 5. SINGLE, MARRIED, WIDOWED OR DIVORCED. Married
(Write the word.)

6. DATE OF BIRTH Oct 3 1839
(Month) (Day) (Year)

7. AGE 74 yrs. 2 mos. 27 ds. IF LESS than 1 day
how many hrs. or min?

8. OCCUPATION
(a) Trade, profession or particular kind of work. Public official
(b) General nature of industry business or establishment in which employed (or employer) Retired

9. BIRTHPLACE
(State or Country) Norway.

10. NAME OF FATHER

11. BIRTHPLACE OF FATHER
(State or Country) Norway

12. MAIDEN NAME OF MOTHER

13. BIRTHPLACE OF MOTHER
(State or Country) Norway

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) W. E. Thomanon
(Address) 5.

15. Filed 12/3/1913 Wm. Thomanon
Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH Dec 30 1913
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from May 1912, to Dec 20 1913
that I last saw him alive on Dec 30 10 AM 1913
and that death occurred on the date stated above, at 4 P. M.

The CAUSE OF DEATH* was as follows:

Pulmonary Tuberculosis

..... (Duration) 2 yrs. mos. ds.

Contributory
(Secondary)

..... (Duration) yrs. mos. ds.

(Signed) Wm. Thomanon M. D.
Jan 3 1914 (Address) Sandpoint

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place In the
of death yrs. mos. ds. State yrs. mos. ds.

Where was disease contracted,

If not at place of death?

Former or

usual residence.

19. PLACE OF BURIAL OR REMOVAL DATE OF BURIAL

Sandpoint 1/2 1914

20. UNDERTAKER ADDRESS

E. M. Brower City

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Form V. S. No. 5. 12½ M. 7-24-11

CERTIFICATE OF DEATH

1. PLACE OF DEATH. Registration District No. 78
 County of Conner Primary Registration District No. 2153
 City of Boise (No. _____, _____ St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

Hanna Thervik

State of Idaho
 BOARD OF HEALTH
 Bureau of Vital Statistics

File No. 6571
 Registered No. 477

If death occurred in a hospital, institution or camp give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX female 4. COLOR OR RACE white 5. SINGLE, MARRIED, WIDOWED OR DIVORCED. married
 (Write the word.)
 6. DATE OF BIRTH Oct 1 1873
 (Month) (Day) (Year)

7. AGE 40 yrs. 2 mos. 30 ds. IF LESS than 1 day how many _____ hrs. or _____ min?

8. OCCUPATION

(a) Trade, profession or particular kind of work.
 (b) General nature of industry business or establishment in which employed (or employer)

9. BIRTHPLACE

(State or Country) Norway

10. NAME OF FATHER

John Catvaag

11. BIRTHPLACE OF FATHER

(State or Country) Norway

12. MAIDEN NAME OF MOTHER

Ellen Catvaag

13. BIRTHPLACE OF MOTHER

(State or Country) Norway

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Knut Thervik
 (Address) Boise Idaho

15.

Filed Jan 1 1914

Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH

Dec 31 1913
 (Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from

Nov 15 1913, to Nov 25 1913

that I last saw him alive on Nov 25 1913

and that death occurred on the date stated above, at 1 A.M.

The CAUSE OF DEATH* was as follows:

Pulmonary Tuberculosis

(Duration) _____ yrs. _____ mos. _____ ds.

Contributory
 (Secondary)

(Duration) _____ yrs. _____ mos. _____ ds.

(Signed) M. M. M. M. M. D.

Jan 1 1913 (Address) San Francisco

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death _____ yrs. _____ mos. _____ ds. In the State _____ yrs. _____ mos. _____ ds.

Where was disease contracted,

If not at place of death?

Former or

usual residence.

19. PLACE OF BURIAL OR REMOVAL

Sandpoint Ida DATE OF BURIAL Jan 3 1914

20. UNDERTAKER

EMM Brewer ADDRESS J.C.

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Form V. S. No. 5. 12½ M. 7-24-11

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics
File No. **6572**
Registered No. **7168**

1. PLACE OF DEATH. Registration District No. **12**
County of **Butte** Primary Registration District No. **2051**
City of **Rathdrum** (No. _____, St.) _____

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME **Anthony W. Green**

If death occurred in a hospital, institution or camp give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX **male** 4. COLOR OR RACE **Negro** 5. SINGLE, MARRIED, WIDOWED OR DIVORCED. **widowed**
(Write the word.)

6. DATE OF BIRTH _____
(Month) (Day) (Year) **1 8 35**

7. AGE **78** yrs. _____ mos. _____ ds. IF LESS than 1 day how many _____ hrs. or _____ min?

8. OCCUPATION
(a) Trade, profession or particular kind of work. **farmer**
(b) General nature of industry business or establishment in which employed (or employer)

9. BIRTHPLACE **Mo.**
(State or Country)

10. NAME OF FATHER _____

11. BIRTHPLACE OF FATHER _____
(State or Country)

12. MAIDEN NAME OF MOTHER _____

13. BIRTHPLACE OF MOTHER _____
(State or Country)

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) **Frank Wang**
(Address) **Rathdrum**

15. Filed **1/10** 191**4** **W. J. Green**
Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH **Dec. 10** 191**3**
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from **Dec. 8.** 191**3**, to **Dec 10** 191**3**
that I last saw him alive on **Dec. 7.** 191**3**
and that death occurred on the date stated above, at **1.9** M.
The CAUSE OF DEATH* was as follows:
Acute, lobar Pneumonia

(Duration) _____ yrs. _____ mos. **3** ds.

Contributory (Secondary) _____

(Duration) _____ yrs. _____ mos. _____ ds.
(Signed) **Frank Wang** M. D.
12/10.1913. (Address) **Rathdrum, Idaho**

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death _____ yrs. _____ mos. _____ ds. In the State _____ yrs. _____ mos. _____ ds.
Where was disease contracted, _____
If not at place of death? _____
Former or usual residence _____

19. PLACE OF BURIAL OR REMOVAL DATE OF BURIAL

Spokane Wash **12/12** 191**3**
20. UNDERTAKER **Babo** ADDRESS **Rathdrum**

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Form V. S. No. 5 20M.1-16-12

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH.

Registration District No. 12County of FootwallPrimary Registration District No. 2051City of Patterson

(No. _____ St.)

File No. 6573Registered No. 567

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

George Phillips

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX

M

4. COLOR OR RACE

W

5. SINGLE, MARRIED, WIDOWED OR DIVORCED.

Single (Write the word.)

6. DATE OF BIRTH

July111893

(Month)

(Day)

(Year)

7. AGE

20

yrs.

mos.

ds.

IF LESS than 1 day
how many hrs. or
..... mins.?

8. OCCUPATION

(a) Trade, profession or particular kind of work

Farmer

(b) General nature of industry business, or establishment in which employed (or employer)

9. BIRTHPLACE

(State or Country)

Range Co Mo

10. NAME OF FATHER

W S Phillips

11. BIRTHPLACE OF FATHER

(State or Country)

Mo

12. MAIDEN NAME OF MOTHER

Mary Butler

13. BIRTHPLACE OF MOTHER

(State or Country)

Mo

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

W S Phillips

(Address)

Patterson, Ida

15.

Filed

1/101913W S Phillips

Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH

Dec91913

(Month)

(Day)

(Year)

17. I HEREBY CERTIFY, That I attended deceased from

1913, to1913,that I last saw h..... alive on..... 1913,

and that death occurred on the date stated above, at..... M.

The CAUSE OF DEATH* was as follows:

accidental fire from gunnery team

(Duration)..... yrs..... mos..... ds.

Contributory.....
(Secondary)

(Duration)..... yrs..... mos..... ds.

(Signed) W S Phillips M. D.12/10 1913 (Address) Patterson

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death..... yrs..... mos..... days. In the State..... yrs..... mos..... days.

Where was disease contracted if not at place of death?

Former or usual residence.....

19. PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

PattersonDec 10 1913

20. UNDERTAKER

ADDRESS

Babo

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Form V. S. No. 5 20M.1-16-12

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics
File No. 6574
Registered No. 366

1. PLACE OF DEATH.

Registration District No. 17

County of *Bo. Tewa*

Primary Registration District No. 2051

City of *Grattan*(No. *1st* St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

W. M. Mackel

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX

M

4. COLOR OR RACE

W

5. SINGLE, MARRIED, WIDOWED OR DIVORCED.

W. (Write the word.)

6. DATE OF BIRTH

(Month) (Day) (Year)

7. AGE

60 yrs. *0* mos. *0* ds.IF LESS than 1 day
how many *hrs.* or
mins.?

8. OCCUPATION

(a) Trade, profession or particular kind of work

Fruit Purchaser

(b) General nature of industry business, or establishment in which employed (or employer)

9. BIRTHPLACE

(State or Country)

Ohio

10. NAME OF FATHER

11. BIRTHPLACE OF FATHER

(State or Country)

12. MAIDEN NAME OF MOTHER

13. BIRTHPLACE OF MOTHER

(State or Country)

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

(Address)

15.

Filed

*1/10*191*4**W. M. Mackel*

Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH

Dec 9 191*3*
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from

Dec 5 191*3*, to *Dec 9* 191*3*that I last saw him alive on *" "* 191*3*and that death occurred on the date stated above, at *M.*

The CAUSE OF DEATH* was as follows:

Pneumonia & Erysipelas

(Duration) yrs. mos. ds.

Contributory
(Secondary)

(Duration) yrs. mos. ds.

(Signed) *W. M. Mackel* M. D.*12/10* 191*3* (Address) *Grattan*

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death yrs. mos. days. In the State yrs. mos. days.

Where was disease contracted if not at place of death?

Former or usual residence *Ohio*

19. PLACE OF BURIAL OR REMOVAL

Grattan

DATE OF BURIAL

12/10 191*3*

20. UNDERTAKER

Beabo

ADDRESS

R

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADE INK—THIS IS A PERMANENT RECORD. N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Form V. S. No. 5. 12½ M. 7-24-11

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics
File No. 6576
Registered No. 364

1. PLACE OF DEATH. Registration District No. 2118
County of Porter Primary Registration District No. 2118
City of Boonville (No. _____, St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Laurie Waller

If death occurred in a hospital, institution or camp give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX Male 4. COLOR OR RACE Indian 5. SINGLE, MARRIED, WIDOWED OR DIVORCED. Single
(Write the word.)
6. DATE OF BIRTH Nov 5 1912
(Month) (Day) (Year)

7. AGE 1 yrs. 1 mos. — ds. IF LESS than 1 day how many _____ hrs. or _____ min?

8. OCCUPATION
(a) Trade, profession or particular kind of work.
(b) General nature of industry business or establishment in which employed (or employer)

9. BIRTHPLACE (State or Country) Reservation

10. NAME OF FATHER Baptiste Waller

11. BIRTHPLACE OF FATHER (State or Country) Flathead Reservation

12. MAIDEN NAME OF MOTHER Delicity

13. BIRTHPLACE OF MOTHER (State or Country) Flathead Reservation

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Baptiste Waller
(Address) Charley Idaho

15. Jan. 10/1914
Filed Jan 10 1913 J. J. Long
Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH Dec 3 1913
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from 191 to 191
that I last saw h. — alive on 191
and that death occurred on the date stated above, at — M.

The CAUSE OF DEATH* was as follows:
Used. No physician
from this place.
(Duration) _____ yrs. _____ mos. _____ ds.
Contributory (Secondary) _____
(Duration) _____ yrs. _____ mos. _____ ds.
(Signed) _____ M. D.
_____ 19 _____ (Address) _____

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place _____ In the _____
of death _____ yrs. _____ mos. _____ ds. State _____ yrs. _____ mos. _____ ds.
Where was disease contracted, _____
If not at place of death? _____
Former or _____
usual residence _____

19. PLACE OF BURIAL OR REMOVAL DATE OF BURIAL Dec 3 1913
20. UNDERTAKER ADDRESS None

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Form V. S. No. 5. 12½ M. 7-24-11

CERTIFICATE OF DEATH

1. PLACE OF DEATH. Registration District No. 2118 12
 County of Butte Primary Registration District No. 2118
 City of Bozeman (No. _____, _____ St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Louisa Cherrapkin

State of Idaho
 BOARD OF HEALTH
 Bureau of Vital Statistics

File No. 6577Registered No. 365

If death occurred in a hospital, institution or camp give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX 4. COLOR OR RACE 5. SINGLE, MARRIED, WIDOWED OR DIVORCED.

Female Indian Single
 (Write the word.)
 6. DATE OF BIRTH July 2 1912
 (Month) (Day) (Year)

7. AGE IF LESS than 1 day
1 yrs. 3 mos. _____ ds. how many _____ hrs. or _____ min?

8. OCCUPATION

(a) Trade, profession or particular kind of work None
 (b) General nature of industry business or establishment in which employed (or employer)

9. BIRTHPLACE

(State or Country) Reservation

10. NAME OF FATHER

Chas. Cherrapkin

11. BIRTHPLACE OF FATHER

(State or Country) Spokane Reservation

12. MAIDEN NAME OF MOTHER

Mary

13. BIRTHPLACE OF MOTHER

(State or Country) Spokane Reservation

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Chas. Cherrapkin
 (Address) Bozeman, Ida

15.

Filed Dec 4 1913 Wm J. Langley
Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH

Dec 2 1913
 (Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from _____ 191____, to _____ 191____

that I last saw him _____ alive on _____ 191____

and that death occurred on the date stated above, at _____ M.

The CAUSE OF DEATH* was as follows:

Convulsions no phy-
sician in attendance

_____ (Duration) _____ yrs. _____ mos. _____ ds.

Contributory
 (Secondary)

_____ (Duration) _____ yrs. _____ mos. _____ ds.

(Signed) _____ M. D.

_____ 19____ (Address)

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place _____ In the _____
 of death _____ yrs. _____ mos. _____ ds. State _____ yrs. _____ mos. _____ ds.

Where was disease contracted,
 If not at place of death?
 Former or
 usual residence _____

19. PLACE OF BURIAL OR REMOVAL DATE OF BURIAL

Dec 4 1913

20. UNDERTAKER

ADDRESS

None

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Form V. S. No. 5 20M.1-16-12

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics
File No. **6578**
Registered No. **361**

1. PLACE OF DEATH. Registration District No. **12**
County of **Routenais** Primary Registration District No. **2051**
City of **Post Falls, P.F.D. #1** (No. _____ St.)
If death occurs away from usual residence, give facts called for under special information.

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME **John Wesley Conway**

PERSONAL AND STATISTICAL PARTICULARS

3. SEX **Male** 4. COLOR OR RACE **White** 5. SINGLE, MARRIED, WIDOWED OR DIVORCED. **Married** (Write the word.)

6. DATE OF BIRTH **September 19, 1843**
(Month) (Day) (Year)

7. AGE **70 yrs. 2 mos. 2 ds.**
IF LESS than 1 day how many _____ hrs. or _____ mins.?

8. OCCUPATION
(a) Trade, profession or particular kind of work **Farmer**
(b) General nature of industry business, or establishment in which employed (or employer)

9. BIRTHPLACE
(State or Country) **Indiana (Dillboro)**

10. NAME OF FATHER **John Conway**

11. BIRTHPLACE OF FATHER
(State or Country) **Indiana**

12. MAIDEN NAME OF MOTHER **Nancy Wilson**

13. BIRTHPLACE OF MOTHER
(State or Country) **Indiana**

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) **Mrs. John W. Conway**

(Address) **Post Falls, Idaho, P.F.D. #1**

15. Filed **12/10** 191**3** **S. D. Shuman**
Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH **Nov. 20, 1913**
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from **Nov 1, 1913**, to **Nov 20, 1913**, that I last saw him alive on **"**, and that death occurred on the date stated above, at **M.**

The CAUSE OF DEATH* was as follows:

Exposure from Valerian Root Disease

(Duration) **1** yrs. **mos.** **ds.**
Contributory (Secondary) **age**

(Duration) **1** yrs. **mos.** **ds.**
(Signed) **S. D. Shuman** M. D.
11/20/13 (Address) **Post Falls**

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death. _____ yrs. _____ mos. _____ days. In the State. _____ yrs. _____ mos. _____ days.

Where was disease contracted if not at place of death?

Former or usual residence _____

19. PLACE OF BURIAL OR REMOVAL **Post Falls** DATE OF BURIAL **Nov. 23, 1913**

20. UNDERTAKER **Cassidy & Nelson** ADDRESS **Cour D'Alene**

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Form V. S. No. 5 20M.1-16-12

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics
File No. 6579
Registered No. 362

1. PLACE OF DEATH
County of Boone
City of Post Falls
Registration District No. 12
Primary Registration District No. 2017
(No. _____, St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Mary E. Mellick

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX _____ 4. COLOR OR RACE _____ 5. SINGLE, MARRIED, WIDOWED OR DIVORCED.
(Write the word.)

6. DATE OF BIRTH

(Month) (Day) (Year)

7. AGE
57 yrs. _____ mos. _____ ds.
IF LESS than 1 day how many _____ hrs. or _____ mins.

8. OCCUPATION.
(a) Trade, profession or particular kind of work _____
(b) General nature of industry, business, or establishment in which employed (or employer) _____

9. BIRTHPLACE
(State or Country) _____

10. NAME OF FATHER

11. BIRTHPLACE OF FATHER
(State or Country) _____

12. MAIDEN NAME OF MOTHER

13. BIRTHPLACE OF MOTHER
(State or Country) _____

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) John Mellick

(Address) _____

15. Filed 1/10 1914 W. D. Sweeney
Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH
September 4th 1913
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from Jan 6 1911, to Sept 3rd 1913 that I last saw him alive on May 4th 1913, and that death occurred on the date stated above, at 3 A.M.

The CAUSE OF DEATH* was as follows:

Pulmonary Tuberculosis complicated by tubercular enteritis

(Duration) 3 yrs. _____ mos. _____ ds.
Contributory Tubercular enteritis
(Secondary)

(Duration) _____ yrs. _____ mos. 21 ds.

(Signed) B. F. Connelley M. D.
Sept 4, 1913 (Address) Post Falls, Idaho

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death _____ yrs. _____ mos. _____ days. In the State _____ yrs. _____ mos. _____ days.

Where was disease contracted if not at place of death? _____

Former or usual residence _____

19. PLACE OF BURIAL OR REMOVAL Pleasant view Cem DATE OF BURIAL Sept 5 1913

20. UNDERTAKER Cassidy & Nelson ADDRESS Cour D'Alene

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Form V. S. No. 5 20M.1-16-12

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH

Registration District No. 12County of PortneuePrimary Registration District No. 2051City of Parklawn

(No. _____, _____ St.)

File No. 6589Registered No. 369

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Harold M. Mueser

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX M4. COLOR OR RACE W

5. SINGLE, MARRIED, WIDOWED OR DIVORCED.

(Write the word.)

6. DATE OF BIRTH

(Month) (Day) (Year)

7. AGE

49 yrs. 0 mos. 0 ds.

IF LESS than 1 day
how many _____ hrs. or
_____ mins.?

8. OCCUPATION

(a) Trade, profession or particular kind of work

(b) General nature of industry business, or establishment in which employed (or employer)

Labr

9. BIRTHPLACE

(State or Country)

Norway

10. NAME OF FATHER

Mueser

11. BIRTHPLACE OF FATHER

(State or Country)

Norway

12. MAIDEN NAME OF MOTHER

—

13. BIRTHPLACE OF MOTHER

(State or Country)

Norway

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

Dr. Sage

(Address)

Parklawn

15.

Filed 1/101914H. Mueser

Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH

(Month)

(Day)

(Year)

17. I HEREBY CERTIFY, That I attended deceased from

Oct. 1913, to Dec 24 1913that I last saw him alive on 23 1913and that death occurred on the date stated above, at 94 M.

The CAUSE OF DEATH* was as follows:

Tuberculosis of Lungs

(Duration)

yrs.

mos.

ds.

Contributory

(Secondary)

(Duration)

yrs.

mos.

ds.

(Signed)

J. D. Mueser

M. D.

12/29 1913 (Address)

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death Co. Harst. Parklawn 2 months
yrs. mos. days. State. yrs. mos. days.

Where was disease contracted if not at place of death?

Former or usual residence St. Maris

19. PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

Parklawn12/28 1913

20. UNDERTAKER

ADDRESS

Rabbs & Son

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Form V. S. No. 5 20M.1-16-12

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH.

Registration District No. "2" 27

County of Franklin

Primary Registration District No. 2119

City of Preston

(No. _____, St.)

File No. 6581

Registered No. 28

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Grus A Smith

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX

Male

4. COLOR OR RACE

White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED.

(Write the word.)

6. DATE OF BIRTH

Dec 31 1913
(Month) (Day) (Year)

7. AGE

63 yrs. 11 mos. 21 ds.

IF LESS than 1 day
how many hrs. or
..... mins.?

8. OCCUPATION

(a) Trade, profession or particular kind of work

Barber

(b) General nature of industry business, or establishment in which employed (or employer)

9. BIRTHPLACE

(State or Country)

England

10. NAME OF FATHER

Geo A Smith

11. BIRTHPLACE OF FATHER

(State or Country)

England

12. MAIDEN NAME OF MOTHER

Sarah Hughes

13. BIRTHPLACE OF MOTHER

(State or Country)

England

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

W. P. Rosman

(Address)

Preston & Co.

15.

Filed

Jan 12 1914 D. A. Cullen

Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH

Dec. 21st 1913

(Month)

(Day)

191

(Year)

17. I HEREBY CERTIFY, That I attended deceased from

Oct. 1913 to Dec. 21st 1913

that I last saw him alive on Dec. 18th 1913

and that death occurred on the date stated above, at 9:45 P.M.

The CAUSE OF DEATH* was as follows:

carcinoma of the throat

(Duration)

6 yrs. 6 mos. 6 ds.

Contributory
(Secondary)

(Duration)

6 yrs. 6 mos. 6 ds.

(Signed)

Alfred Cullen

M. D.

4/23-1913 (Address) Preston

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place

of death. yrs. mos. days.

In the

State. yrs. mos. days.

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

Preston

Dec 24 1913

20. UNDERTAKER

ADDRESS

J. J. Hansen

Preston

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Form V. S. No. 5 20M.1-16-12

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH.

Registration District No.

County of Franklin

Primary Registration District No.

City of Preston

(No. St.)

File No. 6582Registered No. 27

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Elma F. Pinner

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX

4. COLOR OR RACE

5. SINGLE, MARRIED, WIDOWED OR DIVORCED.

Male White (Write the word.)

6. DATE OF BIRTH

Nov 9 1913
(Month) (Day) (Year)

7. AGE

30 yrs. 1 mos. ds.IF LESS than 1 day
how many hrs. or
..... mins.?

8. OCCUPATION

- (a) Trade, profession or particular kind of work
(b) General nature of industry business, or establishment in which employed (or employer)

9. BIRTHPLACE

(State or Country)

10. NAME OF FATHER

11. BIRTHPLACE OF FATHER

(State or Country)

12. MAIDEN NAME OF MOTHER

13. BIRTHPLACE OF MOTHER

(State or Country)

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

(Address)

15.

Filed 1/1 1914 Dr. C. C. Cullen
Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH

December 5 1913
(Month) (Day) (Year)17. I HEREBY CERTIFY, That I attended deceased from Dec 1 1913, to Dec 5 1913, that I last saw him alive on Dec 4 1913, and that death occurred on the date stated above, at 12:30 M.

The CAUSE OF DEATH* was as follows:

Killed in runaway accident(Duration) 1 yrs. 10 mos. 10 hrs. ds.Contributory
(Secondary)(Duration) 1 yrs. 10 mos. 10 hrs. ds.

(Signed)

Dec 5, 1913 (Address) Gardner, Idaho

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death yrs. mos. days. In the State yrs. mos. days.

Where was disease contracted if not at place of death?

Former or usual residence.

19. PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

Bethel, Idaho Dec 7 1913

20. UNDERTAKER

ADDRESS

P. J. Hansen Gardner

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Form V. S. No. 5. 12½ M. 7-24-11

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics
File No. **6583**
Registered No. **15**

1. PLACE OF DEATH. Registration District No. **12**
County of **Boise** Primary Registration District No. **2019**
City of **Pioneerville** (No. _____ St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

Richard Stokes

If death occurred in a hospital, institution or camp give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX **male** 4. COLOR OR RACE **white** 5. SINGLE, MARRIED, WIDOWED OR DIVORCED. **single**
(Write the word.)

6. DATE OF BIRTH _____
(Month) (Day) (Year)

7. AGE **about 90** yrs. mos. ds. IF LESS than 1 day how many hrs. or min?

8. OCCUPATION **Miner**
(a) Trade, profession or particular kind of work.
(b) General nature of industry business or establishment in which employed (or employer)

9. BIRTHPLACE **Ireland**
(State or Country)

10. NAME OF FATHER **unknown**

11. BIRTHPLACE OF FATHER **unknown**
(State or Country)

12. MAIDEN NAME OF MOTHER **unknown**

13. BIRTHPLACE OF MOTHER **unknown**
(State or Country)

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) _____
(Address) _____

15. Filed **1914** **G. G. Lip**
Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH **Dec unknown 1913**
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from **never attended him**
191____, to 191____

that I last saw h_____ alive on _____ 191____
and that death occurred on the date stated above, at _____ M.

The CAUSE OF DEATH* was as follows:
Found dead in bed, we think it is old age.

_____ (Duration) _____ yrs. _____ mos. _____ ds.

Contributory (Secondary) _____

_____ (Duration) _____ yrs. _____ mos. _____ ds.

(Signed) _____ M. D.

_____ 19____ (Address) _____

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place _____ In the _____
of death _____ yrs. _____ mos. _____ ds. State _____ yrs. _____ mos. _____ ds.

Where was disease contracted, _____
If not at place of death? _____
Former or _____
usual residence _____

19. PLACE OF BURIAL OR REMOVAL **Pioneerville** DATE OF BURIAL **Dec 31 1913**

20. UNDERTAKER **Had none** ADDRESS _____

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Form V. S. No. 5 20M.1-16-12

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics
File No. 6584
Registered No. _____

1. PLACE OF DEATH _____
County of Nez Perce Registration District No. 97
City of Lapwai Primary Registration District No. 2174
(No. _____) (St. _____)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Victoria Malige

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX Female 4. COLOR OR RACE White 5. SINGLE, MARRIED, WIDOWED OR DIVORCED. Married
(Write the word.)

6. DATE OF BIRTH Nov. 6 1868
(Month) (Day) (Year)

7. AGE 45 yrs. 1 mos. 20 ds.
IF LESS than 1 day how many _____ hrs. or _____ mins.?

8. OCCUPATION
(a) Trade, profession or particular kind of work House wife
(b) General nature of industry business, or establishment in which employed (or employer) _____

9. BIRTHPLACE France
(State or Country)

10. NAME OF FATHER E. Rodier

11. BIRTHPLACE OF FATHER France
(State or Country)

12. MAIDEN NAME OF MOTHER Barathier

13. BIRTHPLACE OF MOTHER France
(State or Country)

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Julius Malige
(Address) Lapwai Idaho

15. Filed December 2/1913 John N. Allen
Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH December 26th 1913
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from October 20 1913 to December 1913
that I last saw he alive on Decemb. 26 1913
and that death occurred on the date stated above, at home

The CAUSE OF DEATH* was as follows:

Cholelithiasis

(Duration) _____ yrs. 1 mos. 6 ds.

Contributory (Secondary) _____

(Duration) _____ yrs. _____ mos. _____ ds.
(Signed) John N. Allen M. D.

12-29-1913 (Address) Lapwai Idaho

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death _____ yrs. _____ mos. _____ days. In the State _____ yrs. _____ mos. _____ days.

Where was disease contracted if not at place of death? _____

Former or usual residence _____

19. PLACE OF BURIAL OR REMOVAL Lewiston Idaho DATE OF BURIAL Dec. 28 1913

20. UNDERTAKER J. E. Wallan ADDRESS Lapwai

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Form V. S. No. 5. 12½ M. 7-24-11

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH
County of Bear Lake
City of Shannon
Registration District No.
Primary Registration District No.
(No., St.)

File No. 6585
Registered No.

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

Ernest Crossley

If death occurred in a hospital, institution or camp give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX Female 4. COLOR OR RACE W 5. SINGLE, MARRIED, WIDOWED OR DIVORCED. married
(the word.)

6. DATE OF BIRTH Nov 26 1847
(Month) (Day) (Year)

7. AGE 65 yrs. 8 mos. 9 ds. IF LESS than 1 day how many hrs. or min?

8. OCCUPATION
(a) Trade, profession or particular kind of work. Wife and mother
(b) General nature of industry business or establishment in which employed (or employer)

9. BIRTHPLACE England
(State or Country)

10. NAME OF FATHER Samuel Hall

11. BIRTHPLACE OF FATHER England
(State or Country)

12. MAIDEN NAME OF MOTHER Catharine Jones

13. BIRTHPLACE OF MOTHER England
(State or Country)

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) E. J. Crossley
(Address) Shannon Idaho

15. Dr. H. H. King
Filed 191 Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH Aug 5 1913
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from July 4 1913 to Aug 5 1913
that I last saw him alive on Aug 4 1913
and that death occurred on the date stated above, at 9 P. M.
The CAUSE OF DEATH* was as follows:

Encephalitis Bulbar

(Duration) 2 yrs. — mos. — ds.

Contributory (Secondary)

(Duration) — yrs. — mos. — ds.
(Signed) A. D. Crossley M. D.
Aug 6 1913 (Address) Shannon Idaho

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place In the
of death — yrs. — mos. — ds. State — yrs. — mos. — ds.
Where was disease contracted,
If not at place of death?
Former or
usual residence

19. PLACE OF BURIAL OR REMOVAL DATE OF BURIAL

Liberty Idaho Aug. 7. 1913

20. UNDERTAKER ADDRESS

S. V. Hyman Shannon Idaho

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Form V. S. No. 5 20M.1-16-12

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH.

Registration District No.

County of

Primary Registration District No.

City of

(No. St.)

File No. **6586**

Registered No.
If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME **Louise Carnevali**

PERSONAL AND STATISTICAL PARTICULARS

3. SEX **F** 4. COLOR OR RACE **W.** 5. SINGLE, MARRIED, WIDOWED OR DIVORCED.
(Write the word.)

6. DATE OF BIRTH **Aug 2, 1913**
(Month) (Day) (Year)

7. AGE **2** yrs. **7** mos. **7** ds.
IF LESS than 1 day how many hrs. or mins.?

8. OCCUPATION **at Home**
(a) Trade, profession or particular kind of work
(b) General nature of industry, business, or establishment in which employed (or employer)

9. BIRTHPLACE **Salina, California**
(State or Country)

10. NAME OF FATHER **Thomas Carnevali**

11. BIRTHPLACE OF FATHER **Italy**
(State or Country)

12. MAIDEN NAME OF MOTHER **Antonia**

13. BIRTHPLACE OF MOTHER **Italy**
(State or Country)

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) **Nozema Carmichael**
(Address) **Stewart, Idaho**

15. Filed **191** **Ho. S. Lester**
Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH **Oct 9, 1913**
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from **Oct 9, 1913**, to **Oct 9th, 1913**
that I last saw her alive on **Oct 9th, 1913**
and that death occurred on the date stated above, at **M.**

The CAUSE OF DEATH* was as follows:
Gastro-enteritis

(Duration) yrs. mos. **10** ds.

Contributory (Secondary)

(Duration) yrs. mos. ds.

(Signed) **George S. Lester M. D.**
19 (Address) **Kellogg, Ida.**

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death yrs. mos. days. In the State yrs. mos. days.

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL **Greenwood** DATE OF BURIAL **Oct 10, 1913**

20. UNDERTAKER **E. B. Thornhill** ADDRESS **Kellogg, Ida.**

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Form V. S. No. 5 20M.1-16-12

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH.

Registration District No.

County of

Primary Registration District No.

City of

(No. St.)

Registered No.

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME *Samuel Hughes*

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX

M

4. COLOR OR RACE

W

5. SINGLE, MARRIED, WIDOWED OR DIVORCED.

(Write the word.)

6. DATE OF BIRTH

*Jan**1**1884*

(Month)

(Day)

(Year)

7. AGE

29

yrs.

9

mos.

7

ds.

IF LESS than 1 day
how many hrs. or
..... mins.

8. OCCUPATION

(a) Trade, profession or particular kind of work

mines

(b) General nature of industry business, or establishment in which employed (or employer)

9. BIRTHPLACE

(State or Country)

Wales

10. NAME OF FATHER

Samuel Hughes

11. BIRTHPLACE OF FATHER

(State or Country)

12. MAIDEN NAME OF MOTHER

Elizabeth Hughes

13. BIRTHPLACE OF MOTHER

(State or Country)

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

E. B. Thornhill

(Address)

15.

Filed

191

Geo. I. Leeper

Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH

(Month)

(Day)

191

17. I HEREBY CERTIFY, That I attended deceased from

*Oct 5th 1913, to Oct. 8th 1913,*that I last saw him alive on *Oct. 8th 1913*and that death occurred on the date stated above, at *5 P. M.*

The CAUSE OF DEATH* was as follows:

Typhoid Fever(Duration) yrs. mos. *20* ds.Contributory
(Secondary)(Duration) yrs. mos. *20* ds.

(Signed)

Geo. I. Leeper M. D.*Oct. 10 1913* (Address) *Keelogg, Ida.*

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death yrs. mos. days. In the State yrs. mos. days.

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL

Greenwood

DATE OF BURIAL

Oct 12 1913

20. UNDERTAKER

E. B. Thornhill

ADDRESS

Keelogg,

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Form V. S. No. 5 20M.1-16-12

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics
File No. **6588**

1. PLACE OF DEATH.

Registration District No. **87**

County of **Washington**

Primary Registration District No. **2184**

City of **Mural**

(No. _____, _____ St.)

Registered No. _____

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME **Mary Sife**

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX

4. COLOR OR RACE

5. SINGLE, MARRIED, WIDOWED OR DIVORCED.

Female

White

Single
(Write the word.)

6. DATE OF BIRTH

Sept 11 1913
(Month) (Day) (Year)

7. AGE

_____ yrs. **3** mos. _____ ds.

IF LESS than 1 day
how many _____ hrs. or
_____ mins.

8. OCCUPATION

(a) Trade, profession or particular kind of work

(b) General nature of industry business, or establishment in which employed (or employer)

not employed

9. BIRTHPLACE

(State or Country)

Idaho

10. NAME OF FATHER

James A Sife

11. BIRTHPLACE OF FATHER

(State or Country)

Kansas

12. MAIDEN NAME OF MOTHER

Lydia A Colburn

13. BIRTHPLACE OF MOTHER

(State or Country)

Mo

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

James A Sife

(Address)

Mural Id

15.

Filed **Dec 11 1913**

Falschmidt
Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH

Dec 12 1913
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from

Dec 11 1913, to **Dec 12 1913**,

that I last saw him alive on **Dec 12 1913**,

and that death occurred on the date stated above, at **4 A.M.**

The CAUSE OF DEATH* was as follows:

Inanition

(Duration) _____ yrs. _____ mos. _____ ds.

Contributory **Cholera Infantum**
(Secondary)

(Duration) _____ yrs. **2** mos. **3** ds.

(Signed) **Falschmidt** M. D.

Dec 12 1913 (Address) **Mural**

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death _____ yrs. _____ mos. _____ days. In the State _____ yrs. _____ mos. _____ days.

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

Mural Id

Dec 18 1913

20. UNDERTAKER

ADDRESS

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Form V. S. No. 5 20M.1-16-12		CERTIFICATE OF DEATH		State of Idaho BOARD OF HEALTH Bureau of Vital Statistics	
1. PLACE OF DEATH		Registration District No. <u>87</u>		File No. <u>6589</u>	
County of <u>Washington</u>		Primary Registration District No. <u>2154</u>		Registered No. _____	
City of <u>Minneapolis</u>		(No. _____, _____ St.)		If death occurred in a hospital, institution or camp, give its NAME instead of street and number.	
If death occurs away from usual residence, give facts called for under special information.					
2. FULL NAME <u>Emma Schwabauer</u>					
PERSONAL AND STATISTICAL PARTICULARS					
3. SEX <u>Female</u>	4. COLOR OR RACE <u>White</u>	5. SINGLE, MARRIED, WIDOWED OR DIVORCED. <u>Married</u> (Write the word.)			
6. DATE OF BIRTH <u>Mar. 17 1861</u> (Month) (Day) (Year)					
7. AGE <u>52 yrs. 9 mos. 1 ds.</u>		IF LESS than 1 day how many _____ hrs. or _____ mins.?			
8. OCCUPATION (a) Trade, profession or particular kind of work <u>House wife</u> (b) General nature of industry, business, or establishment in which employed (or employer) _____					
9. BIRTHPLACE (State or Country) <u>Russia</u>					
10. NAME OF FATHER <u>Isidor Schatner</u>					
11. BIRTHPLACE OF FATHER (State or Country) <u>Russia</u>					
12. MAIDEN NAME OF MOTHER <u>Rosa Feller</u>					
13. BIRTHPLACE OF MOTHER (State or Country) <u>Russia</u>					
14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE (Informant) <u>Jacob Schwabauer</u> (Address) <u>Minneapolis</u>					
15. Filed <u>Dec-8</u> 191 <u>3</u> <u>F. Schmitt</u> Local Registrar					
MEDICAL CERTIFICATE OF DEATH					
16. DATE OF DEATH <u>Dec. 8 1913</u> (Month) (Day) (Year)					
17. I HEREBY CERTIFY, That I attended deceased from <u>Dec 7 - 1913</u> , to <u>Dec 8 - 1913</u> , that I last saw him alive on <u>Dec 8 - 1913</u> , and that death occurred on the date stated above, at <u>8 A.M.</u> The CAUSE OF DEATH* was as follows: <u>Strangulated Hernia</u>					
(Duration) _____ yrs. _____ mos. <u>2</u> ds.					
Contributory (Secondary) _____					
(Duration) _____ yrs. _____ mos. _____ ds.					
(Signed) <u>F. Schmitt</u> M. D.					
19. (Address) <u>Minneapolis</u>					
*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.					
18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)					
At place of death _____ yrs. _____ mos. _____ days. In the State _____ yrs. _____ mos. _____ days.					
Where was disease contracted if not at place of death? _____					
Former or usual residence _____					
19. PLACE OF BURIAL OR REMOVAL <u>Minneapolis Idaho</u>				DATE OF BURIAL <u>Dec 10 1913</u>	
20. UNDERTAKER <u>F. Schmitt</u>				ADDRESS <u>Minneapolis</u>	

MARGIN RESERVED FOR BINDING
WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Form V. S. No. 5. 12½ M. 7-24-11

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH. Registration District No. 48
County of Lewis Primary Registration District No. 2127
City of Reubens (No. _____, _____ St.)

File No. 6599
Registered No. 3

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

If death occurred in a hospital, institution or camp give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX Male 4. COLOR OR RACE White 5. SINGLE, MARRIED, WIDOWED OR DIVORCED. Single
(Write the word.)

6. DATE OF BIRTH Dec. 18 1913
(Month) (Day) (Year)

7. AGE _____ yrs. _____ mos. 3 ds. IF LESS than 1 day
how many _____ hrs. or _____ min?

8. OCCUPATION

(a) Trade, profession or particular kind of work
(b) General nature of industry business or establishment in which employed (or employer)

9. BIRTHPLACE

(State or Country) Reubens Idaho

10. NAME OF FATHER Charles Ammer

11. BIRTHPLACE OF FATHER

(State or Country) Ohio

12. MAIDEN NAME OF MOTHER Stella Pleasants

13. BIRTHPLACE OF MOTHER

(State or Country) Kansas

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Stella Ammer

(Address) Reubens Idaho

15.

Filed 1-7- 1914 Edwin B. Rogers
Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH

Dec. 21 1913
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from Dec. 18 1913, to Dec. 21 1913 that I last saw him alive on Dec. 21 1913 and that death occurred on the date stated above, at 11 P. M.

The CAUSE OF DEATH* was as follows:

Cerebral Hemorrhage

(Duration) _____ yrs. _____ mos. _____ ds.*

Contributory (Secondary)

(Duration) _____ yrs. _____ mos. _____ ds.

(Signed) George Gaignard M. D.

Dec 21 1913 (Address) Reubens Idaho

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place _____ In the _____
of death _____ yrs. _____ mos. _____ ds. State _____ yrs. _____ mos. _____ ds.
Where was disease contracted,
If not at place of death?
Former or
usual residence _____

19. PLACE OF BURIAL OR REMOVAL DATE OF BURIAL

Reubens Idaho Dec 22 1913

20. UNDERTAKER ADDRESS

J. Y. Pinkerton Reubens

CERTIFICATE OF DEATH

State of Idaho

BOARD OF HEALTH
Bureau of Vital Statistics1. PLACE OF DEATH.
County of Clearwater
City of ProsserRegistration District No. 90
Primary Registration District No. 2168
(No. N. J. Sanitarium St.)File No. 6591Registered No. 48

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

John Nelson

If death occurred in a hospital, institution or camp give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX Male 4. COLOR OR RACE White 5. SINGLE, MARRIED, WIDOWED OR DIVORCED.
Widowed
(Write the word.)6. DATE OF BIRTH 1837
(Month) (Day) (Year)7. AGE 76 yrs. mos. ds. IF LESS than 1 day
how many hrs. or min?8. OCCUPATION
(a) Trade, profession or particular kind of work. Stone Mason
(b) General nature of industry business or establishment in which employed (or employer) None for past 2½ yrs.9. BIRTHPLACE
(State or Country) Sweden

10. NAME OF FATHER ✓

11. BIRTHPLACE OF FATHER ✓
(State or Country)

12. MAIDEN NAME OF MOTHER ✓

13. BIRTHPLACE OF MOTHER ✓
(State or Country)14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) John W. Green
(Address) Prosser, Ida15. Dec 31 1913
Local Registrar J. M. Taylor

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH October 3. 1913
(Month) (Day) (Year)17. I HEREBY CERTIFY, That I attended deceased from Sept 8. 1913, to Oct 3 1913
that I last saw him alive on Oct 3 1913
and that death occurred on the date stated above, at 4 P. M.

The CAUSE OF DEATH* was as follows:

Cerebral hemorrhage.(Duration) yrs. mos. ds.
Contributory Insanity
(Secondary)(Duration) yrs. mos. ds.
(Signed) John W. Green M. D.
Oct 4 1913 (Address) Prosser, Idaho

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place In the
of death yrs. mos. ds. State yrs. mos. ds.
Where was disease contracted,
If not at place of death?
Former or
usual residence.19. PLACE OF BURIAL OR REMOVAL DATE OF BURIAL
Removed to Coeur d'Alene Oct 5 191320. UNDERTAKER ADDRESS
W. E. Stoddard Prosser, Ida

CERTIFICATE OF DEATH

State of Idaho

BOARD OF HEALTH
Bureau of Vital StatisticsFile No. 6592Registered No. 49

If death occurred in a hospital, institution or camp give its NAME instead of street and number.

1. PLACE OF DEATH.

County of BlaineCity of OrfordRegistration District No. 90Primary Registration District No. 2168

(No. _____ St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

Richard Gornuan

PERSONAL AND STATISTICAL PARTICULARS

3. SEX

Male

4. COLOR OR RACE

white

5. SINGLE, MARRIED, WIDOWED OR DIVORCED.

single

(Write the word.)

6. DATE OF BIRTH

1880
(Month) (Day) (Year)

7. AGE

33 yrs. mos. ds.IF LESS than 1 day
how many hrs. or min?

8. OCCUPATION

(a) Trade, profession or particular kind of work.

laborer

(b) General nature of industry business or establishment in which employed (or employer)

9. BIRTHPLACE

(State or Country)

Minnesota

10. NAME OF FATHER

?

11. BIRTHPLACE OF FATHER

(State or Country)

?

12. MAIDEN NAME OF MOTHER

?

13. BIRTHPLACE OF MOTHER

(State or Country)

?

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

(Address)

Geo W. Gornuan
Orford, Idaho

15.

Filed Dec 31 1913

Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH

Oct.311913

(Month)

(Day)

(Year)

17. I HEREBY CERTIFY, That I attended deceased from
Sept. 30 1913, to Oct 31 1913that I last saw him alive on Oct 25 1913and that death occurred on the date stated above, at 6 AM M.

The CAUSE OF DEATH* was as follows:

organic heart disease
for Gorter(Duration) 6 yrs. mos. ds.Contributory
(Secondary)insanity(Duration) 6 yrs. mos. ds.

(Signed)

John M. Gornuan

M. D.

M. U. I. 1913 (Address) Orford, Idaho

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place

In the

of death yrs. mos. ds. State yrs. mos. ds.

Where was disease contracted,

If not at place of death?

Former or

usual residence.

19. PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

The northern Idaho
Sanatorium.Nov. 3 1913

20. UNDERTAKER

ADDRESS

CERTIFICATE OF DEATH

State of Idaho

BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH.

County of dequaterCity of OrfinoRegistration District No. 90Primary Registration District No. 2168

(No. _____, _____ St.)

File No. 6593Registered No. 50

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Patrick Burns.

If death occurred in a hospital, institution or camp give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX

Male

4. COLOR OR RACE 5. SINGLE, MARRIED, WIDOWED OR DIVORCED.

whiteSingle
(Write the word.)

6. DATE OF BIRTH

Mr.121913

(Month)

(Day)

(Year)

7. AGE

57 yrs. mos. ds.IF LESS than 1 day
how many hrs. or min?

8. OCCUPATION

(a) Trade, profession or particular kind of work.

Laborer

(b) General nature of industry business or establishment in which employed (or employer)

9. BIRTHPLACE

(State or Country)

N.Y.

10. NAME OF FATHER

11. BIRTHPLACE OF FATHER

(State or Country)

12. MAIDEN NAME OF MOTHER

13. BIRTHPLACE OF MOTHER

(State or Country)

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

(Address)

5.

filed Dec 31 1913

Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH

Nov.12

1913

(Month)

(Day)

(Year)

17. I HEREBY CERTIFY, That I attended deceased from

Sept. 20

1913, to

Nov. 12

1913

that I last saw him alive on Nov 11 1913and that death occurred on the date stated above, at 11 P. M.

The CAUSE OF DEATH* was as follows:

Cerebral H

(Duration) yrs. mos. ds.

Contributory (Secondary)

Insanity

(Duration) yrs. mos. ds.

(Signed)

Nov 12 1913(Address) Orfino Idaho

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place

In the

of death yrs. mos. ds. State yrs. mos. ds.

Where was disease contracted,

If not at place of death?

Former or

usual residence.

19. PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

✓Nov 14 1913

20. UNDERTAKER

ADDRESS

✓✓

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics
File No. **6594**
Registered No. **57**

PLACE OF DEATH.
County of **Shoshone**
City of **Orfino**

Registration District No. **90**
Primary Registration District No. **2168**
(No., St.)

death occurs away from us-
residence, give facts called
under special information.

2. FULL NAME

Mary McCullough

If death occurred in a hospital, in-
stitution or camp give its NAME
instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

SEX **female** 4. COLOR OR RACE **white** 5. SINGLE, MARRIED, WID-
OWED OR DIVORCED. **married**
(Write the word.)

DATE OF BIRTH
(Month) (Day) (Year)
1

AGE **58** yrs. mos. ds. IF LESS than 1 day
how many hrs. or min?

OCCUPATION
(a) Trade, profession or
particular kind of work. **Housewife**
(b) General nature of industry
business or establishment in
which employed (or employer)

BIRTHPLACE
(State or Country) **Pen-**

NAME OF
FATHER **9**

BIRTHPLACE
OF FATHER **9**
(State or Country)

MAIDEN NAME
OF MOTHER **9**

BIRTHPLACE
OF MOTHER **9**
(State or Country)

THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

Deputy Registrar
(Address) **Orfino, Ida**

Dec 31 1913
J. M. Fairly
Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH
Nov. 30
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from
Nov 21 1913, to **Nov 30** 1913
that I last saw her alive on **Nov 29** 1913
and that death occurred on the date stated above, at **8 AM**
The CAUSE OF DEATH* was as follows:

Gastitis

(Duration) **2** yrs. mos. ds.
Contributory **Insanity**
(Secondary)

(Duration) **2** yrs. mos. ds.
(Signed) **John W. Brown** M. D.
Nov 30 1913 (Address) **Orfino**

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1)
MEANS OF INJURY; (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions,
Transients or Recent Residents.)

At place In the
of death yrs. mos. ds. State yrs. mos. ds.
Where was disease contracted,
If not at place of death?
Former or
usual residence.

19. PLACE OF BURIAL OR REMOVAL **No Idaho Sanitarium** DATE OF BURIAL **Dec 2 1913**

20. UNDERTAKER ADDRESS

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Form V. S. No. 5 20M.1-16-12

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH.

Registration District No. 90County of ClearwaterPrimary Registration District No. 2168City of Frank

(No. _____, _____ St.)

File No. 6596Registered No. 53

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

John W. Pruett

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX

4. COLOR OR RACE

5. SINGLE, MARRIED, WIDOWED OR DIVORCED.

MaleWhiteMarried
(Write the word.)

6. DATE OF BIRTH

June
(Month)

(Day)

1 1841
(Year)

7. AGE

73 yrs.

mos.

ds.

IF LESS than 1 day
how many hrs. or
..... mins.?

8. OCCUPATION

(a) Trade, profession or particular kind of work

Farmer

(b) General nature of industry business, or establishment in which employed (or employer)

9. BIRTHPLACE

(State or Country)

Michigan

10. NAME OF FATHER

11. BIRTHPLACE OF FATHER

(State or Country)

12. MAIDEN NAME OF MOTHER

13. BIRTHPLACE OF MOTHER

(State or Country)

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

(Address)

Carl W. Horanville
Probus, Ida

15.

Filed

July 16 1914
J. M. Fairly
Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH

Dec
(Month)15
(Day)1913
(Year)

17. I HEREBY CERTIFY, That I attended deceased from

14/151913to 12/101913that I last saw him alive on 12/10 1913

and that death occurred on the date stated above, at _____ M.

The CAUSE OF DEATH* was as follows:

Chronic poisoning of body
Cancer of head with
metastases in Lung & Liver.

(Duration)

yrs.

mos.

ds.

Contributory

(Secondary)

(Duration)

yrs.

mos.

ds.

(Signed)

Carl W. Horanville M. D.12/27 1913

(Address)

Probus, Ida

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place

of death

yrs.

mos.

days.

In the

State

yrs.

mos.

days.

Where was disease contracted if not at place of death?

Former or

usual residence

19. PLACE OF BURIAL OR REMOVAL

Frank

DATE OF BURIAL

Dec 16 1913

20. UNDERTAKER

W. E. Stoddard

ADDRESS

Gifford

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Form V. S. No. 5 20M.1-16-12

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH
County of Blaine
City of Orfino
Registration District No. 90
Primary Registration District No. 2168
(No. _____, St.)

File No. 6597
Registered No. 34

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Mary Kidden

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX Female 4. COLOR OR RACE White 5. SINGLE, MARRIED, WIDOWED OR DIVORCED. Married
(Write the word.)

6. DATE OF BIRTH Feb 27 1892
(Month) (Day) (Year)

7. AGE 71 yrs. 0 mos. 0 ds.
IF LESS than 1 day how many hrs. or mins.?

8. OCCUPATION
(a) Trade, profession or particular kind of work House wife
(b) General nature of industry, business, or establishment in which employed (or employer)

9. BIRTHPLACE
(State or Country)

10. NAME OF FATHER Thomas

11. BIRTHPLACE OF FATHER England
(State or Country)

12. MAIDEN NAME OF MOTHER Thomas

13. BIRTHPLACE OF MOTHER Idaho
(State or Country)

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Edw. W. Harnwell
(Address) Orfino, Ida

15. Filed June 10 1913
Local Registrar H. J. Fairly

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH Dec 25 1913
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from Dec 25 1913 to Dec 25 1913
that I last saw her alive on Dec 25 1913

and that death occurred on the date stated above, at 20 M.

The CAUSE OF DEATH* was as follows:

Cancer of Pharynx & palate

(Duration) 1 yrs. 6 mos. 0 ds.

Contributory (Secondary)

(Duration) 0 yrs. 0 mos. 0 ds.

(Signed) E. W. Harnwell M. D.

19 (Address) Orfino

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death.....yrs.....mos.....days. In the State.....yrs.....mos.....days.

Where was disease contracted if not at place of death?.....

Former or usual residence.....

19. PLACE OF BURIAL OR REMOVAL Orfino Ida DATE OF BURIAL Dec 30 1913

20. UNDERTAKER W. C. Stoddard ADDRESS Elfrida Ida

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Form V. S. No. 5 20M.1-16-12

CERTIFICATE OF DEATH—

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics
File No. 6598
Registered No. 55

1. PLACE OF DEATH. Registration District No. 90
County of Clearwater Primary Registration District No. 2168
City of Prosser (No. _____, _____ St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Mary Leman

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX Female 4. COLOR OR RACE White 5. SINGLE, MARRIED, WIDOWED OR DIVORCED. Widowed
(Write the word.)

6. DATE OF BIRTH _____
_____ 1/8/17
(Month) (Day) (Year)

7. AGE 56 yrs. _____ mos. _____ ds.
IF LESS than 1 day how many _____ hrs. or _____ mins.

8. OCCUPATION
(a) Trade, profession or particular kind of work House wife
(b) General nature of industry business, or establishment in which employed (or employer) _____

9. BIRTHPLACE
(State or Country) Idaho

10. NAME OF FATHER ✓

11. BIRTHPLACE OF FATHER
(State or Country) Ireland

12. MAIDEN NAME OF MOTHER Chen

13. BIRTHPLACE OF MOTHER
(State or Country) Ireland

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Arthur Shaw
(Address) Prosser, Ida

15. Filed Jan 10 1917 J. M. Gaily
Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH
On 27 1913
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from 12/25 1913, to 12/26 1913
that I last saw her alive on 12/26 1913,
and that death occurred on the date stated above, at 29 M.

The CAUSE OF DEATH* was as follows:
Thrombosis of coronary artery
(Duration) _____ yrs. _____ mos. _____ ds.

Contributory (Secondary) _____
(Duration) _____ yrs. _____ mos. _____ ds.
(Signed) E. W. Howard M. D.
12/26 1913 (Address) Prosser, Ida

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death _____ yrs. _____ mos. _____ days. In the State _____ yrs. _____ mos. _____ days.
Where was disease contracted if not at place of death? _____

Former or usual residence _____

19. PLACE OF BURIAL OR REMOVAL Long View, Wis DATE OF BURIAL ✓ 1913

20. UNDERTAKER H. C. Stoddard ADDRESS Prosser, Ida

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Form V. S. No. 5. 12-24-11

1. PLACE OF DEATH. Registration District No. 100
 County of Gronov Primary Registration District No. 2178
 City of Symon (No. _____ St.)
 If death occurs away from usual residence, give facts called for under special information. 2. FULL NAME Blanche, Alta, Gronov
 BOARD OF HEALTH
 Bureau of Vital Statistics
 File No. 6600
 Registered No. 39
 If death occurred in a hospital, institution or camp give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX Female 4. COLOR OR RACE White 5. SINGLE, MARRIED, WIDOWED OR DIVORCED. Baby -
 (Write the word.)
 6. DATE OF BIRTH Nov - 29 - 1913
 (Month) (Day) (Year)
 7. AGE _____ yrs. _____ mos. 0 ds. IF LESS than 1 day how many _____ hrs. or _____ min?
 8. OCCUPATION Baby
 (a) Trade, profession or particular kind of work
 (b) General nature of industry business or establishment in which employed (or employer)
 9. BIRTHPLACE Symon Idaho
 (State or Country)
 10. NAME OF FATHER Seth B. Gronov
 11. BIRTHPLACE OF FATHER Symon - Idaho
 (State or Country)
 12. MAIDEN NAME OF MOTHER Hannah Simmons
 13. BIRTHPLACE OF MOTHER Symon Idaho
 (State or Country)
 14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
 (Informant) Marshall Gronov
 (Address) Gronov Idaho
 15. L. L. Espe
 Local Registrar
 Filed 12-1 1913

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH Nov. 29 1913
 (Month) (Day) (Year)
 17. I HEREBY CERTIFY, That I attended deceased from Nov. 29 1913, to Nov. 29 1913
 that I last saw her alive on Nov. 29 1913
 and that death occurred on the date stated above, at 10 P. M.
 The CAUSE OF DEATH* was as follows:
Due to Excessive pressure
 (Duration) 1 yrs. 0 mos. 20 ds.
 Contributory (Secondary) _____
 (Duration) _____ mos. _____ ds.
 (Signed) H. H. Simmons M. D.
Nov. 29, 1913 (Address) Refburg Ida.
 *State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.
 18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
 At place of death _____ yrs. _____ mos. _____ ds. State _____ yrs. _____ mos. _____ ds.
 Where was disease contracted, If not at place of death? _____
 Former or usual residence _____
 19. PLACE OF BURIAL OR REMOVAL Refburg - DATE OF BURIAL 12/1 1913
 20. UNDERTAKER Refburg ADDRESS Refburg

MARGIN RESERVED FOR BINDING
WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PH
CIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact s
ment of OCCUPATION is very important. See instructions on back of certificate.

Form V. S. No. 5 20M-1-16-12

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics
File No. 6601
Registered No. 40

1. PLACE OF DEATH

County of Yamont

City of Sugar

Registration District No. 100

Primary Registration District No. 2178

(No. _____ St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

Ernest Louis Silvestro

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX

Female

4. COLOR OR RACE

White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED

Single
(Write the word.)

6. DATE OF BIRTH

February
(Month)

24
(Day)

1898
(Year)

7. AGE

15 yrs. 9 mos. 12 ds.

IF LESS than 1 day
how many _____ hrs. or
_____ mins.

8. OCCUPATION

(a) Trade, profession or particular kind of work
(b) General nature of industry, business, or establishment in which employed (or employer)

Student

9. BIRTHPLACE

(State or Country)

Moody Creek Idaho

10. NAME OF FATHER

James Silvestro

11. BIRTHPLACE OF FATHER

(State or Country)

England

12. MAIDEN NAME OF MOTHER

Mary Jane Gardner

13. BIRTHPLACE OF MOTHER

(State or Country)

Utah

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

James Silvestro

(Address)

Sugar

15.

Filed

12-6

1913

L. L. Espe

Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

Dec
(Month)

5
(Day)

1913
(Year)

17. I HEREBY CERTIFY, That I attended deceased from
191., to Dec 5 191.
that I last saw h. alive on Dec 5 191.
and that death occurred on the date stated above, at 2 AM

The CAUSE OF DEATH* was as follows:

Opium for apoplexy

(Duration) _____ yrs. _____ mos. _____ ds.

Contributory
(Secondary)

acute gangrene of foot

(Duration) _____ yrs. _____ mos. _____ ds.

(Signed)

R. A. Hays M. D.

19

(Address)

City

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death _____ yrs. _____ mos. _____ days. In the State _____ yrs. _____ mos. _____ days.

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

Idaho

12/6 1913

20. UNDERTAKER

ADDRESS

Idaho

Idaho

Form V. S. No. 5 20M.1-16-12

CERTIFICATE OF DEATH

Wm Walker State of Idaho
 BOARD OF HEALTH
 Bureau of Vital Statistics
 File No. 6603
 Registered No. 42

1. PLACE OF DEATH

Registration District No. 100County of FranklinPrimary Registration District No. 2178City of Hubbard(No. RalphSt.) Rock

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX

4. COLOR OR RACE

5. SINGLE, MARRIED, WIDOWED OR DIVORCED.

MaleWhite

(Write the word.)

6. DATE OF BIRTH

Aug171908

(Month)

(Day)

(Year)

7. AGE

5 yrs. 4 mos. 6 ds.IF LESS than 1 day
how many hrs. or
..... mins.?

8. OCCUPATION

(a) Trade, profession or particular kind of work
(b) General nature of industry business, or establishment in which employed (or employer)Child

9. BIRTHPLACE

(State or Country)

Hubbard Idaho

10. NAME OF FATHER

James Rock

11. BIRTHPLACE OF FATHER

(State or Country)

Utah

12. MAIDEN NAME OF MOTHER

Lilly M Stevens

13. BIRTHPLACE OF MOTHER

(State or Country)

Utah

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

Lilly - Rock -

(Address)

Hubbard

15.

Filed 12-301913L. C. Egan

Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

12241913

(Month)

(Day)

(Year)

17. I HEREBY CERTIFY, That I attended deceased from

1913, to1913,that I last saw him alive on Oct 1913and that death occurred on the date stated above, at M.

The CAUSE OF DEATH* was as follows:

Acute Anterior Poliomyelitis(Duration) 1 yrs. 0 mos. 0 ds.

Contributory

(Secondary)

(Duration) 1 yrs. 0 mos. 0 ds.

(Signed)

James M. D.

19

(Address) Hubbard, Idaho

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death.....yrs.....mos.....days. In the State.....yrs.....mos.....days.

Where was disease contracted if not at place of death?.....

Former or usual residence.....

19. PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

Hubbard12/26 1913

20. UNDERTAKER

ADDRESS

J. R. YoungHubbard

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Form V. S. No. 5 20M.1-16-12

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH.

Registration District No. 100County of MadisonPrimary Registration District No. 2178City of Replury

(No. _____)

St.)

File No. 6604Registered No. 43

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Vaughn Herbert Flamm

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX

Male

4. COLOR OR RACE

White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED.

(Write the word.)

6. DATE OF BIRTH

11

(Month)

29

(Day)

1912

(Year)

7. AGE

1 yrs.mos. 25

ds.

IF LESS than 1 day
how many hrs. or
..... mins.?

8. OCCUPATION

(a) Trade, profession or particular kind of work

(b) General nature of industry business, or establishment in which employed (or employer)

9. BIRTHPLACE

(State or Country) Idaho

10. NAME OF FATHER

Jacob H. Flamm

11. BIRTHPLACE OF FATHER

(State or Country) Idaho

12. MAIDEN NAME OF MOTHER

Delila Larsen

13. BIRTHPLACE OF MOTHER

(State or Country) Idaho

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) J. H. Flamm(Address) Replury

15.

Filed 12-261913Local Registrar J. H. Eape

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH

12

(Month)

24

(Day)

1913

(Year)

17. I HEREBY CERTIFY, That I attended deceased from

Dec 201913

to

Dec 241913that I last saw him alive on Dec 24 1913and that death occurred on the date stated above, at 11:50 P.M.

The CAUSE OF DEATH* was as follows:

Bronchitis

(Duration) yrs. mos. ds.

Contributory

(Secondary)

(Duration) yrs. mos. ds.

(Signed) E. C. Eape

M. D.

19 (Address)

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death yrs. mos. days. In the State yrs. mos. days.

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL

Replury

DATE OF BURIAL

12-24 1913

20. UNDERTAKER

John Phillips

ADDRESS

Replury

Form V. S. No. 5 20M.1-16-12

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH

Registration District No. 150

County of *Franklin*

Primary Registration District No. 2778

City of *Butte*(No. *150*, St.)

File No. 6695

Registered No. 27

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

Anna Valentina

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX

Female

4. COLOR OR RACE

White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED.

Married
(Write the word.)

6. DATE OF BIRTH

September 11 - 1872
(Month) (Day) (Year)

7. AGE

*41 yrs. 3 mos. 18 ds.*IF LESS than 1 day
how many hrs. or
..... mins.?

8. OCCUPATION

(a) Trade, profession or particular kind of work
(b) General nature of industry, business, or establishment in which employed (or employer)*Housewife*

9. BIRTHPLACE

(State or Country)

Hyrum Utah

10. NAME OF FATHER

A. C. Deller

11. BIRTHPLACE OF FATHER

(State or Country)

Illinois

12. MAIDEN NAME OF MOTHER

Mary Ann Deller

13. BIRTHPLACE OF MOTHER

(State or Country)

England

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

(Address)

Hyrum Deller
Salmon - Idaho

15.

Filed *12-30*

1913

L. H. Est

Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH

12 29 1913
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from

*17/15 1913, to 12/29 1913,*that I last saw her alive on *12/29 1913,*and that death occurred on the date stated above, at *2:30 P. M. A*

The CAUSE OF DEATH* was as follows:

Pyothorax(Duration) yrs. *3* mos. ds.Contributory *Ulcer Ventriculi*
(Secondary) *Heart*(Duration) *33* yrs. mos. ds.(Signed) *Job W. Gaster* M. D.*12/29/13* (Address) *Butte, Ida*

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death yrs. mos. days. In the State yrs. mos. days.

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

Butte *1913*

20. UNDERTAKER

ADDRESS

J. H. Gaster *Butte*

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

CERTIFICATE OF DEATH.

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH.

County of Bingham
City of Blackfoot

Registration District No. 121
Primary Registration District No. 1007
(No. Suppl addition St.)

File No. 6619
Registered No. 177

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

Joseph Reese

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

MEDICAL CERTIFICATE OF DEATH

3. SEX Male 4. COLOR OR RACE White 5. SINGLE, MARRIED, WIDOWED OR DIVORCED. 5
(Write the word.)

6. DATE OF BIRTH.

Dec 16 1913
(Month) (Day) (Year)

7. AGE

Yrs. Mos. ds.

IF LESS than 1 day
how many hrs. or
min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work...
(b) General nature of industry, business, or establishment in which employed (or employer)...

9. BIRTHPLACE

(State or Country) Blackfoot Idaho

10. NAME OF FATHER

Alfred C. Reese (26)

11. BIRTHPLACE OF FATHER

(State or Country) Idaho

12. MAIDEN NAME OF MOTHER

Emmeline Pearson (22)

13. BIRTHPLACE OF MOTHER

(State or Country) Idaho

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Alfred C. Reese

(Address) Blackfoot B.T. 1002

15.

Filed Dec 17 1913

W.E. Purdie
Local Registrar

16. DATE OF DEATH

Dec 16 1913
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from Dec 16 1913 to Dec 16 1913,

that I last saw him alive on Dec 16 1913, and that death occurred on the date stated above, at 6:30 P.M.

The CAUSE OF DEATH* was as follows:

Premature 6 mo in utero

(Duration) Yrs. mos. ds.

Contributory (Secondary)

(Duration) Yrs. mos. ds.

(Signed) W.E. Purdie M. D.

19. (Address) Blackfoot Idaho

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death...yrs...mos...days In the State...yrs...mos...days

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL DATE OF BURIAL

Rossia-Thomas Cem. Dec 17 1913

20. UNDERTAKER

ADDRESS

Alfred C. Reese Blackfoot

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICAL state-
ment of OCCUPATION is very important. See instructions on back of certificate.

Form V. S. No. 5. 10M. 6-20-11.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics
File No. 6611
Registered No. 118

1. PLACE OF DEATH. Registration District No. 121
County of Blaine Primary Registration District No. 2194
City of Riverdale (No. , St.)

If death occurs away from usual residence, give facts called for under special information. 2. FULL NAME Marion Selma Koptin

If death occurred in a hospital, institution or camp give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX Female 4. COLOR OR RACE white 5. SINGLE, MARRIED, WID-OWED OR DIVORCED. (Write the word.)

6. DATE OF BIRTH Dec 19, 1913 (Month) (Day) (Year)

7. AGE yrs. 21 mos. 2 ds. IF LESS than 1 day how many hrs. or min.?

8. OCCUPATION (a) Trade, profession, or particular kind of work None (b) General nature of industry business, or establishment in which employed (or employer)

9. BIRTHPLACE (State or Country)

10. NAME OF FATHER Herman H Koptin

11. BIRTHPLACE OF FATHER Germany (State or Country)

12. MAIDEN NAME OF MOTHER Sophia Gerns

13. BIRTHPLACE OF MOTHER Germany (State or Country)

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Marion Crawford (Address) Blackfoot R. F. D. 2

15. Filed Dec 22 1913 M.E. Patric Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH 12 20 1913 (Month) (Day) (Year)

17. I HEREBY CERTIFY That I attended deceased from Dec 19 1913, to Dec 21 1913, that I last saw her alive on Dec 21 1913, and that death occurred on the date stated above, at 4 P. M.

The CAUSE OF DEATH* was as follows: Bronchopneumonia had symptoms 6 hours

(Duration) yrs. mos. ds.

Contributory (Secondary)

(Duration) yrs. mos. ds.

(Signed) M.E. Patric M. D. 12-22 1913 (Address) Blackfoot

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL,

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place In the of death. yrs. mos. ds. State. yrs. mos. ds. Where was Disease contracted, If not at place of death? Former or usual residence.

19. PLACE OF BURIAL OR REMOVAL DATE OF BURIAL Marion Crawford Dec 23 1913

20. UNDERTAKER ADDRESS (Signature just above) M.E.P. Blackfoot

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Form V. S. No. 5. 12½ M. 7-24-11

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH.

Registration District No. 121County of BinghamPrimary Registration District No. 2194City of Blackfoot(No. Orlean Lucile St.)File No. 6612Registered No. 119

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Arden, Lucile Wright

If death occurred in a hospital, institution or camp give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX

Female

4. COLOR OR RACE

White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED.

(Write the word.)

6. DATE OF BIRTH

Mar 4 1913
(Month) (Day) (Year)

7. AGE

9 10
yrs. mos. ds. IF LESS than 1 day
how many.....hrs. or
min?

8. OCCUPATION

- (a) Trade, profession or particular kind of work.....
(b) General nature of industry business or establishment in which employed (or employer)

9. BIRTHPLACE

(State or Country)

Blackfoot

10. NAME OF FATHER

Cyril J Wright

11. BIRTHPLACE OF FATHER

(State or Country)

Franklin Idaho

12. MAIDEN NAME OF MOTHER

Ester Alberta Roberts

13. BIRTHPLACE OF MOTHER

(State or Country)

Franklin Idaho

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

Cyril J Wright
(Address) Blackfoot Idaho

15.

Dec 22 3 M. E. Patie
Filed 1913 Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH

Dec 22 1913
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from

Dec 22 1913, to Dec 22 1913.

that I last saw her alive on Dec 22 1913.

and that death occurred on the date stated above, at 12:30 A.

The CAUSE OF DEATH* was as follows:

Cerebrospinal Meningitis.

(Duration)yrs.mos.ds.

Contributory
(Secondary)

(Duration)yrs.mos.ds.

(Signed) John B. Cooper M. D.
Dec 1913 (Address) Blackfoot

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place In the
of deathyrs.mos.ds. State.....yrs.mos.ds.
Where was disease contracted,
If not at place of death?
Former or
usual residence.....

19. PLACE OF BURIAL OR REMOVAL DATE OF BURIAL

G.C. Cem. Blackfoot Dec 22 1913

20. UNDERTAKER ADDRESS

Cyril Wright Blackfoot

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Form V. S. No. 5 20M.1-16-12

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH.

Registration District No. 121

County of *Bingham*

Primary Registration District No. 2194

City of *Blackfoot*

(No. *Idaho* *Swany* *Groome* St.)

File No. 6613

Registered No. 120

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME *Thomas J. Groome*

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX

Male

4. COLOR OR RACE

White

5. SINGLE, MARRIED, WID-OWED OR DIVORCED.

Single
(Write the word.)

6. DATE OF BIRTH

(Month)

(Day)

(Year)

7. AGE

70 yrs. *—* mos. *—* ds.

IF LESS than 1 day
how many hrs. or
..... mins.?

8. OCCUPATION

(a) Trade, profession or particular kind of work

School Teacher

(b) General nature of industry business, or establishment in which employed (or employer)

9. BIRTHPLACE

(State or Country)

Lebanon, Iowa

10. NAME OF FATHER

Swany Groome

11. BIRTHPLACE OF FATHER

(State or Country)

12. MAIDEN NAME OF MOTHER

13. BIRTHPLACE OF MOTHER

(State or Country)

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

(Address)

15.

Filed

Dec. 29 191*2* *W. E. Putney*
Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH

Dec. 21

(Month)

(Day)

191*3*
(Year)

17. I HEREBY CERTIFY, That I attended deceased from

July 12 191*3*, to *Dec 21* 191*3*

that I last saw h. in alive on *Dec. 21* 191*3*

and that death occurred on the date stated above, at *8-45 PM*

The CAUSE OF DEATH* was as follows:

Gangrene of Lung

(Duration)

yrs.

mos.

2 ds.

Contributory
(Secondary)

Pulmonary Embolism

Don't know (Duration)

yrs.

mos.

ds.

(Signed)

Dec 23 191*3* (Address) *Blackfoot, Idaho*

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place

18

yrs.

mos.

days.

In the

37

yrs.

mos.

days.

Where was disease contracted if not at place of death?

Former or usual residence

Caldwell, Idaho

19. PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

Caldwell Idaho

Dec. 25 191*3*

20. UNDERTAKER

ADDRESS

E. Frank

Blackfoot

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Form V. S. No. 5 20M.1-16-12

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH.

Registration District No. 121County of BinghamPrimary Registration District No. 1007City of Blackfoot(No. North Oak St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

John Ludwig CarlssonFile No. 6614Registered No. 21

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX

Male

4. COLOR OR RACE

White5. SINGLE, MARRIED, WID-
OWED OR DIVORCED.Single
(Write the word.)

6. DATE OF BIRTH

7 (Month) 3 (Day) 1884 (Year)

7. AGE

29 yrs. 5 mos. 11 ds.IF LESS than 1 day
how many hrs. or
..... mins.?

8. OCCUPATION

(a) Trade, profession or particular kind of work
(b) General nature of industry business, or establishment in which employed (or employer)

Farmer

9. BIRTHPLACE

(State or Country)

Sweden

10. NAME OF FATHER

August Carlsson

11. BIRTHPLACE OF FATHER

(State or Country)

Sweden

12. MAIDEN NAME OF MOTHER

Emma Lundquist

13. BIRTHPLACE OF MOTHER

(State or Country)

Sweden

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

(Address)

August Carlsson
Blackfoot Idaho

15.

Filed

Dec. 16 1913W. E. Patrie

Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH

Dec (Month) 14 (Day) 1913 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Nov. 4 1913, to Dec. 14 1913, that I last saw him alive on Dec. 14 1913, and that death occurred on the date stated above, at 6 A M.

The CAUSE OF DEATH* was as follows:

Mystical Insufficiency

(Duration) yrs. mos. ds.

Contributory Rheumatic Fever
(Secondary)

(Duration) yrs. mos. ds.

(Signed) H. J. Simmons M. D.17/5 1913 (Address) Blackfoot Idaho

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death yrs. mos. days. In the State yrs. mos. days.

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

From city cemetery Dec 14 1913

20. UNDERTAKER

ADDRESS

E. J. Park Blackfoot

CERTIFICATE OF DEATH.

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH.

Registration District No. 181
County of Bingham
City of Blackfoot
Primary Registration District No. 2194
(No. _____ St.)File No. 6615
Registered No. 122

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

Julia P. Lindsay

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

MEDICAL CERTIFICATE OF DEATH

3. SEX

4. COLOR OR RACE

5. SINGLE, MARRIED, WIDOWED OR DIVORCED.
Widowed
(Write the word.)

6. DATE OF BIRTH.

Feb. 9 1891
(Month) (Day) (Year)

7. AGE

89 Yrs. 10 Mos. 8 ds.IF LESS THAN 1 day
how many hrs. or
..... min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work.....
(b) General nature of industry, business, or establishment in which employed (or employer).....Housewife

9. BIRTHPLACE

(State or Country)

New York

10. NAME OF FATHER

Wm Parks

11. BIRTHPLACE OF FATHER

(State or Country)

Don't know

12. MAIDEN NAME OF MOTHER

Fannie Hyde

13. BIRTHPLACE OF MOTHER

(State or Country)

Don't know.

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant)

W. P. Lindsay

(Address)

Blackfoot Ida. Route #2

15.

Filed

Dec 11th 1919M. E. Philie
Local Registrar

16. DATE OF DEATH

Dec. 11 1919
(Month) (Day) (Year)17. I HEREBY CERTIFY, That I attended deceased from Intoxicated death
191. to 191.that I last saw him alive on 191
and that death occurred on the date stated above, at 64 M.

The CAUSE OF DEATH* was as follows:

Pneumonia - labor and old age

(Duration) Yrs. mos. ds.

Contributory
(Secondary)

(Duration) Yrs. mos. ds.

(Signed)

M. E. Philie M. D.12-4-19 (Address) Blackfoot Ida

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL OR HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death.....yrs.....mos.....days In the State.....yrs.....mos.....days

Where was disease contracted if not at place of death?.....

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

Parris Idaho

191.

20. UNDERTAKER

ADDRESS

W. P. LindsayBlackfoot

MARGIN - RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Form V. S. No. 5 20M.1-16-12

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH

Registration District No. 121

County of Blaine

Primary Registration District No. 1207

City of Blackfoot

(No. Office on Pacific Mountain)

File No. 6616

Registered No. 123

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

Calvin Bradley

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX

Male

4. COLOR OR RACE

White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED.

Single
(Write the word.)

6. DATE OF BIRTH

Nov 23 1895
(Month) (Day) (Year)

7. AGE

17 yrs. 15 ds.

IF LESS than 1 day
how many hrs. or mins.?

8. OCCUPATION

- (a) Trade, profession or particular kind of work
(b) General nature of industry business, or establishment in which employed (or employer)

9. BIRTHPLACE

(State or Country)

Emery Co Utah

10. NAME OF FATHER

John Bradley

11. BIRTHPLACE OF FATHER

(State or Country)

Sanford Co Utah

12. MAIDEN NAME OF MOTHER

Eveline Story

13. BIRTHPLACE OF MOTHER

(State or Country)

Wis.

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

J B Bradley

(Address)

15.

Filed

Dec 9th 1913M E Pabre
Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH

Dec 8 1913
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from

Dec 7 1913, to Dec 8 1913

that I last saw him alive on Dec 8 1913

and that death occurred on the date stated above, at 3 P. M.

The CAUSE OF DEATH* was as follows:

Fatal shot wound of forehead & brain,
(22 cal. long.)

(Duration) yrs. mos. ds.

Contributory

(Secondary)

(Duration) yrs. mos. ds.

(Signed)

dec 9 1913 M E Pabre M. D.
(Address) Blackfoot Ida.

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death.....yrs.....mos.....days. In the State.....yrs.....mos.....days.

Where was disease contracted if not at place of death?

Former or usual residence.....

19. PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

Morialand Park

Dec 10 1913

20. UNDERTAKER

ADDRESS

E. Heck

Blackfoot

CERTIFICATE OF DEATH.

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH

Registration District No. 121County of BinghamPrimary Registration District No. 2194City of Blackfoot

(No. _____ St.)

File No. 6617, 24
Registered No. _____

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

Might A. Moore

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

MEDICAL CERTIFICATE OF DEATH

3. SEX

M.

4. COLOR OR RACE

White

5. SINGLE, MARRIED, WIDOWED, OR DIVORCED.

Married
(Write the word.)

6. DATE OF BIRTH.

June 26 1830
(Month) (Day) (Year)

7. AGE

83 Yrs. 5 Mos. 8 ds.IF LESS than 1 day
how many _____ hrs. or
_____ min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work...
(b) General nature of industry, business, or establishment in which employed (or employer).....Farmer

9. BIRTHPLACE

(State or Country)

England

10. NAME OF FATHER

Edward Moore

11. BIRTHPLACE OF FATHER

(State or Country)

England

12. MAIDEN NAME OF MOTHER

Wendy Moore

13. BIRTHPLACE OF MOTHER

(State or Country)

England

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant)

P. R. Moore

(Address)

Blackfoot Route # 3

15.

Filed Dec 5 1913M. E. Pate
Local Registrar

16. DATE OF DEATH

Dec 4 1913
(Month) (Day) (Year)17. I HEREBY CERTIFY That I attended deceased from unassisted death
that I last saw him alive on Dec 5 1913.and that death occurred on the date stated above, at 1 P. M.

The CAUSE OF DEATH* was as follows:

Just old age

(Duration) _____ Yrs. _____ mos. _____ ds.

Contributory
(Secondary)

(Duration) _____ Yrs. _____ mos. _____ ds.

(Signed)

M. E. Pate

M. D.

125 1914 (Address) Blackfoot

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death.....yrs.....mos.....days In the State.....yrs.....mos.....days

Where was disease contracted if not at place of death?.....

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

More City Cem. Blackfoot Dec 7 1913

20. UNDERTAKER

ADDRESS

P. R. MooreBlackfoot

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

FORM V. S. No. 5-25 M. 1-16-13

CERTIFICATE OF DEATH.

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH.

Registration District No. 121Primary Registration District No. 2194File No. 6618Registered No. 125County of Bingham
City of Blackfoot

(No. St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

Unnamed Hofer

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

MEDICAL CERTIFICATE OF DEATH

3. SEX

4. COLOR OR RACE

5. SINGLE, MARRIED, WIDOWED OR DIVORCED.

FemaleWhiteSingle

(Write the word.)

6. DATE OF BIRTH.

Dec69/13

(Month)

(Day)

(Year)

7. AGE

..... Yrs. Mos. ds.

IF LESS than 1 day
how many 3 hrs. or
..... min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work...
(b) General nature of industry, business, or establishment in which employed (or employer).....

9. BIRTHPLACE

(State or Country)

Bingham Co. Idaho

10. NAME OF FATHER

August Hofer

11. BIRTHPLACE OF FATHER

(State or Country)

Switzerland

12. MAIDEN NAME OF MOTHER

Louise Burnard

13. BIRTHPLACE OF MOTHER

(State or Country)

Utah

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant)

(Address)

August Hofer
Blackfoot Route # 3

15.

Filed

Dec. 8 1913W.E. Piche
Local Registrar

16. DATE OF DEATH

Dec61913

(Month)

(Day)

(Year)

17. I HEREBY CERTIFY, That I attended deceased from 191 to 191,
that I last saw him alive on 11 P.and that death occurred on the date stated above, at 11 P. M.

The CAUSE OF DEATH* was as follows:

Premature delivery
6 mo.

(Duration) Yrs. mos. ds.

Contributory
(Secondary)

(Duration) Yrs. mos. ds.

(Signed)

Dec 8 1913 (Address)W.E. Piche M. D.
Blackfoot Idaho

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death.....yrs.....mos.....days State.....yrs.....mos.....days

Where was disease contracted if not at place of death?.....

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

Front City Cem. Blackfoot Dec 8 1913

20. UNDERTAKER

ADDRESS

August HoferBlackfoot.

Form V. S. No. 5 20M.1-16-12

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH.

Registration District No. 99

County of Franklin

Primary Registration District No. 2177

City of St. Anthony

(No. _____, St.)

File No. 6619

Registered No. _____

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Nease Singleton

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX Male 4. COLOR OR RACE White 5. SINGLE, MARRIED, WIDOWED OR DIVORCED. Single
(Write the word.)

6. DATE OF BIRTH Dec 9 1913
(Month) (Day) (Year)

7. AGE _____ yrs. _____ mos. 3 ds.
IF LESS than 1 day how many _____ hrs. or _____ mins.

8. OCCUPATION
(a) Trade, profession or particular kind of work none
(b) General nature of industry business, or establishment in which employed (or employer)

9. BIRTHPLACE
(State or Country) Idaho

10. NAME OF FATHER Chas Singleton

11. BIRTHPLACE OF FATHER
(State or Country) Utah

12. MAIDEN NAME OF MOTHER Gra Wright

13. BIRTHPLACE OF MOTHER
(State or Country) Utah

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Chas Singleton
(Address) St. Anthony

15. Filed Jan 8 1914 W. Sweet
Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH Dec 13 1913
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from Dec 9 1913, to Dec 13 1913, that I last saw him alive on Dec 12 1913, and that death occurred on the date stated above, at 8.4 M. The CAUSE OF DEATH* was as follows:

Infantile convulsions

(Duration) _____ yrs. _____ mos. 1/2 ds.
Contributory Weak and poorly nourished
(Secondary)

(Duration) _____ yrs. _____ mos. _____ ds.
(Signed) J. Morfield M. D.
19 _____ (Address) St. Anthony, Idaho

*State the DISEASE CAUSING DEATH; or in death cases, the CAUSES, state the MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death _____ yrs. _____ mos. _____ days. In the State _____ yrs. _____ mos. _____ days.

Where was disease contracted if not at place of death? _____

Former or usual residence _____

19. PLACE OF BURIAL OR REMOVAL Welford Cemetery DATE OF BURIAL Dec 13 1913

20. UNDERTAKER None ADDRESS _____

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Form V. S. No. 5. 12½ M. 7-24-11

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics
File No. 6620
Registered No.

1. PLACE OF DEATH.
County of My Perce
City of Melrose

Registration District No. 16
Primary Registration District No. 2075
(No. _____, _____ St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

If death occurred in a hospital, institution or camp give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX ♂ 4. COLOR OR RACE W 5. SINGLE, MARRIED, WIDOWED OR DIVORCED. ✓
(Write the word.)

6. DATE OF BIRTH 11-4-1913
(Month) (Day) (Year)

7. AGE _____ yrs. _____ mos. _____ ds. IF LESS than 1 day
how many _____ hrs. or _____ min.

8. OCCUPATION

- (a) Trade, profession or particular kind of work. ✓
(b) General nature of industry business or establishment in which employed (or employer).

9. BIRTHPLACE

(State or Country) Ida

10. NAME OF FATHER

Geo. Stevens

11. BIRTHPLACE OF FATHER

(State or Country) Oregon

12. MAIDEN NAME OF MOTHER

Johnson

13. BIRTHPLACE OF MOTHER

(State or Country) Wash

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) George Stevens(Address) Melrose

15.

Filed _____ 191 _____

Local Registrar J. M. Gyle

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH

11 4 1913
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from _____ 191 _____, to _____ 191 _____

that I last saw h _____ alive on _____ 191 _____
and that death occurred on the date stated above, at _____ M.

The CAUSE OF DEATH* was as follows:

Premature. 6 1/2 Mo.

_____ (Duration) _____ yrs. _____ mos. _____ ds.

Contributory (Secondary)

_____ (Duration) _____ yrs. _____ mos. _____ ds.

(Signed) J. M. Gyle

11-5-1913 (Address) Melrose Ida

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place _____ In the _____
of death _____ yrs. _____ mos. _____ ds. State _____ yrs. _____ mos. _____ ds.

Where was disease contracted,

If not at place of death? _____

Former or

usual residence. _____

19. PLACE OF BURIAL OR REMOVAL

Melrose Ida

DATE OF BURIAL

11-5-1913

20. UNDERTAKER

None

ADDRESS

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
M. D.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Form V. S. No. 5. 12½ M. 7-24-11

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics
File No. **6621**
Registered No.

1. PLACE OF DEATH. Registration District No. 16
County of Myer Primary Registration District No. 2075
City of Reck (No., St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

Reuben Brooks

If death occurred in a hospital, institution or camp give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX M 4. COLOR OR RACE W 5. SINGLE, MARRIED, WIDOWED OR DIVORCED. Single
(Write the word.)

6. DATE OF BIRTH Unknown
(Month) (Day) (Year)

7. AGE 65 yrs. mos. ds. IF LESS than 1 day how many hrs. or min?

8. OCCUPATION Miner
(a) Trade, profession or particular kind of work
(b) General nature of industry business or establishment in which employed (or employer)

9. BIRTHPLACE N. Y.
(State or Country)

10. NAME OF FATHER

11. BIRTHPLACE OF FATHER Unknown
(State or Country)

12. MAIDEN NAME OF MOTHER

13. BIRTHPLACE OF MOTHER
(State or Country)

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Mrs. Mary Warren
(Address) Reck, Idaho

15. Filed 1913 J. M. Lytle
Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH 10 14 1913
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from Jan 1913, to Oct. 14 1913
that I last saw him alive on Oct. 14 1913
and that death occurred on the date stated above, at 7⁰ M.

The CAUSE OF DEATH* was as follows:
General break down from alcoholism

(Duration) yrs. mos. ds.

Contributory (Secondary)

(Duration) yrs. mos. ds.

(Signed) J. M. Lytle M. D.
Oct 16 1913 (Address) Reck

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; (2) whether ACCIDENTAL, SUICIDAL OR HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place In the
of death yrs. mos. ds. State yrs. mos. ds.
Where was disease contracted,
If not at place of death?
Former or
usual residence

19. PLACE OF BURIAL OR REMOVAL Reck DATE OF BURIAL 10-14 1913

20. UNDERTAKER None ADDRESS

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Form V. S. No. 5. 12½ M. 7-24-11

CERTIFICATE OF DEATH

1. PLACE OF DEATH.
County of Myer Perce
City of Bozok

Registration District No. 16
Primary Registration District No. 2a75
(No. _____, _____ St.)

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics
File No. 6622
Registered No. _____

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

James Anne Johnson

If death occurred in a hospital, institution or camp give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX F. 4. COLOR OR RACE W 5. SINGLE, MARRIED, WIDOWED OR DIVORCED. Married

(Write the word.)

6. DATE OF BIRTH June 15 1884
(Month) (Day) (Year)

7. AGE 69 yrs. 8 mos. 3 ds. IF LESS than 1 day how many _____ hrs. or _____ min?

8. OCCUPATION

(a) Trade, profession or particular kind of work

(b) General nature of industry business or establishment in which employed (or employer)

Housewife

9. BIRTHPLACE

(State or Country)

Indiana

10. NAME OF FATHER

Stager

11. BIRTHPLACE OF FATHER

(State or Country)

Brandenburg

12. MAIDEN NAME OF MOTHER

13. BIRTHPLACE OF MOTHER

(State or Country)

Germany

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

(Address)

Chas Johnson
Bozok

15.

Filed _____ 191 _____

J. M. Gil
Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH

Sept. 18 1913
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from June 8 1913, to Sept. 18 1913 that I last saw her alive on Sept. 17 1913 and that death occurred on the date stated above, at 10 A. M.

The CAUSE OF DEATH* was as follows:

Cerebral Softening

_____ (Duration) _____ yrs. 3 mos. _____ ds.

Contributory (Secondary)

_____ (Duration) _____ yrs. _____ mos. _____ ds.

(Signed) J. M. Gil M. D.

Bozok (Address)

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; (2) whether ACCIDENTAL, SUICIDAL OR HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place _____ In the _____
of death _____ yrs. _____ mos. _____ ds. State _____ yrs. _____ mos. _____ ds.

Where was disease contracted,

If not at place of death?

Former or usual residence.

19. PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

Bozok

9-19 1913

20. UNDERTAKER

ADDRESS

None

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Form V. S. No. 5. 12½ M. 7-24-11

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics
File No. 6623
Registered No.

1. PLACE OF DEATH.
County of Yuma
City of Steele

Registration District No. 16
Primary Registration District No. 2075
(No. _____, _____ St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

If death occurred in a hospital, institution or camp give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX M 4. COLOR OR RACE W 5. SINGLE, MARRIED, WIDOWED OR DIVORCED.

(Write the word.)

6. DATE OF BIRTH Feb 2 1913
(Month) (Day) (Year)

7. AGE _____ yrs. _____ mos. 10 ds. IF LESS than 1 day how many _____ hrs. or _____ min?

8. OCCUPATION

- (a) Trade, profession or particular kind of work
(b) General nature of industry business or establishment in which employed (or employer)

9. BIRTHPLACE

(State or Country)

10. NAME OF FATHER

11. BIRTHPLACE OF FATHER
(State or Country)

12. MAIDEN NAME OF MOTHER

13. BIRTHPLACE OF MOTHER
(State or Country)

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

(Address)

15.

Filed _____ 191 _____

Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH

2 12 1913
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from _____ 191 _____, to _____ 191 _____

that I last saw h _____ alive on _____ 191 _____

and that death occurred on the date stated above, at _____ M.

The CAUSE OF DEATH* was as follows:

Impaired ability
no physician attending
at time of death
(Duration) _____ yrs. _____ mos. _____ ds.

Contributory (Secondary)

(Duration) _____ yrs. _____ mos. _____ ds.
(Signed) J. M. Lytle M. D.
_____ 19 _____ (Address)

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY, (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place _____ In the _____
of death _____ yrs. _____ mos. _____ ds. State _____ yrs. _____ mos. _____ ds.
Where was disease contracted,
If not at place of death?
Former or
usual residence.

19. PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

Steele Ida 2-13 1913

20. UNDERTAKER

ADDRESS

None

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Form V. S. No. 5 20M.1-16-12

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH.

Registration District No. 88

County of Washington

Primary Registration District No. 2164

City of Cannabridge

(No. _____, _____ St.)

File No. 6626

Registered No. _____

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME James Isaac Kester

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX

4. COLOR OR RACE

5. SINGLE, MARRIED, WIDOWED OR DIVORCED.

Male white

Single
(Write the word.)

6. DATE OF BIRTH

March 11 1910
(Month) (Day) (Year)

7. AGE

3 yrs. 7 mos. 20 ds.

IF LESS than 1 day
how many _____ hrs. or
_____ mins.?

8. OCCUPATION

- (a) Trade, profession or particular kind of work _____
(b) General nature of industry business, or establishment in which employed (or employer) _____

9. BIRTHPLACE

(State or Country) Kansas

10. NAME OF FATHER

Frederick Kester

11. BIRTHPLACE OF FATHER

(State or Country) Kansas

12. MAIDEN NAME OF MOTHER

Emma Sherman

13. BIRTHPLACE OF MOTHER

(State or Country) Kansas

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Frederick Kester

(Address) Cannabridge Ida

15.

Filed Oct 19 1913

C. E. Schumacher
Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH

Oct 18 1913
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from Oct 16 - 13 1913, to Oct 18 1913, that I last saw him alive on Oct 16 1913, and that death occurred on the date stated above, at 7 P.M.

The CAUSE OF DEATH* was as follows:

Cholera Infantum

(Duration) _____ yrs. _____ mos. 7 ds.

Contributory (Secondary)

(Duration) _____ yrs. _____ mos. _____ ds.

(Signed) C. E. Schumacher M. D.

Oct 19 1913. (Address) Cannabridge Ida

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death _____ yrs. _____ mos. _____ days. In the State _____ yrs. _____ mos. _____ days.

Where was disease contracted if not at place of death?

Former or usual residence _____

19. PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

Cannabridge

Oct 19 1913

20. UNDERTAKER

ADDRESS

Jas. Hedelsam

Cannabridge Ida

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Form V. S. No. 5 20M.1-16-12

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH.

Registration District No.

County of WashingtonPrimary Registration District No. 2/14City of Cambodge

(No., St.)

File No. 6627

Registered No.

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

Thomas Edward Towell

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX

Male

4. COLOR OR RACE

White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED.

Married
(Write the word.)

6. DATE OF BIRTH

Oct 12 1867
(Month) (Day) (Year)

7. AGE

44 yrs. 10 mos. 4 ds.

IF LESS than 1 day
how many hrs. or
..... mins.?

8. OCCUPATION

(a) Trade, profession or particular kind of work

(b) General nature of industry business, or establishment in which employed (or employer)

Farmer

9. BIRTHPLACE

(State or Country)

Missouri Monro Co

10. NAME OF FATHER

Colander Towell

11. BIRTHPLACE OF FATHER

(State or Country)

Indiana

12. MAIDEN NAME OF MOTHER

Emily Fletcher

13. BIRTHPLACE OF MOTHER

(State or Country)

Illinois

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Richard Towell(Address) Midvale

15.

Filed Aug 20 1913 C E Schmitt

Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH

Aug 18 1913
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from

Sept 1 1912 to Aug 19 1913,

that I last saw him alive on Aug 15 1913,

and that death occurred on the date stated above, at 6:15 AM.

The CAUSE OF DEATH* was as follows:

Paralysis(Duration) 1 yrs. mos. ds.

Contributory Hæmorrhage of Brain
(Secondary)

(Duration) yrs. mos. ds.(Signed) C E Schmitt M. D.

Aug 20 1913. (Address) Cambodge Idh

(State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death yrs. mos. days. In the State yrs. mos. days.

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

Midvale Idh Aug 20 1913

20. UNDERTAKER

ADDRESS

J A Hushon Cambodge

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Form V. S. No. 5. 12½ M. 7-24-11

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics
File No. **6628**
Registered No. _____

1. PLACE OF DEATH. Registration District No. _____
County of _____ Primary Registration District No. 2170
City of _____ (No. _____, St.) _____

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Orin S. Grow

If death occurred in a hospital, institution or camp give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX Male 4. COLOR OR RACE white 5. SINGLE, MARRIED, WIDOWED OR DIVORCED. Widowed
(Write the word.)

6. DATE OF BIRTH May 17 1830
(Month) (Day) (Year)

7. AGE 82 yrs. 6 mos. 14 ds. IF LESS than 1 day how many _____ hrs. or _____ min?

8. OCCUPATION
(a) Trade, profession or particular kind of work. Farmer.
(b) General nature of industry business or establishment in which employed (or employer) _____

9. BIRTHPLACE (State or Country) New York State.

10. NAME OF FATHER Orin S. Grow

11. BIRTHPLACE OF FATHER (State or Country) New York State

12. MAIDEN NAME OF MOTHER Billings

13. BIRTHPLACE OF MOTHER (State or Country) New York State

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) E. E. Watts
(Address) Bufford Ida.

15. Filed 12-3 1913 E. E. Watts
Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH Dec - 1st 1913
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from Nov 26th 1913, to Dec 1st 1913, that I last saw him alive on Nov 26th 1913, and that death occurred on the date stated above, at 11 A.M.

The CAUSE OF DEATH* was as follows:
Old age & General decay.

_____ (Duration) _____ yrs. _____ mos. 30 ds.
Contributory Rheumatism
(Secondary) 4 weeks.
(Duration) _____ yrs. _____ mos. _____ ds.
(Signed) J. J. Harrington M. D.
Dec 1st 1913 (Address) Bufford Ida.

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place _____ In the _____
of death _____ yrs. _____ mos. _____ ds. State _____ yrs. _____ mos. _____ ds.
Where was disease contracted, _____
If not at place of death? _____
Former or _____
usual residence _____

19. PLACE OF BURIAL OR REMOVAL Myrtle DATE OF BURIAL 12-4 1913

20. UNDERTAKER Carlisle ADDRESS Bufford
H. E. Stoddard

MARGIN RESERVED FOR BINDING
WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Form V. S. No. 5. 12½ M. 7-24-11

CERTIFICATE OF DEATH

1. PLACE OF DEATH.
County of Nezperce
City of Melrose

Registration District No. 92
Primary Registration District No. 2170
(No. _____, _____ St.)

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics
File No. 6630
Registered No. 5

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Elice Platt.

If death occurred in a hospital, institution or camp give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX Girl 4. COLOR OR RACE White 5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.)

6. DATE OF BIRTH Oct 29th 1900
(Month) (Day) (Year)

7. AGE 13 yrs. 1 mos. 16 ds. IF LESS than 1 day how many _____ hrs. or _____ min?

8. OCCUPATION
(a) Trade, profession or particular kind of work. School Girl
(b) General nature of industry business or establishment in which employed (or employer)

9. BIRTHPLACE (State or Country) Melrose, Ida. Nezperce Co.

10. NAME OF FATHER John Platt

11. BIRTHPLACE OF FATHER (State or Country) Ohio

12. MAIDEN NAME OF MOTHER Adeliah M. Doty

13. BIRTHPLACE OF MOTHER (State or Country) Michigan

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Mrs. Lizzie Geomans.
(Address) Melrose Idaho.

15.

Filed 12-16 1913 E. E. Watts
Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH Dec - 15th 1913
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from Nov 24th 1913, to Dec 15th 1913, that I last saw her alive on Monday Dec 14 1913 and that death occurred on the date stated above, at 7:10 A. M.

The CAUSE OF DEATH* was as follows:
Hemorrhage in typhoid fever.

(Duration) _____ yrs. _____ mos. 23 ds.
Contributory (Secondary) General Gallbladder

(Duration) _____ yrs. _____ mos. _____ ds.
(Signed) J. J. Huntington M. D.
Dec 15th 1913 (Address) Jefferson, Ida.

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place _____ In the _____
of death _____ yrs. _____ mos. _____ ds. State _____ yrs. _____ mos. _____ ds.
Where was disease contracted,
If not at place of death?
Former or
usual residence _____

19. PLACE OF BURIAL OR REMOVAL DATE OF BURIAL

W. H. Cemetery Melrose Ida 12/16 1913

20. UNDERTAKER ADDRESS
W. E. Stoddard. Jeffers

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Form V. S. No. 5. 12½ M. 7-24-11

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics
File No. 6631
Registered No. _____

1. PLACE OF DEATH. Registration District No. 92
County of Myer Primary Registration District No. 2170
City of Gifford (No. _____ St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

Samuel F. Grant

If death occurred in a hospital, institution or camp give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX Male 4. COLOR OR RACE White 5. SINGLE, MARRIED, WIDOWED OR DIVORCED. Married
(Write the word.)

6. DATE OF BIRTH Jan 11 1843
(Month) (Day) (Year)

7. AGE 70 yrs 11 mos 17 ds. IF LESS than 1 day
how many _____ hrs. or
_____ min?

8. OCCUPATION

(a) Trade, profession or particular kind of work. Farmer
(b) General nature of industry business or establishment in which employed (or employer)

9. BIRTHPLACE

(State or Country) Knox Co. Mo

10. NAME OF FATHER

Russell Grant

11. BIRTHPLACE OF FATHER

(State or Country)

12. MAIDEN NAME OF MOTHER

Elizabeth Sharp

13. BIRTHPLACE OF MOTHER

(State or Country)

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Shos F. Grant

(Address) Gifford Ida. R.D. #1

15.

Filed 12-28-1913

E. E. Watts
Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH

12 28 1913
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from 12-11 1913, to 12-24 1913

that I last saw him alive on Dec 24 1913

and that death occurred on the date stated above, at _____ M.

The CAUSE OF DEATH* was as follows:

Coronal Hemorrhage

(Duration) _____ yrs. _____ mos. 10 ds.

Contributory
(Secondary)

(Duration) _____ yrs. _____ mos. _____ ds.

(Signed) E. E. Watts M. D.

12-29 1913 (Address) Gifford

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place _____ In the
of death _____ yrs. _____ mos. _____ ds. State _____ yrs. _____ mos. _____ ds.

Where was disease contracted,

If not at place of death?

Former or

usual residence.

19. PLACE OF BURIAL OR REMOVAL DATE OF BURIAL

Gifford 12/30 1913

20. UNDERTAKER ADDRESS

H. E. Stoddard Gifford

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Form V. S. No. 5 20M.1-16-12

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

PLACE OF DEATH.

Registration District No. 8

County of Latah

Primary Registration District No. 2004

City of near Bonanza

(No. near Franklin School, St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Irvin E. Masters

File No. 23 6632

Registered No. 23

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX

4. COLOR OR RACE

5. SINGLE, MARRIED, WIDOWED OR DIVORCED.

Male. White

Single
(Write the word.)

6. DATE OF BIRTH

July 4 1879.
(Month) (Day) (Year)

7. AGE

34 yrs. 4 mos. 29 ds.

IF LESS than 1 day
how many hrs. or
..... mins.

8. OCCUPATION

(a) Trade, profession or particular kind of work

(b) General nature of industry business, or establishment in which employed (or employer)

Retired Merchant

9. BIRTHPLACE

(State or Country)

Mo

10. NAME OF FATHER

Simpson Masters

11. BIRTHPLACE OF FATHER

(State or Country)

Not obtainable

12. MAIDEN NAME OF MOTHER

Elizabeth Parker

13. BIRTHPLACE OF MOTHER

(State or Country)

Mo

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

L. McBurney

(Address)

Boise Idaho

15.

Filed 12-5 1913

McParker

Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH

Dec 3 1913
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from Oct 9th 1913, to Nov 23rd 1913,

that I last saw him alive on Nov 23 1913,

and that death occurred on the date stated above, at M.

The CAUSE OF DEATH* was as follows:

Tuberculosis Pulmonary & general

(Duration) yrs. mos. ds.

Contributory
(Secondary)

(Duration) yrs. mos. ds.

(Signed) J. E. Brown M. D.

12-7-1913 (Address) Boise Idaho

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death yrs. mos. days. In the State yrs. mos. days.

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

Morris Hill Burial Mar 5 1913

20. UNDERTAKER

ADDRESS

Fry & Summers Boise Id

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Form V. S. No. 5 20M.1-16-12

CERTIFICATE OF DEATH

1417
76
1837

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH.

Registration District No. 8

County of Ada

Primary Registration District No. 2004

City of Near Boise

(No. Soldiers Home St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

Robert W Cochran

File No. 126633

Registered No.

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX

Male White

4. COLOR OR RACE

5. SINGLE, MARRIED, WIDOWED OR DIVORCED.

Married
(Write the word.)

6. DATE OF BIRTH

Not Obtainable 837
(Month) (Day) (Year)

7. AGE

76

yrs. mos. ds.

IF LESS than 1 day
how many hrs. or mins.?

8. OCCUPATION

(a) Trade, profession or particular kind of work

Veteran Civil

(b) General nature of industry business, or establishment in which employed (or employer)

War

9. BIRTHPLACE

(State or Country)

Not Obtainable

10. NAME OF FATHER

Not Obtainable

11. BIRTHPLACE OF FATHER

(State or Country)

Not Obtainable

12. MAIDEN NAME OF MOTHER

Not Obtainable

13. BIRTHPLACE OF MOTHER

(State or Country)

Not Obtainable

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

E. B. Bunt

(Address)

Soldiers Home

15.

Filed

12-11

1913

W. S. Parker

Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH

12 11 1913
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from

July 1913, to July 1913,

that I last saw him alive on July 1913,

and that death occurred on the date stated above, at A. M.

The CAUSE OF DEATH* was as follows:

Dehydration of Heart

(Duration) yrs. mos. ds.

Contributory (Secondary)

Arterio Sclerosis

(Duration) yrs. mos. ds.

(Signed)

J. A. Pottenger

M. D.

12/11 1913 (Address) 1211 1314

State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place

of death yrs. mos. days.

In the

State yrs. mos. days.

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

Morris Hill

Dec 12 1913

20. UNDERTAKER

ADDRESS

Try & Sumner Boise

Form V. S. No. 5 20M.1-16-12

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics
File No. **6634**

1. PLACE OF DEATH.

Registration District No. **8**County of **Idaho**Primary Registration District No. **2004**City of **May 13 Ave.**

(No. _____)

St.)

Registered No. **20**

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME **Infant Jensen**

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX

4. COLOR OR RACE

5. SINGLE, MARRIED, WIDOWED OR DIVORCED.

Female**White****Single**
(Write the word.)

6. DATE OF BIRTH

Dec. 19th 1913
(Month) (Day) (Year)

7. AGE

— yrs. — mos. 5 ds.IF LESS than 1 day
how many hrs. or
..... mins.)

8. OCCUPATION

(a) Trade, profession or particular kind of work

(b) General nature of industry business, or establishment in which employed (or employer)

9. BIRTHPLACE

(State or Country) **Idaho**

10. NAME OF FATHER

Jacob Jensen

11. BIRTHPLACE OF FATHER

(State or Country) **Idaho**

12. MAIDEN NAME OF MOTHER

Alma Lartan

13. BIRTHPLACE OF MOTHER

(State or Country) **Michigan**

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) **Jacob Jensen**(Address) **May 13 Ave.**

15.

Filed **12/25** 1913

Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH

Dec 24th 1913
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from

Dec 19 1913, to Dec 20 1913,that I last saw her alive on **Dec 20 1913,**and that death occurred on the date stated above, at **— M.**

The CAUSE OF DEATH* was as follows:

Some congenital defect - exact cause not known(Duration) **— yrs. — mos. 5 ds.**Contributory
(Secondary)(Duration) **— yrs. — mos. — ds.**

(Signed)

J. M. Taylor M. D.
Dec 19 1913 (Address) **Boise, Ida**

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death yrs. mos. days. In the State yrs. mos. days.

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

Fry Creek Cemetery**Dec 26 1913**

20. UNDERTAKER

ADDRESS

Fry & Summers**Boise Ida**

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Form V. S. No. 5 20M.1-16-12

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics
File No. **11 5635**

1. PLACE OF DEATH.

Registration District No. **8**

County of **Ada**

Primary Registration District No. **2004**

City of **Boise** (No. **1** St.)

Registered No. _____

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

Julian Bermensolo

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX **M** 4. COLOR OR RACE **W.** 5. SINGLE, MARRIED, WIDOWED OR DIVORCED. **Single**
(Write the word.)

6. DATE OF BIRTH

Nov 13 1913
(Month) (Day) (Year)

7. AGE

1 yrs. 1 mos. 13 ds.

IF LESS than 1 day
how many hrs. or
..... mins.?

8. OCCUPATION

(a) Trade, profession or particular kind of work
(b) General nature of industry, business, or establishment in which employed (or employer)

None

9. BIRTHPLACE

(State or Country)

Boise, Idaho

10. NAME OF FATHER

Louis Bermensolo

11. BIRTHPLACE OF FATHER

(State or Country)

Spain

12. MAIDEN NAME OF MOTHER

Renuncia Yabica

13. BIRTHPLACE OF MOTHER

(State or Country)

Spain

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

(Address)

Juan Bermensolo
Boise, Ida

15.

Filed **12-26**

1913

W. Parker

Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

Dec 25 1913
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from **Dec 23 1913**, to **Dec 23 1913**, that I last saw him alive on **Dec 23 1913**, and that death occurred on the date stated above, at **M.**

The CAUSE OF DEATH* was as follows:

Peritonitis

(Duration) yrs. mos. **4** ds.

Contributory (Secondary)

(Duration) yrs. mos. ds.

(Signed)

W. H. M. D.

19..... (Address) **Boise, Idaho**

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death yrs. mos. days. In the State yrs. mos. days.

Where was disease contracted if not at place of death?

Former or usual residence.....

19. PLACE OF BURIAL OR REMOVAL DATE OF BURIAL

Boise Cemetery **12/16 1913**

20. UNDERTAKER

ADDRESS

Schreibers & Sons, Boise

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Form V. S. No. 5 20M.1-14-12

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH

Registration District No. 8County of AdaPrimary Registration District No. 2004City of near Ustick(No. near Ustick St.)File No. 26636

Registered No. _____

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

Harace Edmond Perse

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX

M

4. COLOR OR RACE

White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED.

Married
(Write the word.)

6. DATE OF BIRTH

Nov 26 1913
(Month) (Day) (Year)

7. AGE

75 yrs. 1 mos. X ds.IF LESS than 1 day
how many hrs. or
..... mins.?

8. OCCUPATION

(a) Trade, profession or particular kind of work

Raucher

(b) General nature of industry, business, or establishment in which employed (or employer)

9. BIRTHPLACE

(State or Country)

Salome Ohio

10. NAME OF FATHER

not obtainable

11. BIRTHPLACE OF FATHER

(State or Country)

not obtainable

12. MAIDEN NAME OF MOTHER

not obtainable

13. BIRTHPLACE OF MOTHER

(State or Country)

not obtainable

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

Herbert Aldridge

(Address)

Ustick

15.

Filed

12-261913M. S. Parker

Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH

Dec 25 1913
(Month) (Day) (Year)17. I HEREBY CERTIFY, That I attended deceased from
Dec 24 1913, to Dec 25 1913that I last saw him alive on Dec 24 1913,and that death occurred on the date stated above, at 3:00 PM.

The CAUSE OF DEATH* was as follows:

Myocarditis

(Duration) yrs. mos. ds.

Contributory
(Secondary)

(Duration) yrs. mos. ds.

(Signed)

J. E. Hangle M. D.Dec 26 1913 (Address) Boise

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death yrs. mos. days. In the State yrs. mos. days.

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL DATE OF BURIAL

Harris Hill Cemetery 12/26 1913

20. UNDERTAKER

ADDRESS

Schreibers Undertaking Boise, Idaho

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Form V. S. No. 5 20M.1-16-12

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics
File No. 28 6637
Registered No. _____

1. PLACE OF DEATH. Registration District No. _____
County of Ada Primary Registration District No. 2004
City of near Bune (No. Soldiers Home St.)
If death occurs away from usual residence, give facts called for under special information. 2. FULL NAME Thomas Sullivan

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX Male 4. COLOR OR RACE White 5. SINGLE, MARRIED, WID-
OWED OR DIVORCED. Single
(Write the word.)
6. DATE OF BIRTH Not Obtainable 1833
(Month) (Day) (Year)

7. AGE 80 yrs. — mos. — ds. IF LESS than 1 day
how many hrs. or mins.
8. OCCUPATION (a) Trade, profession or particular kind of work Veteran Civil War
(b) General nature of industry business, or establishment in which employed (or employer) _____

9. BIRTHPLACE (State or Country) Not Obtainable
10. NAME OF FATHER Not Obtainable
11. BIRTHPLACE OF FATHER (State or Country) Not Obtainable
12. MAIDEN NAME OF MOTHER Not Obtainable
13. BIRTHPLACE OF MOTHER (State or Country) Not Obtainable

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) E. B. Bennett
(Address) Soldiers Home
15. Filed 12-26 1913 W. S. Parker
Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH 12 24 1913
(Month) (Day) (Year)
17. I HEREBY CERTIFY, That I attended deceased from Aug 1913 to 12/24 1913
that I last saw him alive on 12/23 1913
and that death occurred on the date stated above, at 10A M.
The CAUSE OF DEATH* was as follows:

Chronic Bright's Disease
(Duration) yrs. mos. ds.
Contributory (Secondary) _____
(Duration) yrs. mos. ds.
(Signed) W. S. Parker M. D.
12/26 1913 (Address) Soldiers Bldg

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.
18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death yrs. mos. days. In the State yrs. mos. days.
Where was disease contracted if not at place of death? _____
Former or usual residence _____

19. PLACE OF BURIAL OR REMOVAL DATE OF BURIAL
Morris Hill Cemetery Dec 26 1913
20. UNDERTAKER ADDRESS
Tracy & Summers Borger

Form V. S. No. 5 20M.1-16-12

CERTIFICATE OF DEATH

1. PLACE OF DEATH

Registration District No.

County of *Lemhi*Primary Registration District No. *2153*City of *Leadore*

(No.

St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

Charles Roberson

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

File No.

6638

Registered No.

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX

Male

4. COLOR OR RACE

White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED.

Married
(Write the word.)

6. DATE OF BIRTH

*December 7**1913*

(Month)

(Day)

(Year)

7. AGE

62 yrs. *5* mos. *—* ds.

IF LESS than 1 day
how many hrs. or
..... mins.?

8. OCCUPATION

(a) Trade, profession or particular kind of work

*Timber framer or
min. carpenter*

(b) General nature of industry, business, or establishment in which employed (or employer)

9. BIRTHPLACE

(State or Country)

Illinois

10. NAME OF FATHER

Wm Roberson

11. BIRTHPLACE OF FATHER

(State or Country)

Kentucky

12. MAIDEN NAME OF MOTHER

Underwood

13. BIRTHPLACE OF MOTHER

(State or Country)

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

Mrs C. L. Roberson

(Address)

Leadore Ida.

15.

Filed *Jan. 2, 1914* 191*Frank T. Vane*

Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH

December 7

1913

(Month)

(Day)

(Year)

17. I HEREBY CERTIFY, That I attended deceased from

Mar.

1912

to Dec.

1913

that I last saw him alive on *Sept* 1912and that death occurred on the date stated above, at *M.*

The CAUSE OF DEATH* was as follows:

Carcinoma of sigmoid?
(during past year was consulted
by telephone)(Duration) *1* yrs. *6* mos. *—* ds.

Contributory

(Secondary)

(Duration)

mos.

ds.

(Signed)

C. P. Stratton

M. D.

19

(Address)

Salmon, Ida.

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place

of death yrs. mos. days.

In the

State yrs. mos. days.

Where was disease contracted
if not at place of death?

Former or

usual residence

19. PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

*Leadore Cemetery**12-8*

1913

20. UNDERTAKER

ADDRESS

*Geo Martin**Leadore**Cietugas Such. Ida.*

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Form V. S. No. 5. 10M. 6-20-11.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH.
County of Boise
City of Sweet

Registration District No.
Primary Registration District No.
(No. Susan Day St.)

File No. 6639
Registered No.

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

Susan Day

If death occurred in a hospital, institution or camp give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX Female 4. COLOR OR RACE W 5. SINGLE, MARRIED, WIDOWED OR DIVORCED. married
(Write the word.)

6. DATE OF BIRTH March 27 1849
(Month) (Day) (Year)

7. AGE 64 yrs. 5 mos. 10 ds. IF LESS than 1 day how many hrs. or min.?

8. OCCUPATION Wife
(a) Trade, profession, or particular kind of work
(b) General nature of industry business, or establishment in which employed (or employer)

9. BIRTHPLACE (State or Country) Marathon, Ohio

10. NAME OF FATHER Andrew T. Sweet

11. BIRTHPLACE OF FATHER (State or Country) Kentucky

12. MAIDEN NAME OF MOTHER Elizabeth Morcay

13. BIRTHPLACE OF MOTHER (State or Country) Ohio

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) J. Skippen M.D.
(Address) Sevetch

15. Filed 191 Local Registrar Ed B. Knium

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH Sept. 7th 1913
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from Sept. 7th 1913 to Sept. 7th 1913
that I last saw her alive on Sept. 7th 1913
and that death occurred on the date stated above, at 5 P. M.
The CAUSE OF DEATH* was as follows:

Tuberculosis

(Duration) yrs. mos. ds.
Contributory (Secondary)

(Duration) yrs. mos. ds.
(Signed) Alfred Skippen M. D.
Sept. 7 1913 (Address) Sevetch

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL,

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place yrs. mos. ds. In the yrs. mos. ds.
of death.
Where was Disease contracted,
If not at place of death?
Former or
usual residence

19. PLACE OF BURIAL OR REMOVAL Sweet, Idaho DATE OF BURIAL Sep. 9 1913

20. UNDERTAKER Ed B. Knium ADDRESS Emmish

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Form V. S. No. 5 20M.1-16-12

CERTIFICATE OF DEATH

1. PLACE OF DEATH.

Registration District No. 35

County of Blaine

Primary Registration District No. 2021

City of Blaine Ferry

(No. _____, St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Earl S. Sawyer

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics
File No. 6640

Registered No. _____

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX Male 4. COLOR OR RACE white 5. SINGLE, MARRIED, WIDOWED OR DIVORCED. o (Write the word.)

6. DATE OF BIRTH December 1889
(Month) (Day) (Year)

7. AGE about 24 yrs. — mos. — ds. IF LESS than 1 day how many — hrs. or — mins.

8. OCCUPATION
(a) Trade, profession or particular kind of work Homesteader
(b) General nature of industry business, or establishment in which employed (or employer)

9. BIRTHPLACE
(State or Country)

10. NAME OF FATHER Ben Sawyer

11. BIRTHPLACE OF FATHER
(State or Country)

12. MAIDEN NAME OF MOTHER —

13. BIRTHPLACE OF MOTHER
(State or Country)

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) H. L. Garton

(Address) Mountain Home, Ida.

15. _____

Filed Dec. 20th 1913 J. W. Davis
Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH Dec. 19th 1913
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from 191 to 191, that I last saw h. — alive on 191, and that death occurred on the date stated above, at — M. The CAUSE OF DEATH* was as follows:

Caught by some Ry equipment and run over while attempting to steal a ride on freight train
(Duration) — yrs. — mos. — ds.

Contributory Accidental
(Secondary)
(Duration) — yrs. — mos. — ds.

(Signed) H. L. Garton, Coroner
Dec 20 1913 (Address) Mountain Home, Idaho

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death — yrs. — mos. — days. In the State — yrs. — mos. — days.

Where was disease contracted if not at place of death? —

Former or usual residence —

19. PLACE OF BURIAL OR REMOVAL Blaine's Ferry Idaho DATE OF BURIAL Dec. 20th 1913

20. UNDERTAKER J. W. Davis ADDRESS Mountain Home, Ida.

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Form V. S. No. 5 20M.1-16-12

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics
File No. **6641**

1. PLACE OF DEATH. Registration District No. **5**
County of **Canyon** Primary Registration District No. **2009**
City of **New Plymouth** (No. _____ St.)
If death occurs away from usual residence, give facts called for under special information. 2. FULL NAME **Blanche Harris**

Registered No. _____
If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX **Female** 4. COLOR OR RACE **White** 5. SINGLE, MARRIED, WIDOWED OR DIVORCED. **Single**
(Write the word.)

6. DATE OF BIRTH **June 10 1902**
(Month) (Day) (Year)

7. AGE **13 yrs. 5 mos. 25 ds.**
IF LESS than 1 day how many hrs. or mins.?

8. OCCUPATION
(a) Trade, profession or particular kind of work **Student**
(b) General nature of industry business, or establishment in which employed (or employer)

9. BIRTHPLACE **Idaho**
(State or Country)

10. NAME OF FATHER **H. E. Harris**

11. BIRTHPLACE OF FATHER **Idaho**
(State or Country)

12. MAIDEN NAME OF MOTHER **Flora Richardson**

13. BIRTHPLACE OF MOTHER **Idaho**
(State or Country)

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) **W. E. Harris**
(Address) **New Plymouth, Idaho**

15. Filed **191** **Wm J Drysdale**
Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH **Dec 5 1913**
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from **Dec 3 - 1913**, to **Dec 4 1913**, that I last saw **her** alive on **Dec 4 1913**, and that death occurred on the date stated above, at **5 A.M.**

The CAUSE OF DEATH* was as follows:

Typhoid fever.
(Duration) yrs. **1** mos. **12** ds.
Contributory (Secondary) **Perforation of Bowel**
(Duration) yrs. mos. **7** ds.
(Signed) **Wm J Drysdale** M. D.
Dec 6 1913 (Address) **New Plymouth, Idaho**

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death.....yrs.....mos.....days. In the State.....yrs.....mos.....days.

Where was disease contracted if not at place of death?

Former or usual residence.....

19. PLACE OF BURIAL OR REMOVAL DATE OF BURIAL **New Plymouth, Idaho Dec 6 1913**

20. UNDERTAKER ADDRESS **A. A. Adair Payette, Idaho**

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Form V. S. No. 5 20M.1-16-12

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics
File No. 6642
Registered No. 8

1. PLACE OF DEATH. Registration District No. 58
County of Blaine Primary Registration District No. 2138
City of Hill City, 2 mi. N. W. 1/4 Sec. 36, T. 1 N., R. 10 E., S. 10 N. (No. , St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Mildred Frieda Burnet

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX Female 4. COLOR OR RACE White 5. SINGLE, MARRIED, WIDOWED OR DIVORCED. Single (Write the word.)

6. DATE OF BIRTH Dec 3 1913 (Month) (Day) (Year)

7. AGE yrs. 5 mos. 5 ds. IF LESS than 1 day how many hrs. or mins.?

8. OCCUPATION (a) Trade, profession or particular kind of work None (b) General nature of industry business, or establishment in which employed (or employer)

9. BIRTHPLACE Blaine Co Idaho (State or Country)

10. NAME OF FATHER Fred C Burnet

11. BIRTHPLACE OF FATHER Shoshone Co Idaho (State or Country)

12. MAIDEN NAME OF MOTHER Florence J Barker

13. BIRTHPLACE OF MOTHER Dorset Minn. U.S.A. (State or Country)

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE (Informant) Fred C Burnet (Address) Hill City Idaho

15.

Filed 12-9 1913 D. O. Lipp Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH Dec 8 1913 (Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from Dec 3 1913, to Dec 8 1913, that I last saw her alive on Dec 7 1913, and that death occurred on the date stated above, at 10:00 P.M.

The CAUSE OF DEATH* was as follows:

Premature Birth

(Duration) yrs. mos. ds.

Contributory (Secondary)

(Duration) yrs. mos. ds.

(Signed) O. R. Bloom M. D.

(Address) Hill City Ida.

State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death yrs. mos. days. In the State yrs. mos. days.

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL DATE OF BURIAL

Corral Dec 10 1913

20. UNDERTAKER ADDRESS

Chas. B. Huntington Corral

MARGIN RESERVED FOR BINDING
WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Form V. S. No. 5. 12½M.7-24-11

CERTIFICATE OF DEATH

1. PLACE OF DEATH.

County of *Custer*

City of *Maenay*

Registration District No. *119*

Primary Registration District No. *2187*

(No. _____, _____ St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

John Lehman

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

File No. *6643*

Registered No. *6*

If death occurred in a hospital, institution or camp give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX

m

4. COLOR OR RACE

wh

5. SINGLE, MARRIED, WIDOWED OR DIVORCED.

Married
(Write the word.)

6. DATE OF BIRTH

March

28

1840

(Month)

(Day)

(Year)

7. AGE

73

yrs.

9

mos.

ds.

IF LESS than 1 day

how many.....hrs. or
.....min?

8. OCCUPATION

(a) Trade, profession or particular kind of work

Rancher

(b) General nature of industry business or establishment in which employed (or employer)

9. BIRTHPLACE

(State or Country)

Switzerland -

10. NAME OF FATHER

Don't know.

11. BIRTHPLACE OF FATHER

(State or Country)

Switzerland -

12. MAIDEN NAME OF MOTHER

Annies Fox -

13. BIRTHPLACE OF MOTHER

(State or Country)

Don't know

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

Sophia Lehman

(Address)

Maenay, Idaho

15.

Filed

12/26 1913

H. P. Richards
Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH

12

23

1913

(Month)

(Day)

(Year)

17. I HEREBY CERTIFY, That I attended deceased from

July

1913

to

December 18

1913

that I last saw him alive on

and that death occurred on the date stated above, at *2 A M.*

The CAUSE OF DEATH* was as follows:

Heart Dilatation Heart.

(Duration)

yrs.

mos.

10 ds.

Contributory (Secondary)

Chro Indo- & Myocarditis.

(Duration)

yrs.

mos.

ds.

(Signed)

H. P. Richards

M. D.

12/25

1913

(Address) *Maenay, Idaho*

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place

In the

of death

yrs.

mos.

ds.

State

yrs.

mos.

ds.

Where was disease contracted,

If not at place of death?

Former or

usual residence.

19. PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

Maenay Idaho

12/26 1913

20. UNDERTAKER

ADDRESS

Friends

Maenay, Idaho

MARGIN RESERVED FOR BINDING
WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Form V. S. No. 5 20M.1-16-12

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH.

Registration District No. 3

County of Canyon

Primary Registration District No. 1005

City of Caldwell

(No. _____, _____ St.)

File No. 6644

Registered No. 110

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

Hector Lewis

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX

M.

4. COLOR OR RACE

W

5. SINGLE, MARRIED, WIDOWED OR DIVORCED.

Widower
(Write the word.)

6. DATE OF BIRTH

September 10 1825
(Month) (Day) (Year)

7. AGE

88 yrs. 3 mos. 2 ds.

IF LESS than 1 day
how many _____ hrs. or
_____ mins.

8. OCCUPATION

(a) Trade, profession or particular kind of work

Farmer

(b) General nature of industry business, or establishment in which employed (or employer)

9. BIRTHPLACE

(State or Country)

Kentucky

10. NAME OF FATHER

Asa Lewis

11. BIRTHPLACE OF FATHER

(State or Country)

Kentucky

12. MAIDEN NAME OF MOTHER

Pegg Ellis

13. BIRTHPLACE OF MOTHER

(State or Country)

Kentucky

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

Jennie S. Grimes

(Address)

Caldwell, Idaho.

15.

Filed

Dec. 13 - 1913

John S. Meyer

Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH

12 - 12 1913
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from

3/1/12 191, to 12/12 1913

that I last saw him alive on 12/12/13 191

and that death occurred on the date stated above, at 2 M.

The CAUSE OF DEATH* was as follows:

arteriosclerosis

(Duration) 2 yrs. _____ mos. _____ ds.

Contributory Fractured Hip
(Secondary)

(Duration) 1 yrs. _____ mos. _____ ds.

(Signed) W. B. Dyer M. D.

12/13/1913 (Address) Caldwell

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death _____ yrs. _____ mos. _____ days. In the State _____ yrs. _____ mos. _____ days.

Where was disease contracted if not at place of death?

Former or usual residence.

19. PLACE OF BURIAL OR REMOVAL DATE OF BURIAL

Canyon Hill

12/14 1913

20. UNDERTAKER

W. B. Dyer

ADDRESS

Caldwell

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Form V. S. No. 5. 12½ M. 7-24-11

CERTIFICATE OF DEATH

State of Idaho

BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH.

Registration District No. 3

County of Canyon

Primary Registration District No. 2005

City of Caldwell

(No. Canyon Hospital (Caldwell, Idaho) St.)

File No. 6645

Registered No. 111

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

John Johnson

If death occurred in a hospital, institution or camp give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX

4. COLOR OR RACE

5. SINGLE, MARRIED, WIDOWED OR DIVORCED.

Male. White. Single (Write the word.)

6. DATE OF BIRTH

April 19 - 1882
(Month) (Day) (Year)

7. AGE

31 yrs. 15 mos. 15 ds.

IF LESS than 1 day
how many hrs. or
..... min?

8. OCCUPATION

(a) Trade, profession or particular kind of work.
(b) General nature of industry business or establishment in which employed (or employer)Miner (Mineral)
(Gold & Silver.)

9. BIRTHPLACE

(State or Country)

Sweden

10. NAME OF FATHER

John Johnson

11. BIRTHPLACE OF FATHER

(State or Country)

Sweden

12. MAIDEN NAME OF MOTHER

Don't know

13. BIRTHPLACE OF MOTHER

(State or Country)

Sweden

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

(Address)

15.

Filed Dec. 17 - 1913

Joh. S. Meyer
Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH

Dec. 14 1913
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from

Aug. 30 1913, to Dec. 14 1913

that I last saw him alive on Dec. 13 1913

and that death occurred on the date stated above, at 29 M.

The CAUSE OF DEATH* was as follows:

Septicemia. Re

(Duration) yrs. 3 mos. ds.

Contributory Both arms crushed under
(Secondary) car wheels & were amputated

(Duration) yrs. mos. ds.

(Signed) J. S. Meyer M. D.

1913 (Address) Caldwell, Idaho

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place yrs. mos. ds. In the
of death yrs. mos. ds. State yrs. mos. ds.

Where was disease contracted,

If not at place of death?

Former or

usual residence.

19. PLACE OF BURIAL OR REMOVAL DATE OF BURIAL

Canyon Hill 12/17/ 1913

20. UNDERTAKER ADDRESS

H. C. Dykes Caldwell

(by J. S. M.) Idaho

WRITE PLAINLY, WITH UNFADE INK—THIS IS A PERMANENT RECORD.
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Form V. S. No. 5 20M.1-16-12

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH.

Registration District No.

County of *Canyon*

Primary Registration District No.

City of *Caldwell*

(No. St.)

File No.

Registered No.

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

John Johnson

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX

M

4. COLOR OR RACE

W.

5. SINGLE, MARRIED, WIDOWED OR DIVORCED.

Single
(Write the word.)

6. DATE OF BIRTH

April 194 1882
(Month) (Day) (Year)

7. AGE

About 30 years
37 yrs. *15* mos. *15* ds.IF LESS than 1 day
how many hrs. or
..... mins.

8. OCCUPATION

(a) Trade, profession or particular kind of work

Don't know

(b) General nature of industry, business, or establishment in which employed (or employer)

Miner, (mineral)

9. BIRTHPLACE

(State or Country)

Suveden
Don't know

10. NAME OF FATHER

John Johnson

11. BIRTHPLACE OF FATHER

(State or Country)

Suveden

12. MAIDEN NAME OF MOTHER

Don't know

13. BIRTHPLACE OF MOTHER

(State or Country)

Suveden

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

W. C. Dyer

(Address)

Caldwell Idaho

15.

Filed

Dec. 17-

1913

John D. Meyer

Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH

December 14 1913
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from

Sept 12 1913, to Dec 14 1913
that I last saw him alive on *Dec 13 1913*and that death occurred on the date stated above, at *2 A.M.*

The CAUSE OF DEATH* was as follows:

Septicemia; result of railroad injury both arm crushed under wheels(Duration) yrs. *3* mos. *15* ds.

Contributory

(Secondary)

(Duration) yrs. mos. ds.

(Signed)

W. C. Dyer

M. D.

12/16 1913 (Address) *Caldwell Idaho*

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place

of death. yrs. mos. days.

In the

State. yrs. mos. days.

Where was disease contracted if not at place of death?

Former or

usual residence.

19. PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

*Canyon Hills**12/17 1913*

20. UNDERTAKER

ADDRESS

*W. C. Dyer**Caldwell*

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Form V. S. No. 5 20M.1-16-12

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH. Registration District No. 3
County of Canyon Primary Registration District No. 1005
City of Calderwell (No. _____ St.)

File No. 6646
Registered No. 112

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Mary E. Gleener.

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX Female 4. COLOR OR RACE W. 5. SINGLE, MARRIED, WID-
OWED OR DIVORCED. Married
(Write the word.)

6. DATE OF BIRTH July 14 1860
(Month) (Day) (Year)

7. AGE 53 yrs. 5 mos. 5 ds. IF LESS than 1 day
how many _____ hrs. or
_____ mins.

8. OCCUPATION
(a) Trade, profession or particular kind of work House Keeping
(b) General nature of industry business, or establishment in which employed (or employer)

9. BIRTHPLACE Ill.
(State or Country)

10. NAME OF FATHER Morris J. Evers.

11. BIRTHPLACE OF FATHER Ill.
(State or Country)

12. MAIDEN NAME OF MOTHER Antimissa Jett

13. BIRTHPLACE OF MOTHER Ill.
(State or Country)

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Pearl Gleener.
(Address) Caldwell, Idaho.

15. Filed Dec. 20 - 1913 J. S. Hughes
Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH Dec 19 1913
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from Dec 15 1913, to Dec 19 1913, that I last saw her alive on Dec 19 1913, and that death occurred on the date stated above, at 9⁰⁰ M.

The CAUSE OF DEATH* was as follows:
Cancer of Stomach

(Duration) _____ yrs. _____ mos. _____ ds.
Contributory _____
(Secondary)

(Duration) _____ yrs. _____ mos. _____ ds.
(Signed) S. J. Miller M. D.
12-20-1913 (Address) Caldwell, Idaho

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death _____ yrs. _____ mos. _____ days. In the State _____ yrs. _____ mos. _____ days.

Where was disease contracted if not at place of death?

Former or usual residence _____

19. PLACE OF BURIAL OR REMOVAL Lower Boise DATE OF BURIAL 12/21/1913

20. UNDERTAKER W. B. Dyer ADDRESS Caldwell Idaho

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Form V. S. No. 5 20M.1-16-12

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH.

Registration District No.

3

County of Canyon

Primary Registration District No.

1005

City of Baldwell

(No. _____, _____ St.)

File No. 6643Registered No. 73

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Ann Hillis Ball

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX

4. COLOR OR RACE

5. SINGLE, MARRIED, WIDOWED OR DIVORCED.

FemaleWMarried
(Write the word.)

6. DATE OF BIRTH

February
(Month)13th
(Day)1831
(Year)

7. AGE

82 yrs. 10 mos. 8 ds.IF LESS than 1 day
how many _____ hrs. or
_____ mins.?

8. OCCUPATION

(a) Trade, profession or particular kind of work

Housewife

(b) General nature of industry business, or establishment in which employed (or employer)

9. BIRTHPLACE

(State or Country)

Ireland

10. NAME OF FATHER

Hillis

11. BIRTHPLACE OF FATHER

(State or Country)

Don't know

12. MAIDEN NAME OF MOTHER

Ann Beal Hillis

13. BIRTHPLACE OF MOTHER

(State or Country)

Don't know

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

F. O. Ball Jr

(Address)

Baldwell Idaho

15.

Filed

Dec. 23- 1913John D. Meyer
Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH

Dec
(Month)21
(Day)1913
(Year)

17. I HEREBY CERTIFY, That I attended deceased from

Nov 14

1913, to

Dec 21

1913,

that I last saw he alive on Dec 21 1913,and that death occurred on the date stated above, at 4 P. M.

The CAUSE OF DEATH* was as follows:

Cerebral Hemorrhage
Pneumonia

(Duration) _____ yrs. _____ mos. _____ ds.

Contributory

(Secondary)

(Duration) _____ yrs. _____ mos. _____ ds.

(Signed)

S. D. Miller

M. D.

4-21-1913 (Address) Baldwell Idaho

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place

of death _____ yrs. _____ mos. _____ days.

In the

State _____ yrs. _____ mos. _____ days.

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

W. B. Dyer Canyon 12/23 1913

20. UNDERTAKER

ADDRESS

W. B. Dyer Baldwell

CERTIFICATE OF DEATH.

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH.

Registration District No. 64County of BlainePrimary Registration District No. 2:44City of Troy

(No.)

St.)

File No. 6648

Registered No.

If death occurs away from
usual residence, give facts
called for under special
information.

2. FULL NAME

Celia StrohmIf death occurred in a hos-
pital, institution or camp,
give its NAME instead of
street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX

Female

4. COLOR OR RACE

White5. SINGLE, MARRIED, WID-
OWED OR DIVORCED.Married
(Write the word.)

6. DATE OF BIRTH.

Oct
(Month)30
(Day)1877
(Year)

7. AGE

36 Yrs.1 Mos.11 ds.IF LESS than 1 day
how many hrs. or
..... min.)

8. OCCUPATION

(a) Trade, profession or
particular kind of work.
(b) General nature of in-
dustry, business, or estab-
lishment in which employ-
ed (or employer).Housewife
Farming

9. BIRTHPLACE

(State or Country)

Austria10. NAME OF
FATHEREdward Hank11. BIRTHPLACE
OF FATHER

(State or Country)

Austria12. MAIDEN NAME
OF MOTHERMaria Marie Schvale13. BIRTHPLACE
OF MOTHER

(State or Country)

Austria

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant)

John G. Strohm

(Address)

Troy Idaho.

15.

Filed

Dec 12
19131913W. J. Johnson
Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

Dec
(Month)11
(Day)1913
(Year)

17. I HEREBY CERTIFY, That I attended deceased from

1913 Dec 11 1913that I last saw her alive on Dec 11 1913and that death occurred on the date stated above, at 10:40 A.M.

The CAUSE OF DEATH* was as follows:

Carcinoma Breast
axillas and Neck(Duration) 2 Yrs. mos. ds.Contributory
(Secondary)

(Duration) yrs. mos. ds.

(Signed)

W. J. Johnson M. D.Dec 11, 1913 (Address) Troy Idaho*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1)
MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.18. LENGTH OF RESIDENCE (For Hospitals, Institutions,
Transients or Recent Residents.)

At place of death.....yrs.....mos.....days In the State.....yrs.....mos.....days

Where was disease contracted
if not at place of death?.....Former or
usual residence

19. PLACE OF BURIAL OR REMOVAL

Bethel Cemetery

DATE OF BURIAL

Dec 13 1913

20. UNDERTAKER

Mrs. Russia R. Helms

ADDRESS

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS
should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement
of OCCUPATION is very important. See instructions on back of certificate.

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Form V. S. No. 5. 12½ M. 7-24-11

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics
File No. 6649
Registered No.

1. PLACE OF DEATH. Registration District No. 64
County of Latah Primary Registration District No. 2144
City of Troy (No. St.)

If death Occurs away from usual residence, give facts called for under special information.

2. FULL NAME Elmer Eugene Lindeman

If death occurred in a hospital, institution or camp give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX 4. COLOR OR RACE 5. SINGLE, MARRIED, WIDOWED OR DIVORCED.

Male White Single (Write the word.)

6. DATE OF BIRTH

Aug. 24 1898
(Month) (Day) (Year)

7. AGE

5 yrs. 3 mos. 28 ds.

IF LESS than 1 day
how many hrs. or
.... min?

8. OCCUPATION

(a) Trade, profession or particular kind of work none

(b) General nature of industry business or establishment in which employed (or employer) Farming

9. BIRTHPLACE

(State or Country) Troy Idaho

10. NAME OF FATHER

John Lindeman

11. BIRTHPLACE OF FATHER

(State or Country) Sweden

12. MAIDEN NAME OF MOTHER

Cora Oshund

13. BIRTHPLACE OF MOTHER

(State or Country) Sweden

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) John Lindeman
(Address) Troy Idaho

15.

Filed Nov. 23 1913 L. V. Johnson
Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH

Nov 22 1913
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from Nov 11 1913, to Nov 22 1913

that I last saw him alive on Nov 15 1913

and that death occurred on the date stated above, at 4:30 P.M.

The CAUSE OF DEATH* was as follows:

Tubercular Meningitis
Following blow to back of head in August 1913.

(Duration) yrs. 1½ mos. ds.

Contributory (Secondary)

(Duration) yrs. mos. ds.

(Signed) J. W. Olson M. D.
Nov 23 1913 (Address) Troy Idaho

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death yrs. mos. ds. State yrs. mos. ds.

Where was disease contracted, If not at place of death?

Former or usual residence.

19. PLACE OF BURIAL OR REMOVAL DATE OF BURIAL

Dry Creek Cemetery Nov 25 1913

20. UNDERTAKER ADDRESS

Mrs. Martin Foskey Troy Idaho

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Form V. S. No. 5. 12 1/2 M. 7-24-11

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics
File No. **6650**
Registered No. _____

1. PLACE OF DEATH. Registration District No. **64**
County of **Troy** Primary Registration District No. **2144**
City of **Troy** (No. _____, _____ St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME **Mary Sandberg.**

If death occurred in a hospital, institution or camp give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX **Female** 4. COLOR OR RACE **White** 5. SINGLE, MARRIED, WIDOWED OR DIVORCED. **Married**
(Write the word.)

6. DATE OF BIRTH **Aug. 24 1869**
(Month) (Day) (Year)

7. AGE **44 yrs. 3 mos. 2 ds. 2** IF LESS than 1 day how many _____ hrs. or _____ min?

8. OCCUPATION
(a) Trade, profession or particular kind of work. **House wife**
(b) General nature of industry business or establishment in which employed (or employer)

9. BIRTHPLACE (State or Country) **Sweden**

10. NAME OF FATHER **Henry Johnson**

11. BIRTHPLACE OF FATHER (State or Country) **Sweden**

12. MAIDEN NAME OF MOTHER **Do not know.**

13. BIRTHPLACE OF MOTHER (State or Country) **Sweden**

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) **Eust. Sandberg**
(Address) **Troy Idaho**

15. Filed **Dec 1 1913** **C. V. Johnson**
Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH **Nov 30 1913**
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from **Nov 30 1913**, to **Nov 30 1913**
that I last saw her alive on **Nov 30 1913**
and that death occurred on the date stated above, at **3 P. M.**

The CAUSE OF DEATH* was as follows:
Hæmorrhage from Placenta Previa Controlis

(Duration) _____ yrs. _____ mos. _____ ds.
Contributory **Shock from delivery**
(Secondary) **of child**
(Duration) _____ yrs. _____ mos. _____ ds.
(Signed) **J. Wilson** M. D.
Dec 1 1913 (Address) **Troy Idaho**

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place _____ In the _____
of death _____ yrs. _____ mos. _____ ds. State _____ yrs. _____ mos. _____ ds.
Where was disease contracted, _____
If not at place of death? _____
Former or _____
usual residence _____

19. PLACE OF BURIAL OR REMOVAL **Dry Creek Cemetery** DATE OF BURIAL **Dec 2 1913**

20. UNDERTAKER **Eust. Sandberg** ADDRESS **Troy**

Form V. S. No. 5 20M.1416-12

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH

Registration District No. 64

County of Latah

Primary Registration District No. 2144

City of Troy

(No. St.)

File No.

Registered No.

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

Charles Knust

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX

male

4. COLOR OR RACE

white

5. SINGLE, MARRIED, WIDOWED OR DIVORCED.

widower

(Write the word.)

6. DATE OF BIRTH

February 5th 1828

(Month)

(Day)

(Year)

7. AGE

85 yrs. 10 mos. 4 ds.

IF LESS than 1 day
how many hrs. or
..... mins.

8. OCCUPATION

(a) Trade, profession or particular kind of work

Retired farmer

(b) General nature of industry, business, or establishment in which employed (or employer)

9. BIRTHPLACE

(State or Country)

Germany

10. NAME OF FATHER

John Knust

11. BIRTHPLACE OF FATHER

(State or Country)

Germany

12. MAIDEN NAME OF MOTHER

unknown

13. BIRTHPLACE OF MOTHER

(State or Country)

Germany

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Mrs Julius Schumacher

(Address) Route #3, Troy, Idaho

15.

Filed Dec 13 1913

C. V. Johnson
Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

Dec 12 1913

(Month)

(Day)

(Year)

17. I HEREBY CERTIFY, That I attended deceased from

Nov 1 1913, to Dec 12 1913

that I last saw him alive on Dec 1 1913

and that death occurred on the date stated above, at 29 M.

The CAUSE OF DEATH* was as follows:

Chronic perinephritis
Nephritis

(Duration) several yrs. 2 mos. ds.

Contributory acute attack
(Secondary) nephritis

(Duration) yrs. 2 mos. ds.

(Signed) J. V. Johnson M. D.

Dec 13 1913 (Address) Troy Idaho

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death yrs. mos. days. In the State yrs. mos. days.

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL

Moscow Cemetery

DATE OF BURIAL

Dec 14 1913

20. UNDERTAKER

Emma Schumacher Troy Ida

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Form V, S. No. 5. 12½ M. 7-24-11

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics
File No. 6653
Registered No. _____

1. PLACE OF DEATH. Registration District No. 4
County of Latah Primary Registration District No. 2144
City of Troy (No. _____, _____ St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME David Petrus Fredeen

If death occurred in a hospital, institution or camp give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX Male 4. COLOR OR RACE White 5. SINGLE, MARRIED, WIDOWED OR DIVORCED.
(Write the word.)

6. DATE OF BIRTH April 1891
(Month) (Day) (Year)

7. AGE 22 yrs. 6 mos. 6 ds. IF LESS than 1 day
how many _____ hrs. or _____ min?

8. OCCUPATION
(a) Trade, profession or particular kind of work Farm Labor
(b) General nature of industry business or establishment in which employed (or employer)

9. BIRTHPLACE
(State or Country) Sweden

10. NAME OF FATHER Fredrick Anderson

11. BIRTHPLACE OF FATHER
(State or Country) Sweden

12. MAIDEN NAME OF MOTHER Clara Johanson

13. BIRTHPLACE OF MOTHER
(State or Country) Sweden

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Carl Fredeen
(Address) Troy Ida

15. Filed Oct 31 1913 C. V. Johnson
Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH Oct 30 1913
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from June 1913, to Oct 27 1913
that I last saw him alive on Aug 30 1913
and that death occurred on the date stated above, at _____ M.
The CAUSE OF DEATH* was as follows:

Tuberculosis (Pulmonary)
(Duration) 1 yrs. 6 mos. _____ ds.
Contributory (Secondary) _____
(Signed) J. C. Wick M. D.
Nov 20 1914 (Address) Moscow, Idaho

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place _____ In the _____
of death _____ yrs. _____ mos. _____ ds. State _____ yrs. _____ mos. _____ ds.
Where was disease contracted, _____
If not at place of death? _____
Former or _____
usual residence _____

19. PLACE OF BURIAL OR REMOVAL DATE OF BURIAL
Dry Creek Cemetery Nov. 1 1913
20. UNDERTAKER ADDRESS
John Telford Troy Ida.

WRITE PLAINLY, WITH UNFADEING INK—THIS IS A PERMANENT RECORD.
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Form V. S. No. 5. 12½M.7-24-11

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics
File No. 6654
Registered No. 3

1. PLACE OF DEATH. Registration District No. 43
County of Angus Primary Registration District No. 2120
City of Boise (No. _____, _____ St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

John Burroughs

If death occurred in a hospital, institution or camp give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX Male 4. COLOR OR RACE White 5. SINGLE, MARRIED, WIDOWED OR DIVORCED. Single
(Write the word.)
6. DATE OF BIRTH Unknown 1820
(Month) (Day) (Year)

7. AGE 92 yrs. — mos. — ds. IF LESS than 1 day
how many _____ hrs. or _____ min?

8. OCCUPATION
(a) Trade, profession or particular kind of work. Has been a miner, saloon keeper
(b) General nature of industry business or establishment in which employed (or employer) on ranches at different times

9. BIRTHPLACE
(State or Country) Ontario, Canada

10. NAME OF FATHER William Burroughs

11. BIRTHPLACE OF FATHER
(State or Country) England

12. MAIDEN NAME OF MOTHER Unknown

13. BIRTHPLACE OF MOTHER
(State or Country) England (?)

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) James Siefertson

(Address) The Lamar, Idaho

15. Filed Dec. 24 1913 W. H. Schuyler, M.D.
Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH December, 29, 1913
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from Nov. 1 1913, to Dec. 23 1913
that I last saw him alive on Dec. 23, 1913
and that death occurred on the date stated above, at 5 A.M.
The CAUSE OF DEATH* was as follows:

Old age

(Duration) 6 yrs. — mos. — ds.

Contributory (Secondary)

(Duration) One yrs. — mos. — ds.

(Signed) W. H. Schuyler M. D.

19 (Address) Silver City, Idaho

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death _____ yrs. _____ mos. _____ ds. State _____ yrs. _____ mos. _____ ds.

Where was disease contracted, If not at place of death? _____
Former or usual residence _____

19. PLACE OF BURIAL OR REMOVAL DATE OF BURIAL

On side of K. P. Cemetery near City Dec 24 1913

20. UNDERTAKER ADDRESS

John. Grete Boise City Ida.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Form V. S. No. 5. 12½ M. 7-24-11

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics
File No. 6655
Registered No. 44

1. PLACE OF DEATH. Registration District No. 43
County of Cwyler Primary Registration District No. 2120
City of Idaho (No. _____, St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Lars F. Erickson

If death occurred in a hospital, institution or camp give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX Male 4. COLOR OR RACE White 5. SINGLE, MARRIED, WIDOWED OR DIVORCED. Single
(Write the word.)

6. DATE OF BIRTH Not exactly known
(Month) (Day) (Year)

7. AGE 68 yrs. — mos. — ds. IF LESS than 1 day how many _____ hrs. or _____ min?

8. OCCUPATION

(a) Trade, profession or particular kind of work. Miner
(b) General nature of industry business or establishment in which employed (or employer)

9. BIRTHPLACE

(State or Country) Sweden

10. NAME OF FATHER

Unknown

11. BIRTHPLACE OF FATHER

(State or Country) Unknown

12. MAIDEN NAME OF MOTHER

Unknown

13. BIRTHPLACE OF MOTHER

(State or Country) Unknown

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Henry Olson
(Address) Silver City, Idaho

15.

Filed Dec. 28 1913

W. H. Schuyler M.D.
Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH

December, 26, 1913
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from Dec. 1 1913, to Dec. 26, 1913

that I last saw him alive on Dec. 25, 1913 and that death occurred on the date stated above, at 6:01 M.

The CAUSE OF DEATH* was as follows:

Old age, alcoholism.

(Duration) — yrs. One mos. — ds.

Contributory Alcoholism
(Secondary)

(Duration) 20 yrs. — mos. — ds.

(Signed) W. H. Schuyler M. D.

Dec. 28 1913 (Address) Silver City, Idaho

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death. _____ yrs. _____ mos. _____ ds. In the _____ yrs. _____ mos. _____ ds.

Where was disease contracted,

If not at place of death?

Former or

usual residence.

19. PLACE OF BURIAL OR REMOVAL DATE OF BURIAL

outside of P. Cemetery Silver City, Idaho Dec. 27 1913

20. UNDERTAKER

ADDRESS

John. Grote

Silver City, Idaho

WRITE PLAINLY, WITH UNFADING INK.—THIS IS A PERMANENT RECORD.
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Form V. S. No. 5 20M.1-16-12

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH.

Registration District No. 45

County of Lewis

Primary Registration District No. 2125

City of Hamman

(No. _____ St.)

File No. 6656

Registered No. _____

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

Julia Turner

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX

Female

4. COLOR OR RACE

Indian

5. SINGLE, MARRIED, WIDOWED OR DIVORCED.

Married
(Write the word.)

6. DATE OF BIRTH

don't know
(Month) (Day) (Year)

7. AGE

about 61 yrs. mos. ds.

IF LESS than 1 day
how many hrs. or mins.?

8. OCCUPATION

(a) Trade, profession or particular kind of work

House Keeper

(b) General nature of industry, business, or establishment in which employed (or employer)

9. BIRTHPLACE

(State or Country)

Idaho

10. NAME OF FATHER

Kul Kul Sneydy

11. BIRTHPLACE OF FATHER

(State or Country)

Oregon

12. MAIDEN NAME OF MOTHER

Wampolom

13. BIRTHPLACE OF MOTHER

(State or Country)

Oregon

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

(Address)

Jennetta Davis
Hamman Idaho

15.

Filed 1-5

1914

E. Taylor MD

Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

12 23 1913
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from Dec. 18th. 1913, to Dec. 22nd 1913,

that I last saw her alive on Dec. 22nd 1913,

and that death occurred on the date stated above, at 4 P.M.

The CAUSE OF DEATH* was as follows:

Diabetes mellitus

(Duration) ? yrs. mos. ds.

Contributory
(Secondary)

(Duration) yrs. mos. ds.

(Signed) Wilber F. McMahon, M. D.

12/24/1913. (Address) Hamman, Idaho

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death.....yrs.....mos.....days. In the State.....yrs.....mos.....days.

Where was disease contracted if not at place of death?

Former or usual residence.

19. PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

Indian Cemetery No 2

Dec 26th 1913

20. UNDERTAKER

ADDRESS

C. Johnson

Hamman

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Form V. S. No. 5 20M.1-16-12

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH

Registration District No. 62County of GatahPrimary Registration District No. 2142City of Genesee

(No. _____, St.)

Registered No. 6658

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

Mrs. Mary Hordemann

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX

4. COLOR OR RACE

5. SINGLE, MARRIED, WIDOWED OR DIVORCED

Female Whitemarried
(Write the word.)

6. DATE OF BIRTH

Nov.

(Month)

(Day)

1899
(Year)

7. AGE

64 yrs. 1 mos. ds.IF LESS than 1 day
how many hrs. or
..... mins.

8. OCCUPATION

(a) Trade, profession or particular kind of work

(b) General nature of industry, business, or establishment in which employed (or employer)

Farmer wife

9. BIRTHPLACE

(State or Country)

Wisconsin Racine Co.

10. NAME OF FATHER

Davis

11. BIRTHPLACE OF FATHER

(State or Country)

Europe

12. MAIDEN NAME OF MOTHER

13. BIRTHPLACE OF MOTHER

(State or Country)

Europe

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

W. H. Hordemann

(Address)

Genesee Idaho

15.

Filed 12-291933W. H. Hordemann

Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

Dec271933

(Month)

(Day)

(Year)

17. I HEREBY CERTIFY, That I attended deceased from

Dec1932

to

Dec 261933that I last saw him alive on Dec 26 1933and that death occurred on the date stated above, at 10 P.M.

The CAUSE OF DEATH* was as follows:

Pulmonary Edema

(Duration)

YRS.

mos.

ds.

Contributory (Secondary)

Chronic Interstitial nephritis

(Duration)

YRS.

mos.

ds.

(Signed)

W. H. Hordemann

(Address)

Genesee Idaho

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death

..... yrs. mos. days.

In the State

..... yrs. mos. days.

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

Cath. Ceme12-30 1933

20. UNDERTAKER

ADDRESS

F. E. LambertGenesee Idaho

Form V. S. No. 5. 12½ M. 7-24-11

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
 Bureau of Vital Statistics
 File No. 6659
 Registered No. 189

1. **PLACE OF DEATH.** Registration District No. 10
 County of Idaho Primary Registration District No. 2044
 City of Grangeville (No. _____, _____ St.)

If death occurs away from usual residence, give facts called for under special information.

2. **FULL NAME** not named

If death occurred in a hospital, institution or camp give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. **SEX** male 4. **COLOR OR RACE** white 5. **SINGLE, MARRIED, WIDOWED OR DIVORCED.** Single
 (Write the word.)

6. **DATE OF BIRTH** Dec 25 1913
 (Month) (Day) (Year)

7. **AGE** _____ yrs. _____ mos. _____ ds. IF LESS than 1 day how many 4 hrs. or min?

8. **OCCUPATION**

(a) Trade, profession or particular kind of work. none

(b) General nature of industry business or establishment in which employed (or employer)

9. **BIRTHPLACE**

(State or Country) Idaho

10. **NAME OF FATHER**

Robert Zumwalt

11. **BIRTHPLACE OF FATHER**

(State or Country) Wash

12. **MAIDEN NAME OF MOTHER**

Mary Patterson

13. **BIRTHPLACE OF MOTHER**

(State or Country) Georgia

14. **THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE**

(Informant) Robert Zumwalt
 (Address) Grangeville Idaho

15.

Filed Dec 30 1913 Jesse L Rains
 Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. **DATE OF DEATH**

Dec 25 1913
 (Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from Dec 25 1913, to Dec 25 1913

that I last saw him alive on Dec 25 1913 and that death occurred on the date stated above, at 7 A. M.

The CAUSE OF DEATH* was as follows:

Premature birth

_____ (Duration) _____ yrs. _____ mos. _____ ds.

Contributory (Secondary)

_____ (Duration) _____ yrs. _____ mos. _____ ds.

(Signed) L. S. Strickton M. D.

Dec 25 1913 (Address) Grangeville

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. **LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)**

At place _____ In the _____

of death _____ yrs. _____ mos. _____ ds. State _____ yrs. _____ mos. _____ ds.

Where was disease contracted,

If not at place of death?

Former or

usual residence.

19. **PLACE OF BURIAL OR REMOVAL** **DATE OF BURIAL**

Denver Dec 25 1913

20. **UNDERTAKER****ADDRESS**

none

WRITE PLAINLY, WITH UNFADE INK—THIS IS A PERMANENT RECORD. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Form V. S. No. 5. 10M. 6-20-11.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics
File No. 6660
Registered No. 187

1. PLACE OF DEATH.

Registration District No. 10County of IdahoPrimary Registration District No. 2044City of Lake Placid

(No. _____, _____ St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

Josie Ellen Tilley

If death occurred in a hospital, institution or camp give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX

Female

4. COLOR OR RACE

White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED.

married
(Write the word.)

6. DATE OF BIRTH

July31st1886

(Month)

(Day)

(Year)

7. AGE

2741ds.

IF LESS than 1 day
how many _____ hrs. or
_____ min.)

8. OCCUPATION

(a) Trade, profession or particular kind of work

Farmer's wife

(b) General nature of industry business or establishment in which employed (or employer)

9. BIRTHPLACE

(State or Country)

Arkansas

10. NAME OF FATHER

Benjamin F. Baker

11. BIRTHPLACE OF FATHER

(State or Country)

Illinois

12. MAIDEN NAME OF MOTHER

Masuria Ann Zaster

13. BIRTHPLACE OF MOTHER

(State or Country)

Missouri

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

(Address)

L. P. Tilley
Grangerville

15.

Filed

Dec 30 1913Jesse L. Rains

Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

Dec11913

(Month)

(Day)

(Year)

17. I HEREBY CERTIFY, That I attended deceased from

Nov 301913

to

Dec 11913that I last saw her alive on Nov 1 1913,and that death occurred on the date stated above, at 10 P. M.

The CAUSE OF DEATH* was as follows:

Carcinoma of both kidneys, liver & stomach

(Duration)

yrs.

mos.

ds.

Contributory
(Secondary)Abdomen opened, Nov 20
condition very bad

(Duration)

yrs.

mos.

ds.

(Signed)

G. S. Stettin

M. D.

Dec 2 1913 (Address) Grangerville Idaho

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place

of death

yrs.

mos.

ds.

In the

State

yrs.

mos.

ds.

Where was disease contracted,

If not at place of death?

Former or

usual residence

19. PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

DenverDec 30 1913

20. UNDERTAKER

ADDRESS

E. HancockGrangerville

MADE IN RESERVE FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Form V. S. No. 5 20M.1-16-12		CERTIFICATE OF DEATH		State of Idaho BOARD OF HEALTH Bureau of Vital Statistics	
1. PLACE OF DEATH.		Registration District No. <u>95</u>		File No. <u>6661</u>	
County of <u>Logan</u>		Primary Registration District No. <u>1009</u>		Registered No. <u>35</u>	
City of <u>Lewiston</u> (No. _____ St.)		If death occurs away from usual residence, give facts called for under special information.		If death occurred in a hospital, institution or camp, give its NAME instead of street and number.	
2. FULL NAME <u>Ella Jones</u>					
PERSONAL AND STATISTICAL PARTICULARS					
3. SEX <u>Female</u>		4. COLOR OR RACE <u>White</u>		5. SINGLE, MARRIED, WIDOWED OR DIVORCED. <u>married</u> (Write the word.)	
6. DATE OF BIRTH <u>Feb. 16 1867</u> (Month) (Day) (Year)					
7. AGE <u>46 yrs. 9 mos. 24 ds.</u>				IF LESS than 1 day how many <u>7</u> hrs. or <u>20</u> mins.	
8. OCCUPATION (a) Trade, profession or particular kind of work <u>House wife.</u> (b) General nature of industry, business, or establishment in which employed (or employer)					
9. BIRTHPLACE (State or Country) <u>Johnson Co. Iowa.</u>					
10. NAME OF FATHER <u>William Groff</u>					
11. BIRTHPLACE OF FATHER (State or Country) <u>New York</u>					
12. MAIDEN NAME OF MOTHER <u>Sarah Cathart</u>					
13. BIRTHPLACE OF MOTHER (State or Country) <u>Not known.</u>					
14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE (Informant) <u>O. L. Jones</u> (Address) <u>Lewiston Idaho</u>					
15. Filed <u>1-10-</u> 191 <u>4</u> <u>S. J. Perkins</u> Local Registrar					
MEDICAL CERTIFICATE OF DEATH.					
16. DATE OF DEATH <u>Dec 10 1913</u> (Month) (Day) (Year)					
17. I HEREBY CERTIFY, That I attended deceased from <u>Nov. 1913</u> , to <u>Dec 10 1913</u> , that I last saw her alive on <u>Dec. 10 1913</u> , and that death occurred on the date stated above, at <u>7 P. M.</u>					
The CAUSE OF DEATH* was as follows: <u>Peleiosis of Liver</u> (Duration) <u>Not known</u> yrs. mos. ds. Contributory <u>Dilatation of heart</u> (Secondary) <u>with anasarca</u> (Duration) <u>14</u> yrs. mos. ds. (Signed) <u>L. J. Perkins</u> M. D. <u>1341</u> 191 <u>3</u> (Address) <u>Lewiston Idaho</u>					
*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.					
18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.) At place of death <u>14</u> yrs. <u>14</u> mos. <u>14</u> days. In the State <u>14</u> yrs. <u>14</u> mos. <u>14</u> days. Where was disease contracted if not at place of death? Former or usual residence					
19. PLACE OF BURIAL OR REMOVAL <u>Lewiston Idaho</u>				DATE OF BURIAL <u>12-12 1913</u>	
20. UNDERTAKER <u>O. S. Vassar</u>				ADDRESS <u>Lewiston</u>	

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Form V. S. No. 5 20M.1-16-12

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH.

Registration District No. 96County of Nez PercePrimary Registration District No. 1007City of Lewiston(No. 917, Main St.)File No. 6663Registered No. 67

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

J. H. Fields

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX

M

4. COLOR OR RACE

White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED.

Married
(Write the word.)

6. DATE OF BIRTH

April 10th 1857
(Month) (Day) (Year)

7. AGE

56 yrs. 8 mos. 3 ds.

IF LESS than 1 day
how many hrs. or
..... mins.

8. OCCUPATION

- (a) Trade, profession or particular kind of work
(b) General nature of industry business, or establishment in which employed (or employer)

Restaurant Keep

9. BIRTHPLACE

(State or Country)

Michigan

10. NAME OF FATHER

J. H. Fields

11. BIRTHPLACE OF FATHER

(State or Country)

Michigan

12. MAIDEN NAME OF MOTHER

13. BIRTHPLACE OF MOTHER

(State or Country)

Kentucky

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Mr J. H. Fields(Address) Box 98 Lewiston Ida

15.

Filed 1-10 - 1914 D. Perkins

Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH

December 13 1913
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from

July 15 1913, to Dec 13 1913,
that I last saw him alive on Dec 13 1913,
and that death occurred on the date stated above, at 8:30 P.M.

The CAUSE OF DEATH* was as follows:

Chronic Interstitial Nephritis(Duration) 4 yrs. 6 mos. 0 ds.Contributory
(Secondary)(Duration) 0 yrs. 0 mos. 0 ds.(Signed) R. J. Allen M. D.12/14 1913 (Address) Lewiston Ida

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death yrs. mos. days. In the State yrs. mos. days.

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

Lewiston Ida Dec 15 1913

20. UNDERTAKER

ADDRESS

C. J. Nassar Lewiston

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Form V. S. No. 5. 12½ M. 7-24-11

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics
File No. **6664**
Registered No. **38**

1. PLACE OF DEATH.
County of Nez Perce
City of Lewiston Idaho

Registration District No. 96
Primary Registration District No. 1009
(No. 1937, 9th Ave St.)

If death occurs away from usual residence, give facts called for under special information:

2. FULL NAME

Agnes Spahn

If death occurred in a hospital, institution or camp give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX Female 4. COLOR OR RACE White 5. SINGLE, MARRIED, WIDOWED OR DIVORCED.

(Write the word.)

6. DATE OF BIRTH Dec 14 1913
(Month) (Day) (Year)

7. AGE 1 yrs. — mos. — ds.
IF LESS than 1 day how many — hrs. or — min?

8. OCCUPATION

(a) Trade, profession or particular kind of work. none
(b) General nature of industry business or establishment in which employed (or employer) —

9. BIRTHPLACE

(State or Country)

Washington

10. NAME OF FATHER

Nichols J Spahn

11. BIRTHPLACE OF FATHER

(State or Country)

Russia

12. MAIDEN NAME OF MOTHER

Beaue Nevin

13. BIRTHPLACE OF MOTHER

(State or Country)

Nebraska

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

(Address)

O. Vassar
Lewiston

15.

Filed

1-10- 1917

L. J. Perkins

Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH

Dec 14 1913
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from Dec 14 1913, to Dec 14 1913

that I last saw her alive on Dec 14 1913

and that death occurred on the date stated above, at 9:20 A.M.

The CAUSE OF DEATH* was as follows:

Bronchitis Pneumonia

(Duration) — yrs. 5 mos. — ds.

Contributory (Secondary)

(Duration) — yrs. — mos. — ds.

(Signed)

O. Vassar M. D.

Dec 14 1913 (Address) 902-10 Ave

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place In the
of death — yrs. — mos. — ds. State — yrs. — mos. — ds.

Where was disease contracted,
If not at place of death?

Former or usual residence.

19. PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

Lewiston

Dec 15 1913

20. UNDERTAKER

ADDRESS

O. Vassar

Lewiston

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Form V. S. No. 5 20M.1-16-12

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH.

Registration District No. 92County of Nez PercePrimary Registration District No. 1009City of Leaverton(No. Hospitals St.)File No. 6665Registered No. 59

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Truman Rosenberg

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX M4. COLOR OR RACE W

5. SINGLE, MARRIED, WIDOWED OR DIVORCED.

Married
(Write the word.)

6. DATE OF BIRTH

Feb
(Month)7
(Day)1
(Year)

7. AGE

38 yrs. 10 mos. 11 ds.IF LESS than 1 day
how many hrs. or
..... mins.?

8. OCCUPATION

(a) Trade, profession or particular kind of work

(b) General nature of industry business, or establishment in which employed (or employer)

Housewife

9. BIRTHPLACE

(State or Country)

Nebraska

10. NAME OF FATHER

Oliver P. M. Dutro

11. BIRTHPLACE OF FATHER

(State or Country)

Ill.

12. MAIDEN NAME OF MOTHER

Mary L. Hayder

13. BIRTHPLACE OF MOTHER

(State or Country)

Idaho

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

(Address)

Wassar
Leaverton

15.

Filed 1-10- 1917Local Registrar R. Perkins

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH

12181913

(Month)

(Day)

(Year)

17. I HEREBY CERTIFY, That I attended deceased from

12-16-1913to 12181913that I last saw him alive on 12 18 1913and that death occurred on the date stated above, at 8 P.M.

The CAUSE OF DEATH* was as follows:

Venipal Mercur
(Strangulation)(Duration) yrs. mos. 6 ds.Contributory
(Secondary)Shock

(Duration) yrs. mos. ds.

(Signed)

12-18 1913 (Address) Leaverton, Idaho

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death. yrs. mos. days. In the State. yrs. mos. days.

Where was disease contracted if not at place of death? Lapwai, Ida.Former or usual residence Sweetwater, Ida.

19. PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

Lapwai, Ida.12-20 1913

20. UNDERTAKER

ADDRESS

C. WassarLeaverton

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Form V. S. No. 5 20M.1-16-12

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH

Registration District No. 95County of Nez PercePrimary Registration District No. 1009

City of _____

(No. Domaz St.)File No. 6666Registered No. 6

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX

4. COLOR OR RACE

5. SINGLE, MARRIED, WIDOWED OR DIVORCED.

(Write the word.)

6. DATE OF BIRTH

7. AGE

IF LESS than 1 day
how many _____ hrs. or
_____ mins.?

8. OCCUPATION

- (a) Trade, profession or particular kind of work
(b) General nature of industry business, or establishment in which employed (or employer)

9. BIRTHPLACE

(State or Country)

10. NAME OF FATHER

11. BIRTHPLACE OF FATHER

(State or Country)

12. MAIDEN NAME OF MOTHER

13. BIRTHPLACE OF MOTHER

(State or Country)

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

(Address)

15.

Filed 1-10- 1914

Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH

(Month)

(Day)

1913
(Year)

17. I HEREBY CERTIFY, That I attended deceased from

191 , to191 ,that I last saw h_____ alive on _____ 191 ,

and that death occurred on the date stated above, at _____ M.

The CAUSE OF DEATH* was as follows:

Suicided by Hanging

(Duration) _____ yrs. _____ mos. _____ ds.

Contributory

(Secondary)

(Duration) _____ yrs. _____ mos. _____ ds.

(Signed)

M. D.

19

(Address)

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death _____ yrs. _____ mos. _____ days. In the State _____ yrs. _____ mos. _____ days.

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

Lewiston Ida12-26 1913

20. UNDERTAKER

ADDRESS

E. J. VassarLewiston

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Form V. S. No. 5 20M.1-16-12

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics
File No. 66691

1. PLACE OF DEATH. Registration District No. 29
County of Boole Primary Registration District No. 1050
City of Cour D'Alene (No. _____ St.)

Registered No. 16

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Robert William Wilson

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX Male 4. COLOR OR RACE white 5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.)

6. DATE OF BIRTH

April 4 1909
(Month) (Day) (Year)

7. AGE

4 yrs. 8 mos. 21 ds.

IF LESS than 1 day
how many hrs. or
..... mins.?

8. OCCUPATION

- (a) Trade, profession or particular kind of work
(b) General nature of industry, business, or establishment in which employed (or employer)

9. BIRTHPLACE

(State or Country)

10. NAME OF FATHER

R. W. Wilson

11. BIRTHPLACE OF FATHER

(State or Country)

Campbellton N. B.

12. MAIDEN NAME OF MOTHER

Katie Pritchard

13. BIRTHPLACE OF MOTHER

(State or Country)

Dalhousie N. B.

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

(Address) Mr. R. W. Wilson

15.

Filed Jan. 10 1914 May Robie
Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH

25 Dec. 1913
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from Dec 15 1913, to Dec 24 1913

that I last saw him alive on Dec 24 1913,

and that death occurred on the date stated above, at 59 M.

The CAUSE OF DEATH* was as follows:

Scarlet fever, with hepatitis

(Duration) 4 yrs. 10 mos. 10 ds.

Contributory Cerebrum
(Secondary) from birth

(Duration) 4 yrs. 10 mos. 10 ds.

(Signed) W. H. Holden M. D.

Dec 25 1913 (Address) Cour d Alene

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death.....yrs.....mos.....days. In the State.....yrs.....mos.....days.

Where was disease contracted if not at place of death?

Former or usual residence.

19. PLACE OF BURIAL OR REMOVAL DATE OF BURIAL

Forest Cem. Dec 25 1913

20. UNDERTAKER ADDRESS

Cassidy & Nelson Cour D'Alene

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Form V. S. No. 5 20M.1-16-12

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics
File No. **0670**

1. PLACE OF DEATH Registration District No. **29**
County of **Kootenai** Primary Registration District No. **1050**
City of **Coeur d'Alene** (No. _____ St.)

Registered No. **13**

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

Susan Ritzheimer

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX 4. COLOR OR RACE 5. SINGLE, MARRIED, WIDOWED OR DIVORCED.

Female **White** **Widow**
(Write the word.)

6. DATE OF BIRTH

1846
(Month) (Day) (Year)

7. AGE

67 yrs. mos. ds.

IF LESS than 1 day
how many hrs. or mins.?

8. OCCUPATION

(a) Trade, profession or particular kind of work
(b) General nature of industry, business, or establishment in which employed (or employer)

Housewife

9. BIRTHPLACE

(State or Country)

Id.

10. NAME OF FATHER

John Kelley

11. BIRTHPLACE OF FATHER

(State or Country)

Id.

12. MAIDEN NAME OF MOTHER

Eliza Mathews

13. BIRTHPLACE OF MOTHER

(State or Country)

Id.

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

E. A. Butt

(Address)

15.

Filed

Jan 10

1914

Max D. Dillard
Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH

Dec 17 1913
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from **Dec 8** 1913, to **Dec 17** 1913,

that I last saw him alive on **Dec 16** 1913,

and that death occurred on the date stated above, at **1220 W.**

The CAUSE OF DEATH* was as follows:

Interstitial Nephritis

(Duration) yrs. mos. ds.

Contributory
(Secondary)

(Duration) yrs. mos. ds.

(Signed)

J. C. Dwyer M. D.

Dec 17 1913 (Address) **Coeur d'Alene Idaho**

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death.....yrs.....mos.....days. In the State.....yrs.....mos.....days.

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

Forest Cem.**Dec 18 1913**

20. UNDERTAKER

ADDRESS

Cassedy & Nelson **Coeur d'Alene**

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
 N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Form V. S. No. 5 20M.1-16-12

CERTIFICATE OF DEATH

 State of Idaho
 BOARD OF HEALTH
 Bureau of Vital Statistics

1. PLACE OF DEATH.

Registration District No. 29County of BovalinePrimary Registration District No. 1050City of Carlin Bay

(No. _____, St.)

File No. 6671Registered No. 14

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

Sarah W. W. W.

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX

4. COLOR OR RACE

5. SINGLE, MARRIED, WIDOWED OR DIVORCED.

Female Black(Write the word.) widow

6. DATE OF BIRTH

 _____ 1 _____
 (Month) (Day) (Year)

7. AGE

50 yrs. _____ mos. _____ ds.
 IF LESS than 1 day
 how many _____ hrs. or
 _____ mins.?

8. OCCUPATION

 (a) Trade, profession or particular kind of work
 (b) General nature of industry, business, or establishment in which employed (or employer)
Servant

9. BIRTHPLACE

(State or Country)

Virginia

10. NAME OF FATHER

11. BIRTHPLACE OF FATHER

(State or Country)

12. MAIDEN NAME OF MOTHER

13. BIRTHPLACE OF MOTHER

(State or Country)

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) E. B. Capler(Address) Carlin Bay

15.

Filed Jan. 10 19144

Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH

12/23/13

(Month)

(Day)

191

(Year)

17. I HEREBY CERTIFY, That I attended deceased from

191

to

191

that I last saw him alive on 191

and that death occurred on the date stated above, at M.

The CAUSE OF DEATH* was as follows:

Dropsy(Duration) 5 yrs. _____ mos. _____ ds.

Contributory (Secondary)

(Duration) _____ yrs. _____ mos. _____ ds.

(Signed) J. B. Capler

M. D.

19

(Address) Carlin Bay

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death _____ yrs. _____ mos. _____ days. State _____ yrs. _____ mos. _____ days.

Where was disease contracted if not at place of death?

Former or usual residence.

19. PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

Carlin BayDec 27 1913

20. UNDERTAKER

ADDRESS

S. J. Quiere w a

Form V. S. No. 5 20M.1-16-12

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics
File No. 6672 1
Registered No. 13

1. PLACE OF DEATH.

Registration District No. 29County of HotteraiPrimary Registration District No. 1050City of Coeur d'Alene

(No. _____, St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

Infant of S. C. Simmons

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX

Male

4. COLOR OR RACE

White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED.

(Write the word.)

6. DATE OF BIRTH

Dec71913

(Month)

(Day)

(Year)

7. AGE

_____ yrs. _____ mos. _____ ds.

IF LESS than 1 day
how many _____ hrs. or
_____ mins.?

8. OCCUPATION

(a) Trade, profession or particular kind of work

(b) General nature of industry business, or establishment in which employed (or employer)

9. BIRTHPLACE

(State or Country)

Idaho

10. NAME OF FATHER

S. C. Simmons

11. BIRTHPLACE OF FATHER

(State or Country)

Kansas

12. MAIDEN NAME OF MOTHER

A. Harboun

13. BIRTHPLACE OF MOTHER

(State or Country)

Kansas

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) S. C. Simmons

(Address) _____

15.

Filed Jan 10 19144W. A. Sorensen
Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH

Dec.81913

(Month)

(Day)

(Year)

17. I HEREBY CERTIFY, That I attended deceased from

191

to

Dec. 71913that I last saw him alive on Dec. 8 1913and that death occurred on the date stated above, at 59 M.

The CAUSE OF DEATH* was as follows:

Premature birth.

(Duration)

yrs.

mos. 12 hrs. 45 ds.Contributory
(Secondary)

(Duration)

yrs.

mos. _____ ds.

(Signed)

John O. Wood M. D.

19

(Address)

Coeur d'Alene, Ida.

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place

of death

yrs.

mos.

days.

In the

State

yrs.

mos.

days.

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

Forest CoveDec 81913

20. UNDERTAKER

ADDRESS

Cassidy & NelsonCoeur d'Alene

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Form V. S. No. 5 20M.1-16-12

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH

Registration District No.

29

County of

Primary Registration District No.

1057

City of

(No.

St.)

File No.

66731

Registered No.

12

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

C. S. Haskins

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX

4. COLOR OR RACE

5. SINGLE, MARRIED, WIDOWED OR DIVORCED.

Male

White

Widowed
(Write the word.)

6. DATE OF BIRTH

Apr.

17

1830

(Month)

(Day)

(Year)

7. AGE

83

yrs.

7

mos.

17

ds.

IF LESS than 1 day
how many hrs. or
..... mins.?

8. OCCUPATION

(a) Trade, profession or particular kind of work

Farmer

(b) General nature of industry business, or establishment in which employed (or employer)

9. BIRTHPLACE

(State or Country)

New York

10. NAME OF FATHER

W. B. Haskins

11. BIRTHPLACE OF FATHER

(State or Country)

12. MAIDEN NAME OF MOTHER

Fuller

13. BIRTHPLACE OF MOTHER

(State or Country)

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

W. A. Haskins

(Address)

275 1/2 Rattanwood

15.

Filed

Jan 10

191

4 May 1913

Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH

Dec.

4

1913

(Month)

(Day)

(Year)

17. I HEREBY CERTIFY, That I attended deceased from

Dec. 3.

1913,

to Dec. 4

1913,

that I last saw him alive on Dec. 3.

1913,

and that death occurred on the date stated above, at 10 M.

The CAUSE OF DEATH* was as follows:

Chronic interstitial nephritis.

(Duration)

yrs.

mos.

ds.

Contributory

(Secondary)

(Duration)

yrs.

mos.

ds.

(Signed)

John Elwood

M. D.

Dec 4

1913

(Address)

Coeur d'Alene, Ida.

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place

of death

.....yrs.....mos.....days.

In the

State

.....yrs.....mos.....days.

Where was disease contracted
if not at place of death?

Former or

usual residence

19. PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

Forest Cemetery

Dec 5 1913

20. UNDERTAKER

ADDRESS

Cassedy & Nelson

Coeur d'Alene

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH.

Registration District No. 29County of BoolePrimary Registration District No. 1050City of Coeur d'Alene (No. _____) St. _____File No. 6674Registered No. 11

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

John Quinn Jones

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX

Male

4. COLOR OR RACE

White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED.

Married
(Write the word.)

6. DATE OF BIRTH

June 1837
(Month) (Day) (Year)

7. AGE

76 yrs. 5 mos. 27 ds.IF LESS than 1 day
how many hrs. or
..... mins.

8. OCCUPATION

(a) Trade, profession or particular kind of work
(b) General nature of industry business, or establishment in which employed (or employer)Minister

9. BIRTHPLACE

(State or Country)

Indiana

10. NAME OF FATHER

Jones

11. BIRTHPLACE OF FATHER

(State or Country)

Indiana

12. MAIDEN NAME OF MOTHER

13. BIRTHPLACE OF MOTHER

(State or Country)

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

Barnes S Jones

(Address)

15.

Filed Jan - 10 1914

Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH

Dec 7 1913
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from

Nov. 24 1913, to Dec 3 1913,that I last saw him alive on Dec. 2 1913,and that death occurred on the date stated above, at 8 P M.

The CAUSE OF DEATH* was as follows:

Apoplexy(Duration) yrs. mos. 10 ds.Contributory
(Secondary)

(Duration) yrs. mos. ds.

(Signed)

Dec 4 19 13 (Address) Coeur d'Alene Idaho

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) NATURE OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death yrs. mos. days. In the State yrs. mos. days.

Where was disease contracted
if not at place of death?Former or
usual residence

19. PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

Forest Cem. Dec 7 1913

20. UNDERTAKER

ADDRESS

Caridy & Nelson C.D.A.

WHILE LIVING, WITH UNENDING LIVES IS A PERMANENT RECORD.
B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Form V. S. No. 5 20M.1-16-12

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics
File No. **66751**
Registered No. **10**

1. PLACE OF DEATH.

Registration District No. **29**

County of **Kootenai**

Primary Registration District No. **1030**

City of **Coeur d'Alene**

(No. **13**, **Coeur d'Alene** St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

James Escale

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX

Male

4. COLOR OR RACE

White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED.

Widower

(Write the word.)

6. DATE OF BIRTH

February 21

1830

(Month)

(Day)

(Year)

7. AGE

83 yrs.

mos. **9**

ds. **14**

IF LESS than 1 day
how many hrs. or
mins.?

8. OCCUPATION

(a) Trade, profession or particular kind of work

Mason

(b) General nature of industry, business, or establishment in which employed (or employer)

9. BIRTHPLACE

(State or Country)

England

10. NAME OF FATHER

Escale

11. BIRTHPLACE OF FATHER

(State or Country)

England

12. MAIDEN NAME OF MOTHER

13. BIRTHPLACE OF MOTHER

(State or Country)

England

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

T. W. Escale

(Address)

Coeur d'Alene

15.

Filed

Jan. 10

191

4 May 1914

Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH

Dec.

6

1913

(Month)

(Day)

(Year)

17. I HEREBY CERTIFY, That I attended deceased from

Dec. 6

1913

Dec. 6

1913

that I last saw him **dead before he reached the house** alive on **1913**

and that death occurred on the date stated above, at **4 P. M.**

The CAUSE OF DEATH* was as follows:

Cerebral hemorrhage.

(Duration) yrs. mos. ds.

Contributory
(Secondary)

(Duration) yrs. mos. ds.

(Signed)

Dec. 6 1913

(Address)

**John D. Wood, M. D.
Coeur d'Alene, Ida.**

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place

of death yrs. mos. days.

In the

State yrs. mos. days.

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

Forest Cem.

Dec. 8 1913

20. UNDERTAKER

ADDRESS

Cassidy & Nelson

Coeur d'Alene

MARGIN RESERVE. DO NOT WRITE IN THIS SPACE.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Form V. S. No. 5 20M.1-16-12

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH.

Registration District No. 29

County of Boonville

Primary Registration District No. 1850

City of Conrad

(No. _____, _____ St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME unknown

File No. 6676

Registered No. 9

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX

4. COLOR OR RACE

5. SINGLE, MARRIED, WIDOWED OR DIVORCED.

Male

(Write the word.)

6. DATE OF BIRTH

(Month) (Day) (Year)

7. AGE

About 50 yrs. mos. ds.

IF LESS than 1 day
how many hrs. or mins.

8. OCCUPATION

- (a) Trade, profession or particular kind of work
(b) General nature of industry, business, or establishment in which employed (or employer)

9. BIRTHPLACE

(State or Country)

10. NAME OF FATHER

11. BIRTHPLACE OF FATHER

(State or Country)

12. MAIDEN NAME OF MOTHER

13. BIRTHPLACE OF MOTHER

(State or Country)

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

(Address)

15.

Filed Jan 10 1914

Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH

(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from

1913, to 1913,
that I last saw him alive on 1913,

and that death occurred on the date stated above, at M.

The CAUSE OF DEATH* was as follows:

Cerebral Hemorrhage

(Duration) yrs. mos. ds.

Contributory
(Secondary)

(Duration) yrs. mos. ds.

(Signed) J. H. Shepherd M. D.

1417 193 (Address)

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) Nature of INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death. yrs. mos. days. In the State. yrs. mos. days.

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

Forest Cem.

Dec 1 1913

20. UNDERTAKER

ADDRESS

Cassidy & Nelson

C. D. A.

Form V. S. No. 5 20M.1-16-12

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH.

Registration District No. 29County of BoonePrimary Registration District No. 1050City of Coeur D'Alene

(No. _____, _____ St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Gideon PoirierFile No. 6677Registered No. 8

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX

4. COLOR OR RACE

5. SINGLE, MARRIED, WIDOWED OR DIVORCED.

MaleWhiteMarried
(Write the word.)

6. DATE OF BIRTH

Nov61840

(Month)

(Day)

(Year)

7. AGE

73yrs.24ds.IF LESS than 1 day
how many hrs. or
..... min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work

Laborer

(b) General nature of industry business, or establishment in which employed (or employer)

9. BIRTHPLACE

(State or Country)

Canada

10. NAME OF FATHER

Poirier

11. BIRTHPLACE OF FATHER

(State or Country)

Canada

12. MAIDEN NAME OF MOTHER

13. BIRTHPLACE OF MOTHER

(State or Country)

Canada

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Napoleon Poirier(Address) Coeur D'Alene Idaho

15.

Filed Jan 101914Max Rose
Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH

Nov301913

(Month)

(Day)

(Year)

17. I HEREBY CERTIFY, That I attended deceased from

Nov 151913

to

Nov 291913that I last saw him alive on Nov 29 1913and that death occurred on the date stated above, at 49 M.

The CAUSE OF DEATH* was as follows:

Chronic nephritis(Duration) 4 yrs. 0 mos. 0 ds.Contributory
(Secondary)(Duration) 0 yrs. 0 mos. 0 ds.(Signed) W. H. Hoeden M. D.Nov 30 1913 (Address) Coeur d'Alene Idaho

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death yrs. mos. days. In the State yrs. mos. days.

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

St. Thomas Con.Dec 2 1913

20. UNDERTAKER

ADDRESS

Cassidy & Nelson Coeur D'Alene

MARGIN RESERVED FOR BINDING
WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Form V. S. No. 5 20M.1-16-12

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics
File No. 6678 1
Registered No. 7

1. PLACE OF DEATH. Registration District No. 29
County of Kootenai Primary Registration District No. 1050
City of Coeur d'Alene (No. _____ St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

Emma M. Ebert

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX F 4. COLOR OR RACE White 5. SINGLE, MARRIED, WIDOWED OR DIVORCED.
(Write the word.)

6. DATE OF BIRTH Nov 22 1870
(Month) (Day) (Year)

7. AGE 43 yrs. 0 mos. 24 ds.
IF LESS than 1 day how many _____ hrs. or _____ mins.?

8. OCCUPATION
(a) Trade, profession or particular kind of work House wife
(b) General nature of industry, business, or establishment in which employed (or employer)

9. BIRTHPLACE Germany
(State or Country)

10. NAME OF FATHER Chas. Dokse

11. BIRTHPLACE OF FATHER Germany
(State or Country)

12. MAIDEN NAME OF MOTHER Dora K. Dow

13. BIRTHPLACE OF MOTHER Germany
(State or Country)

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Charles A. Ebert
(Address) Coeur d'Alene

15. Filed Jan. 18 1914 Max E. Ebert
Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH Dec 16th 1913
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from Jan 16 1913 to Dec 16th 1913, that I last saw her alive on Dec 14th 1913, and that death occurred on the date stated above, at 9:09 M.

The CAUSE OF DEATH* was as follows:
Cancer of the stomach

(Duration) 2 yrs. 7 mos. — ds.
Contributory (Secondary)

(Duration) _____ yrs. _____ mos. _____ ds.
(Signed) John Busby M. D.
Dec 16 1913 (Address) Coeur d'Alene Ida.

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MANNER OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death _____ yrs. _____ mos. _____ days. In the State _____ yrs. _____ mos. _____ days.

Where was disease contracted if not at place of death? _____

Former or usual residence _____

19. PLACE OF BURIAL OR REMOVAL Forest Cem DATE OF BURIAL Dec 17 1913

20. UNDERTAKER Cissedy & Nelson ADDRESS Coeur d'Alene

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Form V. S. No. 5 20M.1-16-12

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics
File No. **66791**

1. PLACE OF DEATH.

Registration District No. **29**

County of **Boonville**

Primary Registration District No. **1050**

City of **Boonville**

(No. _____)

St. _____

Registered No. **6**

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME **Julius A. Anderson**

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX **Male**

4. COLOR OR RACE **White**

5. SINGLE, MARRIED, WIDOWED OR DIVORCED. **Married**
(Write the word.)

6. DATE OF BIRTH **Dec 1855**
(Month) (Day) (Year)

7. AGE **57** yrs. **11** mos. **14** ds.

IF LESS than 1 day
how many hrs. or
..... mins.?

8. OCCUPATION **laborer**

(a) Trade, profession or particular kind of work
(b) General nature of industry, business, or establishment in which employed (or employer)

9. BIRTHPLACE **Sweden**
(State or Country)

10. NAME OF FATHER **Anderson**

11. BIRTHPLACE OF FATHER **Sweden**
(State or Country)

12. MAIDEN NAME OF MOTHER

13. BIRTHPLACE OF MOTHER **Sweden**
(State or Country)

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) **Arthur Anderson**

(Address) _____

15. Filed **Jan 10 1914**

Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH **November 20** 191**3**
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from **was called but patient died before my arrival**
that I last saw him **alive on** 191**3**

and that death occurred on the date stated above, at **9:30 P.M.**

The CAUSE OF DEATH* was as follows:

Chronic Alcoholism

about (Duration) **20** yrs. **11** mos. **14** ds.

Contributory (Secondary)

(Duration) **4** yrs. **4** mos. **4** ds.

(Signed) **M. H. Holden** M. D.

19 (Address) **Boonville, Idaho**

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death yrs. mos. days. In the State yrs. mos. days.

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL **Forest Corn**

DATE OF BURIAL **Nov 23 1913**

20. UNDERTAKER **Cassidy & Nelson**

ADDRESS **Boonville, Idaho**

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. N. B.—Every item of information should be carefully supplied. AGE must be state EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Form V. S. No. 5. 10M. 6-20-11.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics
File No. **6681**

1. PLACE OF DEATH.

Registration District No. **21**County of **Blaine**Primary Registration District No. **2042**City of **Belleuve**

(No. _____, _____ St.)

Registered No. **47**

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

Agnes Schaffer.

If death occurred in a hospital, institution or camp give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX

Female

4. COLOR OR RACE 5. SINGLE, MARRIED, WIDOWED OR DIVORCED.

White.

(Write the word.)

6. DATE OF BIRTH

_____ 1 _____
(Month) (Day) (Year)

7. AGE

_____ yrs. _____ mos. _____ ds.

IF LESS than 1 day
how many _____ hrs. or
_____ min.)

8. OCCUPATION

- (a) Trade, profession or particular kind of work _____
(b) General nature of industry business or establishment in which employed (or employer) _____

9. BIRTHPLACE

(State or Country)

Weiser, Ida.

10. NAME OF FATHER

J. H. Schaffer.

11. BIRTHPLACE OF FATHER

(State or Country)

Idaho Falls, Ida.

12. MAIDEN NAME OF MOTHER

Grace Heller.

13. BIRTHPLACE OF MOTHER

(State or Country)

Carey, Ida.

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

W. M. Schaffer.

(Address)

Belleuve, Ida.

15.

Filed

Dec 15 1913**Robert L. Wright**

Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

December 13 1913
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from

Dec 13 1913, to **Dec 13 1913**

that I last saw her alive on **Dec 13 1913**

and that death occurred on the date stated above, at **7 P.M.**

The CAUSE OF DEATH* was as follows:

Acute Cerebral Spinal Meningitis

(Duration) _____ yrs. **about 7** mos. _____ ds.

Contributory
(Secondary)

(Duration) _____ yrs. _____ mos. _____ ds.

(Signed) **O. J. Allen** M. D.

19 _____ (Address) **By Telephone**

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death _____ yrs. _____ mos. _____ ds. State _____ yrs. _____ mos. _____ ds.

Where was disease contracted,

If not at place of death?

Former or
usual residence.

19. PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

Belleuve**Dec 15 1913**

20. UNDERTAKER

ADDRESS

R. D. Harris**Hailing**

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. N. B.—Every item of information should be carefully supplied. AGE should be state EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Form V. S. No. 5. 10M. 6-20-11.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics
File No. **6682**
Registered No. **48**

1. PLACE OF DEATH.

Registration District No. **21**County of **Blaine**Primary Registration District No. **2044**City of **Hailey**

(No. _____)

St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

Edward H Roberts

If death occurred in a hospital, institution or camp give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX

Male

4. COLOR OR RACE 5. SINGLE, MARRIED, WIDOWED OR DIVORCED.

Wht

(Write the word.)

6. DATE OF BIRTH

Feb**10****1881**

(Month)

(Day)

(Year)

7. AGE

82

yrs.

9

mos.

25

ds.

IF LESS than 1 day
how many hrs. or
..... min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work
(b) General nature of industry business or establishment in which employed (or employer)

9. BIRTHPLACE

(State or Country)

10. NAME OF FATHER

11. BIRTHPLACE OF FATHER

(State or Country)

12. MAIDEN NAME OF MOTHER

13. BIRTHPLACE OF MOTHER

(State or Country)

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

Miss Dan Miller

(Address)

Hailey Idaho

15.

Filed

Dec 10 1913**Robert H. Wright**

Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

Dec**6****1913**

(Month)

(Day)

(Year)

17. I HEREBY CERTIFY, That I attended deceased from

Nov 22**1913**

to

Dec 6**1913**that I last saw him alive on **Dec 2** **1913**and that death occurred on the date stated above, at **4:30 P.M.**

The CAUSE OF DEATH* was as follows:

**carcinoma lower lip
Dementia**

(Duration)

2

yrs.

mos.

ds.

Contributory (Secondary)

Dementia

(Duration)

yrs.

mos.

ds.

(Signed)

W. Klemm

M. D.

Dec 8 1913

(Address)

Hailey Idaho

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place

of death

yrs.

mos.

14

In the

ds. State

yrs.

mos.

ds.

Where was disease contracted.

If not at place of death?

Former or usual residence.

Moore Idaho

19. PLACE OF BURIAL OR REMOVAL

Hailey Ida

DATE OF BURIAL

Dec 8 1913

20. UNDERTAKER

R. D. Harris

ADDRESS

Hailey

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. N. B.—Every item of information should be carefully supplied. AGE should be state EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Form V. S. No. 5. 10M. 6-20-11.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics
File No. 6683
Registered No. 49

1. PLACE OF DEATH.

Registration District No. 21County of BlainePrimary Registration District No. 2022

City of _____

(No. _____, St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

William G. Curry

If death occurred in a hospital, institution or camp give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX

Male

4. COLOR OR RACE

Wht

5. SINGLE, MARRIED, WIDOWED OR DIVORCED.

Single
(Write the word.)

6. DATE OF BIRTH

(Month)

(Day)

(Year)

7. AGE

About 60

yrs.

mos.

ds.

IF LESS than 1 day

how many _____ hrs. or _____ min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work
(b) General nature of industry business or establishment in which employed (or employer)

Prison warden

9. BIRTHPLACE

(State or Country)

10. NAME OF FATHER

(State or Country)

11. BIRTHPLACE OF FATHER

(State or Country)

12. MAIDEN NAME OF MOTHER

13. BIRTHPLACE OF MOTHER

(State or Country)

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

(Address)

15.

Filed

Dec 28 1913

Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

Dec

(Month)

25

(Day)

1913

(Year)

17. I HEREBY CERTIFY, That I attended deceased from

191 , to191

that I last saw him alive on

191

and that death occurred on the date stated above, at _____ M.

The CAUSE OF DEATH* was as follows:

Probably typhoid, as no other was diagnosed in
injury.

(Duration)

yrs.

mos.

ds.

Contributory

(Secondary)

(Duration)

yrs.

mos.

ds.

(Signed)

W. G. Curry M. D.1913 (Address)

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and 2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place

In the

of death

yrs.

mos.

ds. State

yrs.

mos.

ds.

Where was disease contracted,

If not at place of death?

Former or

usual residence.

19. PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

BlaineDec 28 1913

20. UNDERTAKER

ADDRESS

W. G. CurryBlaine

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. N. B.—Every item of information should be carefully supplied. AGE should be state EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Form V. S. No. 5. 10M. 6-20-11.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics
File No. 6684
Registered No. 50

1. PLACE OF DEATH.

Registration District No. 21County of BlainePrimary Registration District No. 2099City of Hailey(No.)

St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

Lespea Wertheimer

If death occurred in a hospital, institution or camp give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX

male

4. COLOR OR RACE 5. SINGLE, MARRIED, WIDOWED OR DIVORCED.

whSingle
(Write the word.)

6. DATE OF BIRTH

Jan281854

(Month)

(Day)

(Year)

7. AGE

59

yrs.

10

mos.

28

ds.

IF LESS than 1 day
how many.....hrs.or
.....min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work
(b) General nature of industry business or establishment in which employed (or employer)

Merchant

9. BIRTHPLACE

(State or Country)

Germany

10. NAME OF FATHER

Jonathau Wertheimer

11. BIRTHPLACE OF FATHER

(State or Country)

Phalheim

12. MAIDEN NAME OF MOTHER

Sarah Harrel

13. BIRTHPLACE OF MOTHER

(State or Country)

Phalheim

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

Jonathau Wertheimer

(Address)

Hailey, Idaho

15.

Filed

Jan 11913Robert H. Hays

Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

Dec

(Month)

29

(Day)

1913

(Year)

17. I HEREBY CERTIFY, That I attended deceased from

Dec 28 1913, to Dec 29 1913that I last saw him alive on Dec 29 1913and that death occurred on the date stated above, at 3 P.M.

The CAUSE OF DEATH* was as follows:

Robert H. Hays(Duration) yrs. mos. 4 ds.

Contributory (Secondary)

(Duration) yrs. mos. ds.

(Signed)

Dec 30 1913

(Address)

Hailey, Idaho

*State the DISEASE CAUSING DEATH; or in death from VIOLENT CAUSES, state (1) MEANS OF INJURY; and 2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place yrs. mos. ds. State yrs. mos. ds.

Where was disease contracted,

If not at place of death?

Former or usual residence.

19. PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

Hailey, IdahoJan 1 1914

20. UNDERTAKER

ADDRESS

R. H. HaysHailey, Idaho

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. N. B.—Every item of information should be carefully supplied. AGE should be state EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Form V. S. No. 5. 10M. 6-20-11.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. **PLACE OF DEATH.** Registration District No. 21
County of Blaine Primary Registration District No. 2022
City of Gannett Pa. (No. _____ St.) File No. 6685
Registered No. 51

If death occurs away from usual residence, give facts called for under special information. 2. **FULL NAME** Ellsworth Eels
If death occurred in a hospital, institution or camp give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS		MEDICAL CERTIFICATE OF DEATH	
3. SEX <u>Male</u>	4. COLOR OR RACE <u>Wht</u>	5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.) _____	
6. DATE OF BIRTH <u>Feb 28 1913</u> (Month) (Day) (Year)		16. DATE OF DEATH <u>Dec 28 1913</u> (Month) (Day) (Year)	
7. AGE <u>3</u> yrs. <u>3</u> mos. <u>3</u> ds. IF LESS than 1 day how many _____ hrs. or _____ min.?		17. I HEREBY CERTIFY, That I attended deceased from _____ 191____, to _____ 191____, that I last saw h_____ alive on _____ 191____, and that death occurred on the date stated above, at <u>7 A.M.</u> The CAUSE OF DEATH* was as follows: <u>No attending physician</u>	
8. OCCUPATION (a) Trade, profession or particular kind of work _____ (b) General nature of industry business or establishment in which employed (or employer) _____		(Duration) _____ yrs. _____ mos. _____ ds.	
9. BIRTHPLACE (State or Country) <u>Gannett</u>		Contributory (Secondary) _____ (Duration) _____ yrs. _____ mos. _____ ds.	
10. NAME OF FATHER <u>Archie Eels</u>		(Signed) _____ M. D. _____ 19____ (Address) _____	
11. BIRTHPLACE OF FATHER (State or Country) <u>Wisconsin</u>		*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and 2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.	
12. MAIDEN NAME OF MOTHER <u>Edna Gannett</u>		18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.) At place _____ In the _____ of death _____ yrs. _____ mos. _____ ds. State _____ yrs. _____ mos. _____ ds. Where was disease contracted, _____ If not at place of death? _____ Former or usual residence _____	
13. BIRTHPLACE OF MOTHER (State or Country) <u>Idaho</u>		19. PLACE OF BURIAL OR REMOVAL <u>Gannett Pa.</u>	
14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE (Informant) <u>Mrs L E Gannett</u> (Address) <u>Gannett</u>		DATE OF BURIAL <u>Dec 29 1913</u>	
15. Filed <u>Jan 1 1913</u> Local Registrar <u>[Signature]</u>		20. UNDERTAKER <u>R D Harris</u>	
		ADDRESS <u>Honey</u>	

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
N. B.—Every item of information should be carefully supplied. AGE should be state EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Form V. S. No. 5. 10M. 6-20-11.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH. Registration District No.

County of Minidoka Primary Registration District No.

City of Reupert (No., St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Hilda May Nelson

File No. 6686

Registered No.

If death occurred in a hospital, institution or camp give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX 4. COLOR OR RACE 5. SINGLE, MARRIED, WIDOWED OR DIVORCED.

Female White (Write the word.)

6. DATE OF BIRTH 11 24 1913
(Month) (Day) (Year)

7. AGE IF LESS than 1 day
..... yrs. mos. 7 ds. how many hrs. or min.?

8. OCCUPATION

- (a) Trade, profession or particular kind of work
(b) General nature of industry business or establishment in which employed (or employer)

9. BIRTHPLACE

(State or Country)

10. NAME OF FATHER

11. BIRTHPLACE OF FATHER

(State or Country)

12. MAIDEN NAME OF MOTHER

13. BIRTHPLACE OF MOTHER

(State or Country)

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) William C Nelson

(Address) Reupert, Ida

15. Filed Dec 15 1913 J H Scott
Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

Dec 1 1913
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from Nov. 24 1913, to Dec 1 1913

that I last saw her alive on Dec 1 1913, and that death occurred on the date stated above, at 8 P. M.

The CAUSE OF DEATH* was as follows:

atelectasis

(Duration) yrs. mos. 8 ds.

Contributory (Secondary)

(Duration) yrs. mos. ds.

(Signed) J B Kenney M. D.

12/4 1913 (Address) J B Kenney

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted,

If not at place of death?

Former or usual residence.

19. PLACE OF BURIAL OR REMOVAL DATE OF BURIAL

Reupert 1913

20. UNDERTAKER ADDRESS

H A Goodman Reupert

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Form V. S. No. 5. 10M. 6-20-11.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH. Registration District No. _____
County of Blaine Primary Registration District No. _____
City of Rupert (No. _____, St.) _____

File No. 6687
Registered No. _____

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

Arthur B Jones

If death occurred in a hospital, institution or camp give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX Male 4. COLOR OR RACE White 5. SINGLE, MARRIED, WIDOWED OR DIVORCED. Married

6. DATE OF BIRTH Apr 29 1867
(Month) (Day) (Year)

7. AGE 46 yrs. 9 mos. 2 ds. IF LESS than 1 day how many hrs. or min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work Engineer
(b) General nature of industry business or establishment in which employed (or employer)

9. BIRTHPLACE (State or Country) Massachusetts

10. NAME OF FATHER E. C. Ames

11. BIRTHPLACE OF FATHER (State or Country) New Hampshire

12. MAIDEN NAME OF MOTHER E. C. Townsend

13. BIRTHPLACE OF MOTHER (State or Country) Maine

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) E. C. Ames
(Address) East Hill New H

15. Filed _____ 191____
P. H. Scott
Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH Dec 27 1913
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from Oct. 16 1913 to Dec 27 1913
that I last saw him alive on Dec 27 1913,
and that death occurred on the date stated above, at 4 A. M.

The CAUSE OF DEATH* was as follows:

Pneumonia

(Duration) _____ yrs. _____ mos. _____ ds.
Contributory (Secondary) Locomotor ataxia

(Duration) 7 yrs. _____ mos. _____ ds.
(Signed) P. H. Scott M. D.
Dec 28 1913 (Address) Rupert

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death..... yrs. mos. ds. In the State..... yrs. mos. ds.
Where was disease contracted.
If not at place of death?.....
Former or usual residence.....

19. PLACE OF BURIAL OR REMOVAL Rupert Cemetery DATE OF BURIAL Dec 29 1913

20. UNDERTAKER W. A. Goodenow ADDRESS Rupert

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Form V. S. No. 5 20M.1-16-12

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH

Registration District No. 105County of IdahoPrimary Registration District No. 2183City of Pernamand

(No. _____, St.)

File No. 2 6688

Registered No. _____

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

Lewy J. Johnson

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX

M

4. COLOR OR RACE

White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED.

married
(Write the word.)

6. DATE OF BIRTH

Feb 5th 1894
(Month) (Day) (Year)

7. AGE

79 yrs. 10 mos. 10 ds.

IF LESS than 1 day
how many hrs. or
..... min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work

Farmer
(retired)

(b) General nature of industry business, or establishment in which employed (or employer)

9. BIRTHPLACE

(State or Country)

New York

10. NAME OF FATHER

Sylvester Johnson

11. BIRTHPLACE OF FATHER

(State or Country)

12. MAIDEN NAME OF MOTHER

13. BIRTHPLACE OF MOTHER

(State or Country)

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

Emily E. Johnson

(Address)

Pernamand

15.

Filed

Dec 15th 19131913H B Place

Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH

December 15 1913
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from

Nov. 28 1913, to Dec. 14 1913,
that I last saw him alive on December 13 1913,
and that death occurred on the date stated above, at 59 M.

The CAUSE OF DEATH* was as follows:

Cardiac insufficiency due
to Chronic Interstitial Nephritis.

(Duration) yrs. mos. 17 ds.Contributory
(Secondary)Unknown

(Duration) yrs. mos. ds.

(Signed)

Herby B. Dr. M. D.Dec 15 1913 (Address) Cottonwood, Ida.

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death yrs. mos. days. In the State yrs. mos. days.

Where was disease contracted
if not at place of death?

Former or
usual residence

19. PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

HarrowtownDec. 16 1913

20. UNDERTAKER

ADDRESS

Harry M. WestCottonwood, Ida.

Form V. S. No. 5. 10M. 6-20-11.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics
File No. 16690
Registered No. _____

1. PLACE OF DEATH.

Registration District No. 09County of BlainePrimary Registration District No. 2139City of Arco

(No. _____, _____ St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

Anna Eva Stoddard

If death occurred in a hospital, institution or camp give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX

Female

4. COLOR OR RACE

White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED.

Married
(Write the word.)

6. DATE OF BIRTH

April 7-

(Month)

(Day)

1872
(Year)

7. AGE

42 yrs. 8 mos. 24 ds.

IF LESS than 1 day
how many _____ hrs. or
_____ min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work
(b) General nature of industry business or establishment in which employed (or employer)

House wife

9. BIRTHPLACE

(State or Country)

Milk Creek, Utah

10. NAME OF FATHER

John DeLuane

11. BIRTHPLACE OF FATHER

(State or Country)

Germany

12. MAIDEN NAME OF MOTHER

Louetta Hubo

13. BIRTHPLACE OF MOTHER

(State or Country)

Germany

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

Joseph H. Stoddard

(Address)

Moore, Idaho

15.

Filed

1-1-1914E. W. Fox

Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

12-

(Month)

31

(Day)

1913
(Year)

17. I HEREBY CERTIFY, That I attended deceased from

12-20 1913, to 12-31 1913that I last saw her alive on 12-31 1913and that death occurred on the date stated above, at 4:20 P.M.

The CAUSE OF DEATH* was as follows:

Carcinosis of the Liver
(Hypertrophic)(Duration) 2 yrs. _____ mos. _____ ds.

Contributory (Secondary)

(Duration) _____ yrs. _____ mos. _____ ds.

(Signed) E. W. Fox M. D.1-1- 1914 (Address) Arco - Idaho

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death _____ yrs. _____ mos. _____ ds. State _____ yrs. _____ mos. _____ ds.

Where was disease contracted,

If not at place of death?

Former or

usual residence.

19. PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

Moore1-3 1913

20. UNDERTAKER

ADDRESS

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Form V. S. No. 5. 10M. 6-20-11.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH.
County of Blaine
City of Arco

Registration District No. 59
Primary Registration District No. 2139
(No. _____, _____ St.)

File No. 6691
Registered No. _____

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

Meachum

If death occurred in a hospital, institution or camp give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX Male 4. COLOR OR RACE White 5. SINGLE, MARRIED, WIDOWED OR DIVORCED. Single
(Write the word.)

6. DATE OF BIRTH

12 (Month) 21 (Day) 1913 (Year)

7. AGE

____ yrs. ____ mos. ____ ds.

IF LESS than 1 day
how many ____ hrs. or
____ min.?

8. OCCUPATION

- (a) Trade, profession or particular kind of work
(b) General nature of industry business or establishment in which employed (or employer)

9. BIRTHPLACE

(State or Country)

Arco - Idaho

10. NAME OF FATHER

Charles H. Meachum

11. BIRTHPLACE OF FATHER

(State or Country)

Ab City, Utah

12. MAIDEN NAME OF MOTHER

Anna Rabbit

13. BIRTHPLACE OF MOTHER

(State or Country)

Elba, Idaho

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

(Address)

Mrs Chas MeachumArco - Idaho

15.

Filed

12/231913Dr. Fox

Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

12 (Month) 21 (Day)

17. I HEREBY CERTIFY, That I attended deceased

12-21-1913 to 12-21

that I last saw him alive on 12-21

and that death occurred on the date stated above, at 10

The CAUSE OF DEATH* was as follows:

Pulmonary Hemorrhage
at Elba, Idaho

(Duration) ____ yrs. ____ mos.

Contributory
(Secondary)

(Duration) ____ yrs. ____ mos.

(Signed)

12/23/1913 (Address) Arco, Idaho

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions or Recent Residents.)

At place of death ____ yrs. ____ mos. ____ ds. In the State ____ yrs. ____ mos. ____ ds.

Where was disease contracted,

If not at place of death?

Former or

usual residence.

19. PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

Arco, Idaho

12-23 1913

20. UNDERTAKER acting as

ADDRESS

Chas Meachum

Arco, Idaho

MARGIN RESERVE FOR BINDING
WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Form V. S. No. 5. 12½M. 7-24-11

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics
File No. **6693**
Registered No. **6**

1. PLACE OF DEATH. Registration District No. **170**
County of **Cassia** Primary Registration District No. **2199**
City of **Oakley** (No. _____, St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME **Mary Ann Mc Murray**

If death occurred in a hospital, institution or camp give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX **Female** 4. COLOR OR RACE **White** 5. SINGLE, MARRIED, WIDOWED OR DIVORCED. **married**
(Write the word.)
6. DATE OF BIRTH **April 17 1845**
(Month) (Day) (Year)

7. AGE **68** yrs. **7** mos. **25** ds. IF LESS than 1 day how many _____ hrs. or _____ min?

8. OCCUPATION
(a) Trade, profession or particular kind of work **Housewife**
(b) General nature of industry business or establishment in which employed (or employer)

9. BIRTHPLACE
(State or Country) **Illinois**

10. NAME OF FATHER **Wilford Hudson**

11. BIRTHPLACE OF FATHER
(State or Country) **Don't know**

12. MAIDEN NAME OF MOTHER **Julia Ann Graybill**

13. BIRTHPLACE OF MOTHER
(State or Country) **Don't know**

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) **M. E. Mc Murray**
(Address) **Oakley Idaho**

15. Filed **1-7-1914** **E. Polldham**
Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH **Dec 12 1913**
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from **Nov 20 1913**, to **Dec 12 1913** that I last saw her alive on **Dec 12 1913** and that death occurred on the date stated above, at **6:30 P.M.**

The CAUSE OF DEATH* was as follows:
Cerebral Hemorrhage

..... (Duration) **3** yrs. **3** mos. **3** ds.
Contributory (Secondary) **Gastritis**
(Duration) **1 1/2** yrs. **0** mos. **0** ds.
(Signed) **H. C. Haight** M. D.
..... 19 **Oakley Idaho** (Address)

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place In the
of death. yrs. mos. ds. State. yrs. mos. ds.
Where was disease contracted,
If not at place of death?
Former or
usual residence.

19. PLACE OF BURIAL OR REMOVAL **Oakley Idaho** DATE OF BURIAL **12/14 1913**

20. UNDERTAKER **E. Polldham** ADDRESS **Oakley Idaho**
H. C. Haight

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Form V. S. No. 5. 12½ M. 7-24-11

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics
File No. **6694**
Registered No. **128**

1. PLACE OF DEATH.
County of **Latah**
City of **Moscow**

Registration District No. **61**
Primary Registration District No. **1011**
(No. , St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME **Bert Mitzberg**

If death occurred in a hospital, institution or camp give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX **Male** 4. COLOR OR RACE **white** 5. SINGLE, MARRIED, WIDOWED OR DIVORCED.
(Write the word.)

6. DATE OF BIRTH **Nov 17 1913**
(Month) (Day) (Year)

7. AGE **21** yrs. mos. ds. IF LESS than 1 day how many hrs. or min?

8. OCCUPATION

- (a) Trade, profession or particular kind of work.
(b) General nature of industry business or establishment in which employed (or employer)

9. BIRTHPLACE **Moscow Idaho**
(State or Country)

10. NAME OF FATHER **J. H. Mitzberg**

11. BIRTHPLACE OF FATHER **Iowa**
(State or Country)

12. MAIDEN NAME OF MOTHER **Catharine Rutterville**

13. BIRTHPLACE OF MOTHER **Wash.**
(State or Country)

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) **J. H. Mitzberg**
(Address) **Moscow**

15. Filed **Dec 8 1913** **D. F. Rae**
Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH **Dec 8 1913**
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from **191** to **191**

that I last saw h. alive on **191**

and that death occurred on the date stated above, at **M.**

The CAUSE OF DEATH* was as follows:

Supposed it suffocated during the night

(Duration) yrs. mos. ds.

Contributory (Secondary)

(Duration) yrs. mos. ds.

(Signed) **J. H. Clarke** M. D.

19 (Address)

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place In the of death yrs. mos. ds. State yrs. mos. ds.

Where was disease contracted, If not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL **Moscow** DATE OF BURIAL **Dec 8 1913**

20. UNDERTAKER **Geo Slitz** ADDRESS **Moscow**

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Form V. S. No. 5 20M.1-16-12

CERTIFICATE OF DEATH

 State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH.

Registration District No.

2141 61

County of

Primary Registration District No.

2141

City of

(No.

St.)

File No.

6695

Registered No.

126

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

John M Potter

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX

Male

4. COLOR OR RACE

white

5. SINGLE, MARRIED, WIDOWED OR DIVORCED.

married
(Write the word.)

6. DATE OF BIRTH

Mar

19

1844

(Month)

(Day)

(Year)

7. AGE

69 yrs. 8 mos. 25 ds.

 IF LESS than 1 day
how many hrs. or
..... mins.?

8. OCCUPATION

 (a) Trade, profession or particular kind of work
(b) General nature of industry, business, or establishment in which employed (or employer)

Farmer

9. BIRTHPLACE

(State or Country)

Tiga Del.

10. NAME OF FATHER

David Potter

11. BIRTHPLACE OF FATHER

(State or Country)

Virginia

12. MAIDEN NAME OF MOTHER

Mary E. E. E.

13. BIRTHPLACE OF MOTHER

(State or Country)

Ohio

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

Emma E. Potter

(Address)

M. E. E.

15.

Filed

Dec 14

191

3 D F Roe

Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH

Dec

14

1913

(Month)

(Day)

(Year)

17. I HEREBY CERTIFY, That I attended deceased from

Dec 13

1913

to Dec 14

1913

that I last saw him alive on Dec 13 1913

and that death occurred on the date stated above, at 2 A.M.

The CAUSE OF DEATH* was as follows:

Nephritis

(Duration) 5 yrs. mos. ds.

Contributory Arterio Sclerosis (Secondary)

(Duration) 3 yrs. mos. ds.

(Signed) Joseph Ashray M. D.

Dec 15 1913 (Address) Joseph Ashray

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death yrs. mos. days. In the State yrs. mos. days.

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

M. E. E.

Dec 16 1913

20. UNDERTAKER

ADDRESS

E. E. E.

M. E. E.

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Form V. S. No. 5 20M.1-16-12

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH. Registration District No. 61
County of Latah Primary Registration District No. 1011
City of Moscow (No. _____, St.)

File No. 6695
Registered No. 129

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Clair Mildred McEluffie

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX F.M. 4. COLOR OR RACE white 5. SINGLE, MARRIED, WIDOWED OR DIVORCED.
(Write the word.)

6. DATE OF BIRTH Jan 15 1913
(Month) (Day) (Year)

7. AGE 1 yrs. 11 mos. 11 ds.
IF LESS than 1 day how many hrs. or mins.?

8. OCCUPATION
(a) Trade, profession or particular kind of work none
(b) General nature of industry business, or establishment in which employed (or employer)

9. BIRTHPLACE (State or Country) Latah Co. Idaho

10. NAME OF FATHER Maynard McEluffie

11. BIRTHPLACE OF FATHER (State or Country) Haft, Idaho

12. MAIDEN NAME OF MOTHER Eva L. Shepherd

13. BIRTHPLACE OF MOTHER (State or Country) Latah Co. Idaho

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Harren T. Shepherd
(Address) Plummer Idaho

15. Filed Dec 29 1913 J. F. Rae
Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH Dec 26 1913
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from Dec 17 1913, to Dec 26 1913, that I last saw her alive on Dec 26 1913, and that death occurred on the date stated above, at 102 M.

The CAUSE OF DEATH* was as follows:

Dysentery

(Duration) yrs. mos. 9 ds.

Contributory (Secondary)

(Duration) yrs. mos. ds.

(Signed) W. A. Adams M. D.
Dec 27 1913 (Address) Moscow Idaho

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death yrs. mos. days. In the State yrs. mos. days.

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL St. Marys DATE OF BURIAL 29 1913

20. UNDERTAKER Geo. Stoltz ADDRESS Moscow

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Form V. S. No. 5. 12½ M. 7-24-11

CERTIFICATE OF DEATH

1. PLACE OF DEATH. Registration District No. 61
 County of Latah Primary Registration District No. 1011
 City of Moscow (No. _____, _____ St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

Wm Harry Belton

State of Idaho
 BOARD OF HEALTH
 Bureau of Vital Statistics

File No. 6697
 Registered No. 125

If death occurred in a hospital, institution or camp give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX 4. COLOR OR RACE 5. SINGLE, MARRIED, WIDOWED OR DIVORCED.

Male White Married
 (Write the word)

6. DATE OF BIRTH

April 4 1858
 (Month) (Day) (Year)

7. AGE

60 yrs. 8 mos. 12 ds.

IF LESS than 1 day
 how many hrs. or
 min?

8. OCCUPATION

(a) Trade, profession or particular kind of work.

(b) General nature of industry business or establishment in which employed (or employer)

Contracting, Paint
ing, filer
working

9. BIRTHPLACE

(State or Country)

Kentucky

10. NAME OF FATHER

Christopher Belton

11. BIRTHPLACE OF FATHER

(State or Country)

Ireland

12. MAIDEN NAME

(State or Country)

Mary McCreff

13. BIRTHPLACE OF MOTHER

(State or Country)

Kentucky

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

Mollie Belton
Moscow Idaho

(Address)

15.

Filed Dec 13 1913

S F Rar
 Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH

Dec 12 1913
 (Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from

Sept 29 1913, to Dec 12 1913

that I last saw him alive on Dec 11 1913

and that death occurred on the date stated above, at 8:20 P.M.

The CAUSE OF DEATH* was as follows:

Parenchymatous
Nephritis

(Duration) 3 yrs. mos. ds.

Contributory
 (Secondary)

(Duration) yrs. mos. ds.

(Signed)

J. M. Leitch M. D.
19 (Address) Moscow Idaho

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place

In the

of death yrs. mos. ds. State yrs. mos. ds.

Where was disease contracted,

If not at place of death?

Former or

usual residence.

19. PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

Moscow Cemetery Dec 14 1913

20. UNDERTAKER

ADDRESS

Geo Stith Moscow

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Form V. S. No. 5. 12½M.7-24-11

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics
File No. **6698**
Registered No. **127**

1. PLACE OF DEATH. Registration District No. **61**
County of **Salah** Primary Registration District No. **1011**
City of **Moscow** (No. _____ St. _____)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME **Leslie Alfred Pierce**

If death occurred in a hospital, institution or camp give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX **M** 4. COLOR OR RACE **W** 5. SINGLE, MARRIED, WIDOWED OR DIVORCED. **Married**
(Write the word.)

6. DATE OF BIRTH **October 8 1855**
(Month) (Day) (Year)

7. AGE **58 yrs. 2 mos. 15 ds.** IF LESS than 1 day how many _____ hrs. or _____ min?

8. OCCUPATION **Farmer**
(a) Trade, profession or particular kind of work.
(b) General nature of industry business or establishment in which employed (or employer)

9. BIRTHPLACE **New York**
(State or Country)

10. NAME OF FATHER **David Pierce**

11. BIRTHPLACE OF FATHER **Do not know**
(State or Country)

12. MAIDEN NAME OF MOTHER **Andrews Nancy**

13. BIRTHPLACE OF MOTHER **Penn.**
(State or Country)

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) **Florence Lucile Pierce**
(Address) **Moscow Idaho**

15. Filed **Dec 26 1913** **J. F. Roe**
Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH **Dec 23 1913**
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from **Oct 23 1913** to **Dec 23 1913**
that I last saw him alive on **Dec 22 1913**
and that death occurred on the date stated above, at **11 P. M.**
The CAUSE OF DEATH* was as follows:
Acute ascending paralysis

(Duration) **6** yrs. **6** mos. **6** ds.
Contributory (Secondary)

(Duration) **6** yrs. **6** mos. **6** ds.
(Signed) **Joseph Aspray M. D.**
Dec 24 1913 (Address) **Moscow Ida**

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place In the
of death _____ yrs. _____ mos. _____ ds. State _____ yrs. _____ mos. _____ ds.
Where was disease contracted,
If not at place of death? _____
Former or
usual residence _____

19. PLACE OF BURIAL OR REMOVAL **Durango Colorado** DATE OF BURIAL **1913**

20. UNDERTAKER **Geo. Petty** ADDRESS **Moscow**

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Form V. S. No. 5 20M.1-16-12

CERTIFICATE OF DEATH

1. PLACE OF DEATH.

County of CusterCity of Clayton

If death occurs away from usual residence, give fact called for under special information.

Registration District No. 14Primary Registration District No. 2060

(No. _____, _____ St.)

2. FULL NAME

State of Idaho
BOARD OF HEALTH
Bureau of Vital StatisticsFile No. 6699Registered No. 61

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX

Female wh.

4. COLOR OR RACE

5. SINGLE, MARRIED, WIDOWED OR DIVORCED.

Single
(Write the word.)

6. DATE OF BIRTH

Oct 4 1913
(Month) (Day) (Year)

7. AGE

1 yrs. 2 mos. 2 ds.IF LESS than 1 day
how many _____ hrs. or
_____ mins.?

8. OCCUPATION

- (a) Trade, profession or particular kind of work
(b) General nature of industry, business, or establishment in which employed (or employer)

none

9. BIRTHPLACE

(State or Country)

10. NAME OF FATHER

11. BIRTHPLACE OF FATHER

(State or Country)

12. MAIDEN NAME OF MOTHER

13. BIRTHPLACE OF MOTHER

(State or Country)

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

(Address)

15.

Filed 191

Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH

Nov 1 1913
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from

191 to 191,
that I last saw him alive and at 191and that death occurred on the date stated above, at M.

The CAUSE OF DEATH* was as follows:

Infant
not specified(Duration) _____ yrs. 1 mos. 2 ds.

Contributory

(Secondary)

(Duration) _____ yrs. _____ mos. _____ ds.

(Signed)

19 (Address)

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death _____ yrs. _____ mos. _____ days. In the State _____ yrs. _____ mos. _____ days.

Where was disease contracted if not at place of death? _____

Former or usual residence _____

19. PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

Clayton Nov 1 1913

20. UNDERTAKER

ADDRESS

Family Clayton

Form V. S. No. 5. 12½M.7-24-11

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH. Registration District No. 14
 County of Custer Primary Registration District No. 9061
 City of Clayton (No. _____, _____ St.)

File No. 6700
 Registered No. 57

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

Bessie Arnold Simpson

If death occurred in a hospital, institution or camp give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX 4. COLOR OR RACE 5. SINGLE, MARRIED, WIDOWED OR DIVORCED.

male white Single
 (Write the word.)

6. DATE OF BIRTH

Jan 7 1910
 (Month) (Day) (Year)

7. AGE

2 yrs. 8 mos. 27 ds.

IF LESS than 1 day
 how many.....hrs. or
min?

8. OCCUPATION

(a) Trade, profession or particular kind of work.....

child

(b) General nature of industry business or establishment in which employed (or employer)

9. BIRTHPLACE

(State or Country)

Idaho

10. NAME OF FATHER

Harry E. Simpson

11. BIRTHPLACE OF FATHER

(State or Country)

Utah

12. MAIDEN NAME OF MOTHER

Offie Morris

13. BIRTHPLACE OF MOTHER

(State or Country)

Utah

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

Harry Simpson

(Address)

Clayton, Ida.

15.

Filed 10/61913

E. H. Hickey
 Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH

Oct 4 1913
 (Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from Oct 4 1913, to Oct 4 1913

that I last saw h.....alive on.....191.....

and that death occurred on the date stated above, at 11:00 A.M.

The CAUSE OF DEATH* was as follows:

Accidentally shot in head with revolver.

..... (Duration) yrs. mos. 20 min

Contributory
 (Secondary)

..... (Duration) yrs. mos. ds.

(Signed) J. W. Kelley M. D.

Oct 4 1913 (Address) Challis

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place In the
 of death..... yrs. mos. ds. State..... yrs. mos. ds.

Where was disease contracted,
 If not at place of death?

Former or
 usual residence.....

19. PLACE OF BURIAL OR REMOVAL DATE OF BURIAL

Clayton 10/6 1913

20. UNDERTAKER ADDRESS

Friends Clayton

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH.

Registration District No. 73

County of Custer

Primary Registration District No. 2150

City of

(No. St.)

File No. 6701

Registered No. 60

If death occurs away from usual residence, give facts called for under special information.

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME (not named) Peel

PERSONAL AND STATISTICAL PARTICULARS

3. SEX

M

4. COLOR OR RACE

Wh.

5. SINGLE, MARRIED, WIDOWED OR DIVORCED.

single (Write the word.)

6. DATE OF BIRTH

Sept. 26th 1913
(Month) (Day) (Year)

7. AGE

yrs. mos. ds.

IF LESS than 1 day
how many hrs. or
14 mins.

8. OCCUPATION

- (a) Trade, profession or particular kind of work
-
- (b) General nature of industry business, or establishment in which employed (or employer)

Rancher

9. BIRTHPLACE

(State or Country) Custer Co

10. NAME OF FATHER

Marion Peel

11. BIRTHPLACE OF FATHER

(State or Country) Iowa

12. MAIDEN NAME OF MOTHER

Lucy Stevens

13. BIRTHPLACE OF MOTHER

(State or Country) Ida.

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Marion Peel

(Address) Clayton, Ida.

15.

Filed Oct. 10th. 1913

C. L. Kirtley
Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH

Sept. 10th. 1913
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from

191. to 191.
that I last saw h. alive on 191.

and that death occurred on the date stated above, at M.

The CAUSE OF DEATH* was as follows:

Born at 7mo. Mother was infected
at time of birth. and no milk.

(Duration) yrs. mos. ds.

Contributory
(Secondary)

(Duration) yrs. mos. ds.

(Signed) C. L. Kirtley M. D.

19 (Address) Challis

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death yrs. mos. days. In the State yrs. mos. days.

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

Buried at ranch

10/10/13 191.

20. UNDERTAKER

ADDRESS

family

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Form V. S. No. 5. 10M. 6-20-11.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH

Registration District No. 20County of ConyonPrimary Registration District No. 1012City of Emmett(No. St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

Aurelia LakeFile No. 6702Registered No.

If death occurred in a hospital, institution or camp give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX

Female

4. COLOR OR RACE

white

5. SINGLE, MARRIED, WIDOWED OR DIVORCED.

married
(Write the word.)

6. DATE OF BIRTH

Nov 12 1871
(Month) (Day) (Year)

7. AGE

42 yrs. — 1 mos. 1 ds.

IF LESS than 1 day
how many hrs. or
 min.)

8. OCCUPATION

(a) Trade, profession, or particular kind of work
(b) General nature of industry business, or establishment in which employed (or employer)

Housewife

9. BIRTHPLACE

(State or Country)

Mexico

10. NAME OF FATHER

Juan Pieze

11. BIRTHPLACE OF FATHER

(State or Country)

Mexico

12. MAIDEN NAME OF MOTHER

Don't Know

13. BIRTHPLACE OF MOTHER

(State or Country)

"

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

D. E. Lake

(Address)

Emmett Idaho

15.

Filed 12-18 1913

J. J. Reynolds
Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

Nov 13 1913
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from

Oct 27 1913, to Nov 13 1913

that I last saw her alive on Nov 13 1913,

and that death occurred on the date stated above, at 11 9 M.

The CAUSE OF DEATH* was as follows:

Chronic Nephritis

(Duration) 2 yrs. mos. ds.

Contributory (Secondary)

(Duration) yrs. mos. ds.

(Signed)

J. J. Reynolds

M. D.

12-18 1913 (Address) Emmett Ida

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place

In the

of death yrs. mos. ds. State yrs. mos. ds.

Where was Disease contracted,

If not at place of death?

Former or

usual residence

19. PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

Emmett CemeteryNov 14 1913

20. UNDERTAKER

ADDRESS

Ed BucknumEmmett

MARGIN RESERVED FOR BINDING

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Form V. S. No. 5. 10M. 6-20-11.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH.
County of Canyon
City of Emmett

Registration District No. 2010
Primary Registration District No. 1010
(No. B, St.)

File No. 6703
Registered No. _____

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Bileen Kathryn Mains

If death occurred in a hospital, institution or camp give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX female 4. COLOR OR RACE white 5. SINGLE, MARRIED, WIDOWED OR DIVORCED.
Infant
(Write the word.)

6. DATE OF BIRTH Oct 1 1913
(Month) (Day) (Year)

7. AGE _____ yrs. _____ mos. _____ ds. IF LESS than 1 day how many _____ hrs. or _____ min.?

8. OCCUPATION
(a) Trade, profession, or particular kind of work Infant
(b) General nature of industry business, or establishment in which employed (or employer) _____

9. BIRTHPLACE
(State or Country) Emmett Idaho

10. NAME OF FATHER G. B. Mains

11. BIRTHPLACE OF FATHER
(State or Country) Wis.

12. MAIDEN NAME OF MOTHER Martha Keenan

13. BIRTHPLACE OF MOTHER
(State or Country) Ohio

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) G. B. Mains
(Address) Emmett Idaho

15. Filed 12-18 1913 J. H. Reynolds
Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH Nov 29 1913
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from Nov 20 1913, to Nov 29 1913 that I last saw him alive on Nov 28 1913, and that death occurred on the date stated above, at 11 A. M.

The CAUSE OF DEATH* was as follows:
meningitis

(Duration) _____ yrs. _____ mos. 7 ds.

Contributory (Secondary) _____

(Duration) _____ yrs. _____ mos. _____ ds.
(Signed) R. H. Cunningham M. D.
11/29 1913 (Address) Emmett

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL,

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place _____ In the _____
of death _____ yrs. _____ mos. _____ ds. State _____ yrs. _____ mos. _____ ds.
Where was Disease contracted, _____
If not at place of death? _____
Former or _____
usual residence. _____

19. PLACE OF BURIAL OR REMOVAL Emmett Cemetery DATE OF BURIAL Nov 30 1913

20. UNDERTAKER C. D. Bucknum ADDRESS Emmett

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Form V. S. No. 5. 10M. 6-20-11.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH. Registration District No. _____
County of Ada Primary Registration District No. _____
City of Star (No. _____, St.) _____

File No. 6704
Registered No. _____

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

Samuel Snider

If death occurred in a hospital, institution or camp give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX M 4. COLOR OR RACE W 5. SINGLE, MARRIED, WIDOWED OR DIVORCED. married
(Write the word.)

6. DATE OF BIRTH Oct 13 1913
(Month) (Day) (Year)

7. AGE 62 yrs. 8 mos. 7 ds. IF LESS than 1 day how many _____ hrs. or _____ min.?

8. OCCUPATION Blacksmith
(a) Trade, profession, or particular kind of work
(b) General nature of industry business, or establishment in which employed (or employer)

9. BIRTHPLACE Kentucky
(State or Country)

10. NAME OF FATHER Prescott Snider

11. BIRTHPLACE OF FATHER _____
(State or Country)

12. MAIDEN NAME OF MOTHER Leahusue Morn

13. BIRTHPLACE OF MOTHER _____
(State or Country)

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Mrs. Frances Snider
(Address) Star Idaho

15. Albert Snider
Filed _____ 191____ Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH May 7 1913
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from May 1 191____, to June 7 191____, that I last saw him alive on 6 June 191____, and that death occurred on the date stated above, at 79 M.

The CAUSE OF DEATH* was as follows:

Cardiac Insufficiency
(Duration) _____ yrs. _____ mos. _____ ds.

Contributory (Secondary) Pross Liver

(Signed) Albert Snider M. D.
19____ (Address) Star Idaho

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place _____ In the _____
of death _____ yrs. _____ mos. _____ ds. State _____ yrs. _____ mos. _____ ds.

Where was Disease contracted, _____
If not at place of death? _____
Former or usual residence _____

19. PLACE OF BURIAL OR REMOVAL Star Cemetery DATE OF BURIAL June 9 1913

20. UNDERTAKER Try & Summers ADDRESS Boise Id

A stillbirth must be registered both as a birth and death. The date of death should be the date of delivery and the death certificate should further state, if known, the cause of the stillbirth and the period of utero gestation in months.

STATEMENT OF OCCUPATION.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer, Physician, Stenographer, Composer, Architect, Locomotive engineer, Civil engineer, Stationary firemen*, etc. But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner*, (b) *Cotton mill*; (a) *Salesman*, (b) *Grocery*; (a) *Foreman*, (b) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification, as *Day laborer, Farm laborer, Laborer—Coal mine*, etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers*, who receive a definite salary), may be entered as *Housewife, Housework*, or *At home*, and children, not gainfully employed, as *At school* or *At home*. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer (retired, 6 yrs.)*. For persons who have no occupation whatever, write *None*.

STATEMENT OF CAUSE OF DEATH.—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebro-*

spinal fever (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid Pneumonia") *Lobar pneumonia; Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritoneum*, etc., *Carcinoma, Sarcoma*, etc., of (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent affection need not be stated unless important. Example: *Measles* (disease causing death), 29 ds.; *Bronchopneumonia* (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "Asthenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility, (Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Haemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uraemia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify as "PUERPERAL septicemia," "PUERPERAL peritonitis," etc., all diseases resulting from childbirth or miscarriage. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning; Struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "Contributory."

2

6

MARGIN RESERVED FOR BINDING
WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Form V. S. No. 5. 10M. 6-20-11.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

File No. **6705**

Registered No. _____
If death occurred in a hospital, institution or camp give its NAME instead of street and number.

1. PLACE OF DEATH. Registration District No. _____
County of **Ada** Primary Registration District No. _____
City of **Payson** (No. _____ St.)
If death occurs away from usual residence, give facts called for under special information. 2. FULL NAME **Phelps Everett Hansen**

PERSONAL AND STATISTICAL PARTICULARS

3. SEX **M** 4. COLOR OR RACE **W** 5. SINGLE, MARRIED, WIDOWED OR DIVORCED. **Single**
(Write the word.)

6. DATE OF BIRTH **Dec 19 1913**
(Month) (Day) (Year)

7. AGE _____ yrs. _____ mos. **6** ds. IF LESS than 1 day how many _____ hrs. or _____ min. **✓**

8. OCCUPATION **None**
(a) Trade, profession, or particular kind of work
(b) General nature of industry, business, or establishment in which employed (or employer)

9. BIRTHPLACE **Ada Co Ida**
(State or Country)

10. NAME OF FATHER **Arten J Hansen**

11. BIRTHPLACE OF FATHER **Minnesota**
(State or Country)

12. MAIDEN NAME OF MOTHER **Mabel Everts**

13. BIRTHPLACE OF MOTHER **Idaho**
(State or Country)

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) **Mabel Everts**
(Address) **Payson Ida**

15. **Old Hall**
Filed _____ 191 _____
Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH **Dec 25 1913**
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from **Dec 19 1913** to **Dec 25 1913**
that I last saw him alive on **Dec 25 1913**
and that death occurred on the date stated above, at **4 P.M.**

The CAUSE OF DEATH* was as follows:
Premature Labor
(Duration) _____ yrs. _____ mos. **6** ds.

Contributory (Secondary) **✓**
(Signed) **Old Hall, Ida** M. D.
(Address) **19**

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place _____ In the _____
of death _____ yrs. _____ mos. _____ ds. State _____ yrs. _____ mos. _____ ds.
Where was Disease contracted, _____
If not at place of death? _____
Former or usual residence _____

19. PLACE OF BURIAL OR REMOVAL **Star Idaho** DATE OF BURIAL **Dec 26 1913**
20. UNDERTAKER **None** ADDRESS _____

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Form V. S. No. 5. 10M. 6-20-1.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

File No. 6706

Registered No.

If death occurred in a hospital, institution or camp give its NAME instead of street and number.

1. PLACE OF DEATH Registration District No. _____
County of Idaho Primary Registration District No. _____
City of Star, Idaho No. _____, St.)
If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME See Verinner

PERSONAL AND STATISTICAL PARTICULARS

3. SEX Male COLOR OR RACE _____ 5. SINGLE, MARRIED, WIDOWED OR DIVORCED. _____
(Write the word.)

6. DATE OF BIRTH

Oct 29 1846
(Month) (Day) (Year)

7. AGE

67

yrs. 1 mos. 24 ds.

IF LESS than 1 day
how many hrs. or min.?

8. OCCUPATION

(a) Trade, profession, or particular kind of work
(b) General nature of industry, business, or establishment in which employed (or employer)

Turning

9. BIRTHPLACE

(State or Country)

Ohio

10. NAME OF FATHER

John Verinner

11. BIRTHPLACE OF FATHER

(State or Country)

Ohio
Lickin

12. MAIDEN NAME OF MOTHER

Emma Laws

13. BIRTHPLACE OF MOTHER

(State or Country)

Ohio
Emma Laws Lickin

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

(Address)

Part Verinner
Star, Idaho

15.

Filed

191

Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

December 1913
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from Nov 3 1913, to Dec 25 1913, that I last saw him alive on 21 Dec 1913, and that death occurred on the date stated above, at 7 A M.

The CAUSE OF DEATH* was as follows:

Parenchymatous Nephritis(Duration) 3 yrs. — mos. — ds.

Contributory (Secondary)

Myocarditis

(Signed)

Dec 19 1913 (Address) Star, Idaho

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place In the
of death, yrs. mos. ds. State. yrs. mos. ds.

Where was Disease contracted,

If not at place of death?

Former or

usual residence.

19. PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

Star Cemetery Dec 27 1913

20. UNDERTAKER

ADDRESS

Fry Verinner Star

Form V. S. No. 5 20M.1-16-12

CERTIFICATE OF DEATH

 State of Idaho
 BOARD OF HEALTH
 Bureau of Vital Statistics

1. PLACE OF DEATH.

Registration District No. 79County of BonnerPrimary Registration District No. 2156City of Copeland

(No. _____, _____ St.)

File No. 6707

Registered No. _____

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME _____

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX

Female

4. COLOR OR RACE

White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED.

Single
(Write the word.)

6. DATE OF BIRTH

Nov. 16th, 1913.
 (Month) (Day) (Year)

7. AGE

 _____ yrs. _____ mos. 3 ds.

 IF LESS than 1 day
 how many _____ hrs. or
 _____ mins.

8. OCCUPATION

(a) Trade, profession or particular kind of work _____

(b) General nature of industry business, or establishment in which employed (or employer) _____

9. BIRTHPLACE

(State or Country)

Copeland, Idaho.

10. NAME OF FATHER

Ralph Kerr

11. BIRTHPLACE OF FATHER

(State or Country)

Indiana

12. MAIDEN NAME OF MOTHER

Marie Thompson.

13. BIRTHPLACE OF MOTHER

(State or Country)

Michigan

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) _____

(Address) _____

Ralph Kerr
Copeland, Idaho.

15.

Filed

Dec. 26 - 1913
E. E. Fry
 Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH

Nov. 19th, 1913.
 (Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from

_____ 191____, to _____ 191____,

that I last saw h _____ alive on _____ 191____,

and that death occurred on the date stated above, at _____ M.

The CAUSE OF DEATH* was as follows:

Prematurity (7 months)

_____ (Duration) _____ yrs. _____ mos. _____ ds.

Contributory _____
(Secondary)

_____ (Duration) _____ yrs. _____ mos. _____ ds.

(Signed) _____ M. D.

_____ 19____ (Address) _____

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death _____ yrs. _____ mos. _____ days. In the State _____ yrs. _____ mos. _____ days.

Where was disease contracted if not at place of death? _____

Former or usual residence _____

19. PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

Copeland, Idaho, Nov. 19, 1913.

20. UNDERTAKER

ADDRESS

None

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Form V. S. No. 5 20M.1-16-12

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics
File No. **6709**

1. PLACE OF DEATH. Registration District No. **79**
County of **Bonner** Primary Registration District No. **2156**
City of **Bonners Ferry, Idaho** (St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME **Maria Kalden**

Registered No.

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX **Female** 4. COLOR OR RACE **White** 5. SINGLE, MARRIED, WIDOWED OR DIVORCED **married**
(Write the word.)

6. DATE OF BIRTH **December 19 1872**
(Month) (Day) (Year)

7. AGE **34** yrs. **10** mos. **10** ds.
IF LESS than 1 day how many hrs. or mins.?

8. OCCUPATION
(a) Trade, profession or particular kind of work **Housewife**
(b) General nature of industry business, or establishment in which employed (or employer)

9. BIRTHPLACE **Norway**
(State or Country)

10. NAME OF FATHER **Giver Distumet**

11. BIRTHPLACE OF FATHER **Norway**
(State or Country)

12. MAIDEN NAME OF MOTHER **Lorise Kristad**

13. BIRTHPLACE OF MOTHER **Norway**
(State or Country)

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) **Magnus Distumet**
(Address) **E 2715 - 36 - ave**

15. **10/8** 1913 **Spokane Wash**
Filed **EE** Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH **Oct 8** 1913
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from **Oct 5** 1913, to **Oct 8** 1913,
that I last saw her alive on **Oct 8** 1913,
and that death occurred on the date stated above, at **7 P.M.**

The CAUSE OF DEATH* was as follows:

Nephritis graviorum

(Duration) yrs. mos. **6** ds. (?)

Contributory (Secondary)

(Duration) yrs. mos. ds.
(Signed) **L. J. Stauffer** M. D.
19 (Address) **Bonners Ferry, Idaho**

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death yrs. mos. days. In the State yrs. mos. days.

Where was disease contracted if not at place of death?

Former or usual residence.

19. PLACE OF BURIAL OR REMOVAL DATE OF BURIAL **10/10 1913**

20. UNDERTAKER ADDRESS **John J. Maden Bonners Ferry, Idaho**

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Form V. S. No. 5 20M.1-16-12

CERTIFICATE OF DEATH

1. PLACE OF DEATH
County of Bonneville
City of _____
(No. _____, St.)

Registration District No. 73
Primary Registration District No. 211-0

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Mari Neuman

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics
File No. 6712
Registered No. 91

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX Female 4. COLOR OR RACE White 5. SINGLE, MARRIED, WIDOWED OR DIVORCED married
(Write the word.)

6. DATE OF BIRTH Apr 1 1879
(Month) (Day) (Year)

7. AGE 34 yrs. 3 mos. 6 ds.
IF LESS than 1 day how many _____ hrs. or _____ mins.?

8. OCCUPATION
(a) Trade, profession or particular kind of work at Home
(b) General nature of industry, business, or establishment in which employed (or employer) _____

9. BIRTHPLACE (State or Country) Sweden

10. NAME OF FATHER Carlson

11. BIRTHPLACE OF FATHER (State or Country) Sweden

12. MAIDEN NAME OF MOTHER ?

13. BIRTHPLACE OF MOTHER (State or Country) ?

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) A. N. Neuman
(Address) Iona, Ida

15. Filed Dec 9 1913 C. E. Neuman
Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH Dec 6 1913
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from _____ 191____, to _____ 191____, that I last saw h_____ alive on _____ 191____, and that death occurred on the date stated above, at 6 P. M.
The CAUSE OF DEATH* was as follows:

Pulmonary tuberculosis
7
(Duration) ? yrs. _____ mos. _____ ds.

Contributory (Secondary) _____

(Duration) _____ yrs. _____ mos. _____ ds.

(Signed) C. E. Neuman M. D.

12/9 1913 (Address) Edna Falls Ida

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death _____ yrs. _____ mos. _____ days. In the State _____ yrs. _____ mos. _____ days.

Where was disease contracted if not at place of death? _____

Former or usual residence _____

19. PLACE OF BURIAL OR REMOVAL Shelton DATE OF BURIAL 12/9 1913

20. UNDERTAKER C. E. Neuman ADDRESS Edna Falls Ida

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Form V. S. No. 5 20M.1-16-12

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH.

Registration District No. 73

County of Bonner

Primary Registration District No. 215-0

City of Snake Falls

(No. _____, St.)

File No. 6713

Registered No. 96

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME William Robertson Hummel

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX

Male

4. COLOR OR RACE

White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED.

Married
(Write the word.)

6. DATE OF BIRTH

April 19 1913
(Month) (Day) (Year)

7. AGE

6 yrs. 0 mos. 0 ds.

IF LESS than 1 day
how many _____ hrs. or
_____ mins.?

8. OCCUPATION

(a) Trade, profession or particular kind of work

Banker

(b) General nature of industry business, or establishment in which employed (or employer)

9. BIRTHPLACE

(State or Country)

Danville, Ky.

10. NAME OF FATHER

James Hummel

11. BIRTHPLACE OF FATHER

(State or Country)

Indiana

12. MAIDEN NAME OF MOTHER

Elizabeth Hahn

13. BIRTHPLACE OF MOTHER

(State or Country)

Germany

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) W. Hummel

(Address) Snake Falls, Id.

15.

Filed Dec 10 1913 W. Hummel
Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH

Dec. 7 1913
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from

Dec. 7 1913, to Dec. 7 1913,
that I last saw him alive on Dec. 7 1913,
and that death occurred on the date stated above, at 3 P.M.

The CAUSE OF DEATH* was as follows: Thrombosis

Thrombosis

(Duration) _____ yrs. _____ mos. _____ ds.

Contributory

(Secondary)

(Duration) _____ yrs. _____ mos. _____ ds.

(Signed) W. Hummel

M. D.

Dec 10 1913 (Address) Snake Falls, Id.

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place

of death _____ yrs. _____ mos. _____ days.

In the

State _____ yrs. _____ mos. _____ days.

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

Snake Falls, Id. Dec 10 1913

20. UNDERTAKER

ADDRESS

C. C. D. D. D. Snake Falls, Id.

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Form V. S. No. 5 20M.1-16-12

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics
6714

1. PLACE OF DEATH

Registration District No. 7

County of Bonneville

Primary Registration District No. 2156

City of Ucon

(No. , St.)

File No.

Registered No. 97

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Ada E. Cady

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX

Female

4. COLOR OR RACE

White

5. SINGLE, MARRIED, WID-
OWED OR DIVORCED.

Married
(Write the word.)

6. DATE OF BIRTH

Nov. 7 1886
(Month) (Day) (Year)

7. AGE

27 yrs. 13 ds.

IF LESS than 1 day
how many hrs. or
mins.

8. OCCUPATION

(a) Trade, profession or
particular kind of work

at home

(b) General nature of industry
business, or establishment in
which employed (or employer)

9. BIRTHPLACE

(State or Country)

Colorado

10. NAME OF
FATHER

R. J. Rogers

11. BIRTHPLACE
OF FATHER

(State or Country)

Mich.

12. MAIDEN NAME
OF MOTHER

Catherine Lowrey

13. BIRTHPLACE
OF MOTHER

(State or Country)

England

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

A. E. Cady

(Address)

Ucon

15.

Filed Dec 10 1913

Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

Dec 7 1913
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from
July 20 1913, to Dec 7 1913,
that I last saw her alive on Nov 30 1913

and that death occurred on the date stated above, at 1:30 P.M.

The CAUSE OF DEATH* was as follows:

Relief Antoinette

(Duration) yrs. 4 mos. 17 ds.

Contributory
(Secondary)

(Duration) yrs. 7 mos. ds.

(Signed) A. E. Cady M. D.

Dec 7 1913 (Address) Idaho Falls, Id.

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death. yrs. mos. days. In the State. yrs. mos. days.

Where was disease contracted if not at place of death?

Former or usual residence.

19. PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

Ucon 12/10/1913

20. UNDERTAKER

ADDRESS

E. E. Rinewoodey Idaho Falls

MARGIN RESERVED FOR BINDING
WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
N. B.—Every item of information should be carefully supplied. AGE should be stated in full years, months and days. If death occurs away from usual residence, give facts called for under special information. 2. FULL NAME
GIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. See instructions on back of certificate. ment of OCCUPATION is very important. See instructions on back of certificate.

S. No. 5 20M.1-16-12

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics
File No. 6715

PLACE OF DEATH.

Registration District No.

of Barnesville
Dona

Primary Registration District No.

(No.

St.)

Registered No.

h occurs away from usu-
dence, give facts called
nder special information. 2.

FULL NAME

Elijah Chas. Clapp

If death occurred in a hospital, in-
stitution or camp, give its NAME
instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX

Male

4. COLOR OR RACE

White

5. SINGLE, MARRIED, WID-
OWED OR DIVORCED.

Married
(Write the word.)

6. DATE OF BIRTH

Dec 11 1857
(Month) (Day) (Year)

7. AGE

56 yrs. 0 mos. 1 ds.

IF LESS than 1 day
how many hrs. or
..... mins.?

8. OCCUPATION

(a) Trade, profession or
particular kind of work
(b) General nature of industry
business, or establishment in
which employed (or employer)

Farming

9. BIRTHPLACE

(State or Country)

Utah

10. NAME OF
FATHER

Benj. Clapp

11. BIRTHPLACE
OF FATHER

(State or Country)

U.S.

12. MAIDEN NAME
OF MOTHER

Katherine Mortensen

13. BIRTHPLACE
OF MOTHER

(State or Country)

Denmark

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

Norothy Clapp

(Address)

Dona, Ida

15.

Filed

Jan 13 1913

1913

E. E. Clapp
Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH

Dec 12 1913
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from

about Nov 25 1913, to Dec 2 1913,

that I last saw him alive on Dec 2nd 1913,

and that death occurred on the date stated above, at 4:00 M.

The CAUSE OF DEATH* was as follows:

Was a sufferer from Diabetes
millaris and Rheumatism

(Duration) yrs. mos. ds.

Contributory
(Secondary)

(Duration) yrs. mos. ds.

(Signed)

G. W. Boudleton

M. D.

1913

(Address) Idaho Falls, Idaho

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1)
MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions,
Transients or Recent Residents.)

At place of death yrs. mos. days. In the State yrs. mos. days.

Where was disease contracted
if not at place of death?

Former or
usual residence

19. PLACE OF BURIAL OR REMOVAL

Dona

DATE OF BURIAL

12/14 1913

20. UNDERTAKER

B. E. Dinwoody

ADDRESS

Idaho Falls

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Form V. S. No. 5 20M.1-16-12

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH.

Registration District No. 73

County of Bonneville
City of Idaho Falls

Primary Registration District No. 214

(No. _____ St.)

File No. 6716

Registered No. 7

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Denny Tometen

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX Male 4. COLOR OR RACE White 5. SINGLE, MARRIED, WIDOWED OR DIVORCED. Married
(Write the word.)

6. DATE OF BIRTH

Dec. 20 1913
(Month) (Day) (Year)

7. AGE

54 yrs. 20 mos. 20 ds.

IF LESS than 1 day
how many hrs. or
..... mins.?

8. OCCUPATION

(a) Trade, profession or particular kind of work
(b) General nature of industry, business, or establishment in which employed (or employer)

Farmer

9. BIRTHPLACE

(State or Country)

Iowa

10. NAME OF FATHER

Denny Tometen

11. BIRTHPLACE OF FATHER

(State or Country)

Germany

12. MAIDEN NAME OF MOTHER

Louise Stinker

13. BIRTHPLACE OF MOTHER

(State or Country)

Germany

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

H. H. Tometen

(Address)

Idaho Falls

15.

Filed Dec 13 1913

Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH

Dec. 10 1913
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from Tue. Dec 8th 1913, to Dec 10th 1913,

that I last saw him alive on Dec 9- 1913,

and that death occurred on the date stated above, at 3 P.M.

The CAUSE OF DEATH* was as follows:

Following accident causing an injury to the spinal cord

(Duration) yrs. mos. ds.

Contributory

(Secondary)

(Duration) yrs. mos. ds.

(Signed)

W. H. Sulthard M. D.

11/18/1913 (Address) Idaho Falls Id.

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death.....yrs.....mos.....days. In the State.....yrs.....mos.....days.

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL DATE OF BURIAL

Idaho Falls 12-15 1913

20. UNDERTAKER

ADDRESS

G. H. Hunt Idaho Falls

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
N. B.—Every item of information should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Form V. S. No. 5 20M.1-16-12

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH.

Registration District No. 73

County of Bonneville
City of Idaho Falls

Primary Registration District No. 2157

(No. _____, _____ St.)

File No. 6717

Registered No. 101

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Itaro Konishi

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX

Male

4. COLOR OR RACE

Yellow

5. SINGLE, MARRIED, WIDOWED OR DIVORCED.

Single
(Write the word.)

6. DATE OF BIRTH

Mar. 10 1878
(Month) (Day) (Year)

7. AGE

43 yrs. 9 mos. 6 ds.

IF LESS than 1 day
how many _____ hrs. or
_____ min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work
(b) General nature of industry, business, or establishment in which employed (or employer)

Farmer

9. BIRTHPLACE

(State or Country)

Japan

10. NAME OF FATHER

S. Konishi

11. BIRTHPLACE OF FATHER

(State or Country)

Japan

12. MAIDEN NAME OF MOTHER

Unknown

13. BIRTHPLACE OF MOTHER

(State or Country)

Japan

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

L. O. Okamoto

(Address)

Idaho Falls, Ida

15.

Filed

Dec 17

1913

C. J. Conners

Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH

Dec. 16 1913
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from

_____ 191____, to _____ 191____,

that I last saw h_____ alive on _____ 191____,

and that death occurred on the date stated above, at 6 P. M.

The CAUSE OF DEATH* was as follows:

Died from accident
received in Reraway
Tractor of Skull

(Duration) _____ yrs. _____ mos. _____ ds.

Contributory

(Secondary)

(Duration) _____ yrs. _____ mos. _____ ds.

(Signed)

1217 1913 (Address) Idaho Falls, Idaho

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death _____ yrs. _____ mos. _____ days. In the State _____ yrs. _____ mos. _____ days.

Where was disease contracted if not at place of death? _____

Former or usual residence _____

19. PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

Idaho Falls

12-18 1913

20. UNDERTAKER

ADDRESS

C. J. Conners

Idaho Falls

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Form V. S. No. 5 20M.1-16-12

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics
File No. **6718**

1. PLACE OF DEATH.

Registration District No. 73County of CamevillePrimary Registration District No. 2117City of Idaho Falls(No. St.)Registered No. 112

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Egertal Lee

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX

4. COLOR OR RACE

5. SINGLE, MARRIED, WID-
OWED OR DIVORCED
married
(Write the word.)

6. DATE OF BIRTH

7. AGE

IF LESS than 1 day
how many hrs. or
..... mins.?

8. OCCUPATION

(a) Trade, profession or
particular kind of work(b) General nature of industry
business, or establishment in
which employed (or employer)

9. BIRTHPLACE

(State or Country)

10. NAME OF
FATHER11. BIRTHPLACE
OF FATHER

(State or Country)

12. MAIDEN NAME
OF MOTHER13. BIRTHPLACE
OF MOTHER

(State or Country)

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

(Address)

Filed

1913

Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH

17. I HEREBY CERTIFY, That I attended deceased from

Aug 17 1913, to Dec 25 1913that I last saw him alive on Dec 25 1913and that death occurred on the date stated above, at 9:25 P.M.

The CAUSE OF DEATH* was as follows:

Tuberculosis Kidney(Duration) 6 yrs. 6 mos. ds.Contributory Tuberculosis Spine
(Secondary)(Duration) 3 yrs. mos. ds.(Signed) William M. D.Dec 29 1913 (Address) Idaho Falls, Id.

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death.....yrs.....mos.....days. In the State.....yrs.....mos.....days.

Where was disease contracted if not at place of death?.....

Former or usual residence.....

19. PLACE OF BURIAL OR REMOVAL DATE OF BURIAL

Idaho Falls 12/28 1913

20. UNDERTAKER ADDRESS

C. C. Woodward Idaho Falls

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Form V. S. No. 5 20M.1-16-12

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH.

Registration District No. 73

County of Bonner
City of Idaho Falls

Primary Registration District No. 215-6

(No. 5, St.)

File No. 6721

Registered No. 101

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

Fredrick Clark

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX

Male

4. COLOR OR RACE

White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED.

married
(Write the word.)

6. DATE OF BIRTH

Nov. 16 1868
(Month) (Day) (Year)

7. AGE

45 yrs. 1 mos. 4 ds.

IF LESS than 1 day
how many hrs. or
..... mins.?

8. OCCUPATION

(a) Trade, profession or particular kind of work

(b) General nature of industry, business, or establishment in which employed (or employer)

Teamster

9. BIRTHPLACE

(State or Country)

Iowa

10. NAME OF FATHER

Warren Clark

11. BIRTHPLACE OF FATHER

(State or Country)

Iowa

12. MAIDEN NAME OF MOTHER

Unknown

13. BIRTHPLACE OF MOTHER

(State or Country)

Iowa

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

John Clark

(Address)

Idaho Falls

15.

Filed Jan 31 1913

Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH

Dec. 20 1913
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from

191, to 191,

that I last saw h. alive on 191,

and that death occurred on the date stated above, at M.

The CAUSE OF DEATH* was as follows:

Suicidal
Styphnure Poison

(Duration) yrs. mos. ds.

Contributory
(Secondary)

(Duration) yrs. mos. ds.

(Signed)

Dr. Morley
Idaho Falls, Idaho

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death yrs. mos. 1 day In the State 16 yrs. mos. days.

Where was disease contracted if not at place of death?

Former or usual residence

Idaho Falls, Idaho

19. PLACE OF BURIAL OR REMOVAL

Idaho Falls

DATE OF BURIAL

Dec. 31 1913

20. UNDERTAKER

G. H. Hunt

ADDRESS

Idaho Falls

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Form V. S. No. 5 20M.1-16-12

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH.

Registration District No. 73County of ConnevillePrimary Registration District No. 315City of Idaho Falls(No.)

St.)

File No. 6722Registered No. 106

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Alonzo B. Van Sickle

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX

4. COLOR OR RACE

5. SINGLE, MARRIED, WIDOWED OR DIVORCED.

MaleWhiteSingle
(Write the word.)

6. DATE OF BIRTH

Oct
(Month)1
(Day)1872
(Year)

7. AGE

43 yrs. 7 mos. ds.

IF LESS than 1 day
how many hrs. or
..... mins.?

8. OCCUPATION

(a) Trade, profession or particular kind of work

(b) General nature of industry, business, or establishment in which employed (or employer)

Merchant

9. BIRTHPLACE

(State or Country)

Ill.

10. NAME OF FATHER

Abraham B. Van Sickle

11. BIRTHPLACE OF FATHER

(State or Country)

Ill.

12. MAIDEN NAME OF MOTHER

13. BIRTHPLACE OF MOTHER

(State or Country)

U. S.

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

E. S. Van Sickle, Jr.

(Address)

Idaho Falls

15.

Filed Jan 1

1913

Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

(Month) (Day) (Year)
Dec. 30 1913 31

17. I HEREBY CERTIFY, That I attended deceased from Dec. 30 1913, to Dec. 31 1913,
that I last saw him alive on Dec. 31 1913,
and that death occurred on the date stated above, at 6 P.M.

The CAUSE OF DEATH* was as follows:

Pneumonia

(Duration) yrs. mos. ds.

Contributory

(Secondary)

(Duration) yrs. mos. ds.

(Signed) A. Soderquist Chas. Rogers M. D.

Dec 31 1913 (Address) Idaho Falls

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death yrs. mos. days. In the State yrs. mos. days.

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

Bedford, Iowa1/1/14 1913

20. UNDERTAKER

ADDRESS

C. J. DimondIdaho Falls

-SUPPLEMENTARY DEATH CERTIFICATE-

(Please reply on this sheet to
the registrar of Vital Statistics)

Death Certificate No. 6722

Name Alonzo B. Van Sickle

Date of Death Dec. 31, 1913

Cause of Death Bronchial Pneumonia

Contributory Cause of death

(Sign here) A. P. Soderquist M.D.

City of Idaho Falls.

A. R. SODERQUIST, M. D.
CITY PHYSICIAN.

IDAHO FALLS, IDAHO, Feb. 16th. 1914.

Dr. Ralph Falk,

Boise, Ida.

Dear Doctor; I only saw Mr. Van Sicle a few hours before he died so it was hard for me to specify what kind of Pneumonia but inclined to think bronchial.

Respectfully,

A. R. Soderquist M.D.

FEB 20 1914

SECRETARY'S
STATE BOARD OF HEALTH

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Form V. S. No. 5 20M.1-16-12

CERTIFICATE OF DEATH

1. PLACE OF DEATH.

County of Bonner

City of Lewistown

Registration District No. 73

Primary Registration District No. 12000

(No. 1)

St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Thomas Thornhill

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics
File No. 6723

Registered No. 107

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX

Male

4. COLOR OR RACE

White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED.

Single
(Write the word.)

6. DATE OF BIRTH

X X 1 X
(Month) (Day) (Year)

7. AGE

56 yrs. 0 mos. 0 ds.

IF LESS than 1 day
how many hrs. or mins.?

8. OCCUPATION

(a) Trade, profession or particular kind of work
(b) General nature of industry, business, or establishment in which employed (or employer)

Farming

9. BIRTHPLACE

(State or Country)

West Va

10. NAME OF FATHER

Jos. Thornhill

11. BIRTHPLACE OF FATHER

(State or Country)

West Va

12. MAIDEN NAME OF MOTHER

Eliz. Keymer

13. BIRTHPLACE OF MOTHER

(State or Country)

West Va

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Emma Thornhill

(Address) Idaho Falls

15.

Filed Jan 2 1913

Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

Dec 31 1913
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from

Dec 24 1913, to Dec 31 1913

that I last saw him alive on Dec 31 1913

and that death occurred on the date stated above, at M.

The CAUSE OF DEATH* was as follows:

Obstruction Bowels

(Duration) yrs. mos. ds.

Contributory
(Secondary)

(Duration) yrs. mos. ds.

(Signed) C. J. [Signature] M. D.

1/2 1913 (Address) Idaho Falls

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death. yrs. mos. days. In the State. yrs. mos. days.

Where was disease contracted if not at place of death?

Former or usual residence.

19. PLACE OF BURIAL OR REMOVAL DATE OF BURIAL

Lewisville Id 1/2 1914

20. UNDERTAKER

ADDRESS

B. B. [Signature] Idaho Falls

Form V. S. No. 5 20M.1-16-12

CERTIFICATE OF DEATH

1. PLACE OF DEATH.

Registration District No.

County of Bingham

Primary Registration District No.

City of

(No., St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Alean NelsonState of Idaho
BOARD OF HEALTH
Bureau of Vital StatisticsFile No. 6724

Registered No.

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX

Female

4. COLOR OR RACE

White5. SINGLE, MARRIED, WID-
OWED OR DIVORCED.Child
(Write the word.)

6. DATE OF BIRTH

Dec 16 1903
(Month) (Day) (Year)

7. AGE

9 yrs. 11 mos. 12 ds.IF LESS than 1 day
how many hrs. or
..... mins.?

8. OCCUPATION

(a) Trade, profession or
particular kind of work(b) General nature of industry
business, or establishment in
which employed (or employer)Child

9. BIRTHPLACE

(State or Country)

Idaho10. NAME OF
FATHERGust. Nelson11. BIRTHPLACE
OF FATHER

(State or Country)

Ill.12. MAIDEN NAME
OF MOTHERDelia Clark13. BIRTHPLACE
OF MOTHER

(State or Country)

Utah

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Gus J Nelson

(Address)

15.

Filed Jan 13 1913

Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH

Dec 11 1913
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from

Dec 8th 1913, to Dec 11th 1913,that I last saw her alive on Dec 11th 1913,and that death occurred on the date stated above, at 10 PM.

The CAUSE OF DEATH* was as follows:

Crematoria(Duration) yrs. mos. 2 ds.Contributory
(Secondary)

(Duration) yrs. mos. ds.

(Signed) F. J. Roberts M. D.12 16 1913 (Address) Shelley Idaho

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death yrs. mos. days. In the State yrs. mos. days.

Where was disease contracted
if not at place of death?Former or
usual residence

19. PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

Payson Bunk 12/17 1913

20. UNDERTAKER

ADDRESS

C. E. Dinwoody Idaho Falls

-SUPPLEMENTARY DEATH CERTIFICATE-

(Please reply on this sheet to
the registrar of Vital Statistics)

Death Certificate No. 6724

Name Alean Nelson

Date of Death Dec. 11, 1913

Cause of Death Broncho-pneumonia

Contributory Cause of death It is quite possible that I did not make this report complete so for the purpose of doing so will say this little girl was hit on the knee at school with a ball; she walked on it and the joint became badly inflamed; about the 3rd day I was called and ordered hot ~~stoves~~ ^(cups) applied which was carelessly done, getting the bed wet; being in a cold room she developed the pneumonia from which she died. M.D.

Sign here

F. E. Roberts

M.D.

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Form V. S. No. 5. 12½ M. 7-24-11

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH. Registration District No. 39
County of Latah Primary Registration District No. 2087
City of Buhl (No. _____ St.)

File No. 6725
Registered No. _____

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Betsy Jane Parker

If death occurred in a hospital, institution or camp give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX Female 4. COLOR OR RACE _____ 5. SINGLE, MARRIED, WIDOWED OR DIVORCED. Single
(Write the word.)

6. DATE OF BIRTH Jan 9 1892
(Month) (Day) (Year)

7. AGE 21 yrs. 10 mos. 20 ds. IF LESS than 1 day how many _____ hrs. or _____ min?

8. OCCUPATION
(a) Trade, profession or particular kind of work. Asst Post Mistress
(b) General nature of industry business or establishment in which employed (or employer) Buhl Ida

9. BIRTHPLACE (State or Country) Umatilla Oregon

10. NAME OF FATHER W R Parker

11. BIRTHPLACE OF FATHER (State or Country) Albion N. Y.

12. MAIDEN NAME OF MOTHER Alma D Markham

13. BIRTHPLACE OF MOTHER (State or Country) Umatilla Oregon

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) W R Parker
(Address) Buhl Ida

15. Filed 12-2 1913 J. Humphrey
Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH Nov 30 1913
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from Nov 22 1913, to Nov 30 1913, that I last saw her alive on Nov 30 1913 and that death occurred on the date stated above, at 2:30 AM.

The CAUSE OF DEATH* was as follows:
apendicitis

(Duration) _____ yrs. _____ mos. 1 ds.
Contributory (Secondary) None

(Signed) J. Humphrey M. D.
12-30 1913 (Address) Buhl Ida

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place _____ In the _____
of death _____ yrs. _____ mos. _____ ds. State _____ yrs. _____ mos. _____ ds.
Where was disease contracted, _____
If not at place of death? _____
Former or _____
usual residence _____

19. PLACE OF BURIAL OR REMOVAL Buhl DATE OF BURIAL 12-2 1913

20. UNDERTAKER H. B. Evans ADDRESS Buhl

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Form V. S. No. 5 20M.1-16-12

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics
File No. **6726**
Registered No. _____

1. PLACE OF DEATH _____ Registration District No. **39**
County of **Twin Falls** Primary Registration District No. **2087**
City of **Buhl** (No. _____ St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME **James Otto Todd**

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX **Male** 4. COLOR OR RACE **W** 5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.)

6. DATE OF BIRTH **Dec 18 1893**
(Month) (Day) (Year)

7. AGE **10** yrs. **4** mos. **4** ds. IF LESS than 1 day how many hrs. or mins.?

8. OCCUPATION
(a) Trade, profession or particular kind of work _____
(b) General nature of industry, business, or establishment in which employed (or employer) _____

9. BIRTHPLACE **Idaho**
(State or Country)

10. NAME OF FATHER **Alv. Todd**

11. BIRTHPLACE OF FATHER **Idaho**
(State or Country)

12. MAIDEN NAME OF MOTHER **R. May Cox**

13. BIRTHPLACE OF MOTHER **Idaho**
(State or Country)

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) **Alv. Todd**
(Address) **Buhl Ida**

15. Filed **12-23 1913** **J. T. Mungley**
Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH **Dec 22 1913**
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from **12-20 1913** to **12-22 1913**, that I last saw him alive on **12-20 1913**, and that death occurred on the date stated above, at **9 P.M.**

The CAUSE OF DEATH* was as follows:

Lock Bowel

(Duration) yrs. mos. **3** ds.
Contributory (Secondary)

(Duration) yrs. mos. ds.
(Signed) **J. T. Mungley M. D.**
12-22-1913 (Address) **Buhl Ida**

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death yrs. mos. days. In the State yrs. mos. days.

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL **Buhl** DATE OF BURIAL **12/23 1913**

20. UNDERTAKER **W. O. Evans** ADDRESS **Buhl**

MARGIN RESERVED FOR BINDING
WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Form V, S. No. 5. 12½ M. 7-24-11

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics
File No. 6727
Registered No. _____

1. PLACE OF DEATH. Registration District No. 39
County of Blaine Primary Registration District No. 2687
City of Buhl (No. _____, _____ St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Roy C Hawk

If death occurred in a hospital, institution or camp give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX male 4. COLOR OR RACE white 5. SINGLE, MARRIED, WIDOWED OR DIVORCED. single
(Write the word.)

6. DATE OF BIRTH Feb 27 1907
(Month) (Day) (Year)

7. AGE 6 yrs. 10 mos. 3 ds. IF LESS than 1 day how many _____ hrs. or _____ min?

8. OCCUPATION
(a) Trade, profession or particular kind of work none
(b) General nature of industry business or establishment in which employed (or employer)

9. BIRTHPLACE
(State or Country) Kan.

10. NAME OF FATHER Balus Hawk

11. BIRTHPLACE OF FATHER
(State or Country) Kan.

12. MAIDEN NAME OF MOTHER Maud V. Cook

13. BIRTHPLACE OF MOTHER
(State or Country) Ill.

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Balus Hawk
(Address) Buhl Ida.

15. Filed 12-31 1913 J. Murphy
Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH Dec 30 1913
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from Dec 30 1913, to Dec 30 1913 that I last saw him alive on Dec 30 1913 and that death occurred on the date stated above, at 4 P. M.

The CAUSE OF DEATH* was as follows:

Pneumonia

_____ (Duration) _____ yrs. _____ mos. 3 ds.
Contributory measles,
(Secondary)

_____ (Duration) _____ yrs. _____ mos. 10 ds.
(Signed) Chas. W. Wetburn M. D.
Dec 31 1913 (Address) Buhl Ida.

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place _____ In the _____
of death _____ yrs. _____ mos. _____ ds. State _____ yrs. _____ mos. _____ ds.
Where was disease contracted,
If not at place of death?
Former or
usual residence _____

19. PLACE OF BURIAL OR REMOVAL Buhl Ida DATE OF BURIAL 1-1 1914

20. UNDERTAKER H. B. Evans ADDRESS Buhl

Form V. S. No. 5 20M.1-16-12

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

File No. 6728

Registered No. 22

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

1. PLACE OF DEATH.

Registration District No. 8

County of Ada

Primary Registration District No. 2004

City of Boise

(No. Soldiers Home St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

Hirshmanus Dewitt

PERSONAL AND STATISTICAL PARTICULARS

3. SEX

Male

4. COLOR OR RACE

white
American

5. SINGLE, MARRIED, WIDOWED OR DIVORCED.

married
(Write the word.)

6. DATE OF BIRTH

not obtainable

(Month)

(Day)

(Year)

7. AGE

81 yrs. — mos. — ds.

IF LESS than 1 day
how many hrs. or
mins.?

8. OCCUPATION

(a) Trade, profession or particular kind of work

Civil War Vet.

(b) General nature of industry, business, or establishment in which employed (or employer)

9. BIRTHPLACE

(State or Country)

not obtainable

10. NAME OF FATHER

11. BIRTHPLACE OF FATHER

(State or Country)

12. MAIDEN NAME OF MOTHER

13. BIRTHPLACE OF MOTHER

(State or Country)

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

H. G. Burnett

(Address)

Soldiers Home

15.

Filed

Nov 25

1913

M. S. Parker

Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH

11 24 1913
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from

11/20 1913, to 11/24 1913

that I last saw him alive on 11/23 1913

and that death occurred on the date stated above, at 11 A.M.

The CAUSE OF DEATH* was as follows:

Pneumonia - Lobar

(Duration) yrs. mos. ds.

Contributory
(Secondary)

(Duration) yrs. mos. ds.

(Signed)

J. A. Bennett M. D.

11/23 1913 (Address) Soldiers Home

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death yrs. mos. days. In the State yrs. mos. days.

Where was disease contracted if not at place of death?

Former or usual residence.

19. PLACE OF BURIAL OR REMOVAL DATE OF BURIAL

Morris Hill Cem 11/28 1913

20. UNDERTAKER

ADDRESS

Fry & Summer B Boise

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Form V. S. No. 5 20M.1-16-12

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics
File No. 6729

1. PLACE OF DEATH. Registration District No. 70
County of Shoshone Primary Registration District No. 1011
City of Wallace (No. , St.)

Registered No. 89
If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

Floyd G. Holbrook

PERSONAL AND STATISTICAL PARTICULARS

3. SEX male 4. COLOR OR RACE white 5. SINGLE, MARRIED, WIDOWED OR DIVORCED. single
(Write the word.)

6. DATE OF BIRTH

March 9th 1876
(Month) (Day) (Year)

7. AGE

37 yrs. mos. ds.

IF LESS than 1 day
how many hrs. or
mins.?

8. OCCUPATION

(a) Trade, profession or particular kind of work miner
(b) General nature of industry business, or establishment in which employed (or employer)

9. BIRTHPLACE

(State or Country)

Nevada

10. NAME OF FATHER

G. S. Holbrook

11. BIRTHPLACE OF FATHER

(State or Country)

Illinois

12. MAIDEN NAME OF MOTHER

Jane Bromhead

13. BIRTHPLACE OF MOTHER

(State or Country)

Nebr.

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

E. L. Davis

(Address)

Mullan Ida

15.

Filed

Nov. 9, 1913

1913

H. Leo Dwyer
Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

November 7th 1913
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from

Nov 7, 1913, to Nov 7, 1913

that I last saw him alive on Nov 7, 1913

and that death occurred on the date stated above, at 12:30 PM

The CAUSE OF DEATH* was as follows:

Pneumonia

(Duration) yrs. mos. ds. 7

Contributory
(Secondary)

(Duration) yrs. mos. ds.

(Signed)

J. M. McLean M.D.

11/9/13

(Address) Mullan Ida

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL OR HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death yrs. mos. days. In the State yrs. mos. days.

Where was disease contracted if not at place of death?

Former or usual residence.

19. PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

Butte Mont

Nov. 10, 1913

20. UNDERTAKER

ADDRESS

Wards Undertaking Co. Wallace Idaho

-SUPPLEMENTARY DEATH CERTIFICATE-

(Please reply on this sheet to
the registrar of Vital Statistics)

Death Certificate No. 6729

Name Floyd H. Holbrook

Date of Death Nov. 7. 1913.

Cause of Death Lobar Pneumonia

Contributory Cause of death _____

(Sign here) James R. Bean M.D.

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Form V. S. No. 5 20M.1-16-12

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH

Registration District No.

County of *Jerome*

Primary Registration District No.

City of *St. Anthony*

(No., St.)

File No. **6730**

Registered No.

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME *Hyrum Marion Vance Garlick*

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX

Male

4. COLOR OR RACE

White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED.

Single
(Write the word.)

6. DATE OF BIRTH

Sept 27th

1913

(Month)

(Day)

(Year)

7. AGE

1 yrs. *22* mos. *22* ds.

IF LESS than 1 day
how many hrs. or
..... mins.

8. OCCUPATION

(a) Trade, profession or particular kind of work

(b) General nature of industry business, or establishment in which employed (or employer)

9. BIRTHPLACE

(State or Country)

St Anthony Idaho

10. NAME OF FATHER

David Garlick

11. BIRTHPLACE OF FATHER

(State or Country)

Scotts Utah

12. MAIDEN NAME OF MOTHER

Mary Campbell

13. BIRTHPLACE OF MOTHER

(State or Country)

Utah

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

David Garlick

(Address)

St Anthony Idaho

15.

Filed *Dec 5* 191*3* *W. J. Carson*

Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

Nov

18th

191*3*

(Month)

(Day)

(Year)

17. I HEREBY CERTIFY, That I attended deceased from

Nov 17th

191*3*

Nov 18th 191*3*

that I last saw him alive on *Nov 15th* 191*3*

and that death occurred on the date stated above, at *11³⁰* A.M.

The CAUSE OF DEATH* was as follows:

Gastro-enteritis

(Duration) yrs. mos. *4* ds.

Contributory
(Secondary)

(Duration) yrs. mos. ds.

(Signed)

Nov 19th 1913

(Address)

St Anthony

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death yrs. mos. days. In the State yrs. mos. days.

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

St Anthony Idaho

Nov 19th 191*3*

20. UNDERTAKER

ADDRESS

Wm Jager

St Anthony

Form V. S. No. 5 20M.1-16-12

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH.

Registration District No. 122County of ShoshonePrimary Registration District No. 2200City of Burke

(No. _____, _____ St.)

File No. 6731

Registered No. _____

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME _____

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX

Male

4. COLOR OR RACE

White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED.

(Write the word.)

6. DATE OF BIRTH

October241913

(Month)

(Day)

(Year)

7. AGE

_____ yrs. _____ mos. 1 ds.IF LESS than 1 day
how many _____ hrs. or
_____ mins.?

8. OCCUPATION

- (a) Trade, profession or particular kind of work
-
- (b) General nature of industry, business, or establishment in which employed (or employer)

9. BIRTHPLACE

(State or Country)

Idaho

10. NAME OF FATHER

Fred A. Bennett

11. BIRTHPLACE OF FATHER

(State or Country)

Nebraska

12. MAIDEN NAME OF MOTHER

Burdene F. Myers

13. BIRTHPLACE OF MOTHER

(State or Country)

Illinois

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

Fred A. Bennett

(Address)

Burke, Ida.

15.

Filed 111913B. H. Mowbray

Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH

October241913

(Month)

(Day)

(Year)

17. I HEREBY CERTIFY, That I attended deceased from

10-231913

to

10-24

—

1913

,

that I last saw him alive on 10-24 — 1913,and that death occurred on the date stated above, at 2 P.M.

The CAUSE OF DEATH* was as follows:

Superior Health, Inc.,
Pulmonary Congestion(Duration) _____ yrs. _____ mos. 1 ds.Contributory
(Secondary)Pneumonia

(Duration) _____ yrs. _____ mos. _____ ds.

(Signed)

A. S. Scher M. D.10-28-1913 (Address) Burke, Ida.

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death _____ yrs. _____ mos. _____ days. In the State _____ yrs. _____ mos. _____ days.

Where was disease contracted if not at place of death?

Former or usual residence _____

19. PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

Burke, Ida.10-28-1913

20. UNDERTAKER

ADDRESS

Worsted Co.Wallace,

MARGIN RESERVED FOR BINDING
WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Form V. S. No. 5 20M.1-16-12

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics
File No. 6732

1. PLACE OF DEATH.

Registration District No. 10

County of Idaho

Primary Registration District No. 2044

City of _____

(No. _____, St.)

Registered No. 186

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Infant (not named)

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX

Female

4. COLOR OR RACE

White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED.

(Write the word.)

6. DATE OF BIRTH

Nov 12 1913
(Month) (Day) (Year)

7. AGE

_____ yrs. _____ mos. 7 ds.

IF LESS than 1 day
how many _____ hrs. or
_____ mins.?

8. OCCUPATION

(a) Trade, profession or particular kind of work

(b) General nature of industry business, or establishment in which employed (or employer)

9. BIRTHPLACE

(State or Country)

Grangeville Idaho

10. NAME OF FATHER

Hugh Williams

11. BIRTHPLACE OF FATHER

(State or Country)

Arkansas

12. MAIDEN NAME OF MOTHER

Bessie Foster

13. BIRTHPLACE OF MOTHER

(State or Country)

Arkansas

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

G. S. Stretton

(Address)

Grangeville Idaho

15.

Filed Nov. 18 1913

Josef Rains
Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH

Nov 18 1913
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from Nov 12 1913 to Nov 18 1913

that I last saw him alive on Nov 16 1913

and that death occurred on the date stated above, at 4.9 M.

The CAUSE OF DEATH* was as follows:

Inanition
7 months child.

(Duration) _____ yrs. _____ mos. _____ ds.

Contributory
(Secondary)

(Duration) _____ yrs. _____ mos. _____ ds.

(Signed)

G. S. Stretton M. D.

Nov 18 1913 (Address) Grangeville Idaho

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death _____ yrs. _____ mos. _____ days. In the State _____ yrs. _____ mos. _____ days.

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

Fairview Cemetery

Nov. 19 1913

20. UNDERTAKER

ADDRESS

W. E. Graham Grangeville

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Form V. S. No. 5. 10M. 6-20-11.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics
File No. 6733

Registered No. 178

If death occurred in a hospital, institution or camp give its NAME instead of street and number.

1. PLACE OF DEATH.

Registration District No. 10

County of Idaho

Primary Registration District No. 1001

City of Grangeville

(No. , St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

Jesse L. Jones

PERSONAL AND STATISTICAL PARTICULARS

3. SEX

male

4. COLOR OR RACE

white

5. SINGLE, MARRIED, WIDOWED OR DIVORCED.

single
(Write the word.)

6. DATE OF BIRTH

August — Eight — 1889
Eighth (Month) (Day) (Year)

7. AGE

24 yrs. 2 mos. 26 ds.

IF LESS than 1 day
how many hrs. or min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work
(b) General nature of industry business or establishment in which employed (or employer)

Labourer

9. BIRTHPLACE

(State or Country)

Maine

10. NAME OF FATHER

Louney Jones

11. BIRTHPLACE OF FATHER

(State or Country)

unknown

12. MAIDEN NAME OF MOTHER

Mrs. Hulchinson

13. BIRTHPLACE OF MOTHER

(State or Country)

unknown

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

(Address)

B. B. Hamlin
Cottonwood

15.

Filed Nov. 6 1913

Jesse L. Rain
Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

Nov 4 1913
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from

Oct 28 1913, to Nov 4 1913

that I last saw him alive on Nov 3 1913

and that death occurred on the date stated above, at 3 a.m.

The CAUSE OF DEATH* was as follows:

acute encephalitis

(Duration) yrs. mos. 21 ds.

Contributory (Secondary)

Don't know

(Duration) yrs. mos. ds.

(Signed) M. D.

Nov 5 1913 (Address) Grangeville, Idaho

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death yrs. mos. ds. State yrs. mos. ds.

Where was disease contracted,

If not at place of death?

Former or

usual residence.

19. PLACE OF BURIAL OR REMOVAL

Califorming mousoria

DATE OF BURIAL

1913

20. UNDERTAKER

E. S. Hancock

ADDRESS

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Form V. S. No. 5 20M.1-16-12

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics
File No. 18734
Registered No. _____
If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

1. PLACE OF DEATH _____
County of Idaho Registration District No. 10
City of Grangeville Primary Registration District No. 1001
(No. _____, St.)
If death occurs away from usual residence, give facts called for under special information. 2. FULL NAME Not named

PERSONAL AND STATISTICAL PARTICULARS

3. SEX Male 4. COLOR OR RACE White 5. SINGLE, MARRIED, WIDOWED OR DIVORCED. _____
(Write the word.)
6. DATE OF BIRTH October 29 1913
(Month) (Day) (Year)
7. AGE 7 yrs. 7 mos. 7 ds.
IF LESS than 1 day
how many _____ hrs. or
_____ mts.

8. OCCUPATION
(a) Trade, profession or particular kind of work _____
(b) General nature of industry business, or establishment in which employed (or employer) _____

9. BIRTHPLACE
(State or Country) Idaho (Grangeville)

10. NAME OF FATHER Platt P. Ring

11. BIRTHPLACE OF FATHER
(State or Country) Washington

12. MAIDEN NAME OF MOTHER Laddie D. Olson

13. BIRTHPLACE OF MOTHER
(State or Country) Oregon

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Platt P. Ring
(Address) Grangeville Idaho

15. Filed Nov 6 1913 Jose L. Rains
Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH Nov 5 1913
(Month) (Day) (Year)
17. I HEREBY CERTIFY, That I attended deceased from Oct 29 1913 to Nov 5 1913
that I last saw him alive on Nov 5 1913
and that death occurred on the date stated above, at 3 P.M.
The CAUSE OF DEATH* was as follows:

Atelectasis

(Duration) _____ yrs. _____ mos. 7 ds.
Contributory (Secondary) _____
(Signed) J. S. Stockton M. D.
Nov 6 1913 (Address) Grangeville Ida.

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death _____ yrs. _____ mos. _____ days. In the State _____ yrs. _____ mos. _____ days.
Where was disease contracted if not at place of death? _____
Former or usual residence _____

19. PLACE OF BURIAL OR REMOVAL Prairie View Cemetery DATE OF BURIAL Nov 6 1913

20. UNDERTAKER W. E. Graham ADDRESS Grangeville

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

N. B.—Every item of information should be carefully supplied. AGE should be state EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Form V. S. No. 5. 10M. 6-20-11.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH
County of *Schoshone*
City of *Grangeville*

Registration District No. *10*
Primary Registration District No. *1001*
(No. _____ St.)

File No. *6735*
Registered No. *180*

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME *John Swan*

If death occurred in a hospital, institution or camp give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX *Male* 4. COLOR OR RACE *White* 5. SINGLE, MARRIED, WIDOWED OR DIVORCED. *married*
(Write the word.)

6. DATE OF BIRTH
March (Month) *1st* (Day) *1836* (Year)

7. AGE *77* yrs. *7* mos. *3* ds. IF LESS than 1 day how many..... hrs. or min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work *Farmer*
(b) General nature of industry business or establishment in which employed (or employer)

9. BIRTHPLACE
(State or Country) *Pennsylvania*

10. NAME OF FATHER *not known*

11. BIRTHPLACE OF FATHER
(State or Country) *not known*

12. MAIDEN NAME OF MOTHER *not known*

13. BIRTHPLACE OF MOTHER
(State or Country) *not known*

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) *Jesse Swan*
(Address) *Grangeville*

15. Filed *Nov. 8* 191*3* *John L. Rains*
Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH
Nov *3* 191*3*
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from *Nov 2* 191*3*, to *Nov 3* 191*3* that I last saw him alive on *Nov 2* 191*3*, and that death occurred on the date stated above, at *7 A. M.*

The CAUSE OF DEATH* was as follows:

Arterio-sclerosis

(Duration) *not known* yrs. mos. ds.
Contributory (Secondary) *not known*

(Duration) yrs. mos. ds.
(Signed) *J. S. Stocilton* M. D.
Nov 8 191*3* (Address) *Grangeville Ida*

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death..... yrs..... mos..... ds. State..... yrs..... mos..... ds.
Where was disease contracted.
If not at place of death?
Former or usual residence.

19. PLACE OF BURIAL OR REMOVAL *Prairie View Cemetery* DATE OF BURIAL *Nov. 8* 191*3*

20. UNDERTAKER *E. H. Hancock* ADDRESS *Grangeville*

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. N. B.—Every item of information should be carefully supplied. AGE should be state EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Form V. S. No. 5. 10M. 6-20-11.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH.

Registration District No. 10

County of Idaho

Primary Registration District No. 1001

City of Grangeville

(No. _____ St.)

File No. 6736

Registered No. 181

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

Capt. James Woodward

If death occurred in a hospital, institution or camp give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX

male

4. COLOR OR RACE 5. SINGLE, MARRIED, WIDOWED OR DIVORCED.

white

widower
(Write the word.)

6. DATE OF BIRTH

Dec 30 (Month) 1836 (Year)
30 (Day)

7. AGE

76 yrs. 10 mos. 8 ds.

IF LESS than 1 day
how many _____ hrs. or
_____ min.

8. OCCUPATION

(a) Trade, profession or particular kind of work
(b) General nature of industry business or establishment in which employed (or employer)

Storner

9. BIRTHPLACE

(State or Country)

Erie Co. New York

10. NAME OF FATHER

not obtainable

11. BIRTHPLACE OF FATHER

(State or Country)

not obtainable

12. MAIDEN NAME OF MOTHER

not obtainable

13. BIRTHPLACE OF MOTHER

(State or Country)

not obtainable

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Claude M. Woodward

(Address) Whitebird, Idaho

15.

Filed Nov. 10 1913

Jesse L. Paines
Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

Nov (Month) 7 (Day) 1913 (Year)

17. I HEREBY CERTIFY, That I attended deceased from

May 1 1910, to Nov 7 1913

that I last saw him alive on Nov 7 1913

and that death occurred on the date stated above, at 11 P. M.

The CAUSE OF DEATH* was as follows:

Arterio-Sclerosis

(Duration) not known yrs. mos. ds.

Contributory (Secondary)

(Duration) _____ yrs. mos. ds.

(Signed) G. S. Stockton M. D.

Nov 10 1913 (Address) Grangeville, Idaho

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death _____ yrs. _____ mos. _____ ds. State _____ yrs. _____ mos. _____ ds.

Where was disease contracted,

If not at place of death?

Former or

usual residence.

19. PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

Buried in cemetery

Nov 14 1913

20. UNDERTAKER

ADDRESS

Ed Hancock

Grangeville

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Form V. S. No. 5 20M.1-16-12

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics
File No. 6737
Registered No. 182

1. PLACE OF DEATH

Registration District No. 10County of IdahoPrimary Registration District No. 2044City of Haileyville

(No. _____ St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

John Edward Liston

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX

Male

4. COLOR OR RACE

White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED.

married
(Write the word.)

6. DATE OF BIRTH

June (Month) 24 (Day) 1853 (Year)

7. AGE

60 yrs. 4 mos. 18 ds.IF LESS than 1 day
how many _____ hrs. or
_____ mins.?

8. OCCUPATION

(a) Trade, profession or particular kind of work

Farmer

(b) General nature of industry business, or establishment in which employed (or employer)

9. BIRTHPLACE

(State or Country)

Ireland

10. NAME OF FATHER

Maurice Liston

11. BIRTHPLACE OF FATHER

(State or Country)

Ireland

12. MAIDEN NAME OF MOTHER

Elizabeth Hanlon

13. BIRTHPLACE OF MOTHER

(State or Country)

Ireland

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

Michael J. Liston

(Address)

Columbus Ohio

15.

Filed

Nov. 13 1933Jose L. Tains

Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

Nov 12 1933
(Month) (Day) (Year)17. I HEREBY CERTIFY, That I attended deceased from
Nov 7 1933 to Nov 12 1933that I last saw him alive on Nov 9 1933and that death occurred on the date stated above, at 9 P.M.

The CAUSE OF DEATH* was as follows:

Carcinoma of face + tongue(Duration) 7 yrs. — mos. — ds.Contributory
(Secondary)(Duration) 7 yrs. — mos. — ds.

(Signed)

E. S. Stollon M. D.Nov. 13 1933 (Address) Haileyville Idaho

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death _____ yrs. _____ mos. _____ days. In the State _____ yrs. _____ mos. _____ days.

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

Denver CemeteryNov. 14 1933

20. UNDERTAKER

ADDRESS

W. E. Graham Haileyville

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. N. B.—Every item of information should be carefully supplied. AGE should be state EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Form V. S. No. 5. 10M. 6-20-11.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH.

Registration District No. 10

County of Idaho

Primary Registration District No. 2044

City of Grangeville

(No. , St.)

File No. 6738

Registered No. 183

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Margaret Holzer

If death occurred in a hospital, institution or camp give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX

Female

4. COLOR OR RACE

white

5. SINGLE, MARRIED, WIDOWED OR DIVORCED.

widow
(Write the word.)

6. DATE OF BIRTH

Dec (Month) 4 (Day) 1836 (Year)

7. AGE

76 yrs. 11 mos. 4 ds.

IF LESS than 1 day
how many hrs. or min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work

Farmers wife

(b) General nature of industry business or establishment in which employed (or employer)

9. BIRTHPLACE

(State or Country)

Germany

10. NAME OF FATHER

Bernhart Brassley

11. BIRTHPLACE OF FATHER

(State or Country)

Germany

12. MAIDEN NAME OF MOTHER

Caroline

13. BIRTHPLACE OF MOTHER

(State or Country)

Germany

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

Mrs. F. W. Holzer

(Address)

Grangeville Ida.

15.

Filed Nov. 10 1913

Jose P. Rain

Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

November 8th 1913
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from

Oct 19 1913, to Nov 8 1913

that I last saw her alive on Oct 28 1913

and that death occurred on the date stated above, at 2 P. M.

The CAUSE OF DEATH* was as follows:

abdominal growth,

(Duration) Don't know yrs. mos. ds.

Contributory (Secondary)

Don't know

(Duration) 8 yrs. mos. ds.

(Signed) G. S. Stockton M. D.

Nov 10 1913 (Address) Grangeville Ida.

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death. yrs. mos. ds. State. yrs. mos. ds.

Where was disease contracted.

If not at place of death?

Former or usual residence.

19. PLACE OF BURIAL OR REMOVAL

Prairie View Cemetery

DATE OF BURIAL

Nov. 10 1913

20. UNDERTAKER

Esthara

ADDRESS

Grangeville

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Form V. S. No. 5 20M.1-16-12

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH.

Registration District No. 10

County of Idaho

Primary Registration District No. 1001

City of Grangerville

(No. _____, St.)

File No. 6739

Registered No. 1984

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME John E. Briscoe

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX

male

4. COLOR OR RACE

White

5. SINGLE, MARRIED, ~~WIDOWED~~ OR ~~DIVORCED~~.

(Write the word.)

6. DATE OF BIRTH

Dec 19 1917
(Month) (Day) (Year)

7. AGE

15 yrs. 10 mos. 26 ds.

IF LESS than 1 day
how many hrs. or
..... mins.?

8. OCCUPATION

(a) Trade, profession or particular kind of work

Farmer

(b) General nature of industry, business, or establishment in which employed (or employer)

9. BIRTHPLACE

(State or Country)

Arkansas

10. NAME OF FATHER

John Briscoe

11. BIRTHPLACE OF FATHER

(State or Country)

12. MAIDEN NAME OF MOTHER

Clanton

13. BIRTHPLACE OF MOTHER

(State or Country)

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

W. R. Briscoe

(Address)

Grangerville Idaho

15.

Filed

Nov. 15

1913

John L. Rains
Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

Nov 15 1913
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from Jan 1 1917, to Nov 15 1913

that I last saw him alive on Nov 12 1913

and that death occurred on the date stated above, at 120

The CAUSE OF DEATH* was as follows:

Arterio-sclerosis

(Duration) some known yrs. mos. ds.

Contributory Valvular Heart Lesion
(Secondary)

(Duration) some known yrs. mos. ds.

(Signed) E. S. Stott M. D.

Nov 15 1913 (Address) Grangerville Idaho

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death yrs. mos. days. In the State yrs. mos. days.

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

Prairie View Cemetery

Nov. 16 1913

20. UNDERTAKER

ADDRESS

W. E. Graham Grangerville

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFAADING INK—THIS IS A PERMANENT RECORD.
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Form V. S. No. 5. 12½M.7-24-11

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics
File No. 6740
Registered No. 7

1. PLACE OF DEATH. Registration District No. 116
County of Bingham Primary Registration District No. 2195
City of Aberdeen (No. _____, _____ St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Ralph Edwin Baumgardner

If death occurred in a hospital, institution or camp give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX male 4. COLOR OR RACE white 5. SINGLE, MARRIED, WIDOWED OR DIVORCED. single
(Write the word.)

6. DATE OF BIRTH June 3 1913
(Month) (Day) (Year)

7. AGE 6 yrs. 6 mos. 20 ds. IF LESS than 1 day how many _____ hrs. or _____ min?

8. OCCUPATION
(a) Trade, profession or particular kind of work _____
(b) General nature of industry business or establishment in which employed (or employer) _____

9. BIRTHPLACE Idaho
(State or Country)

10. NAME OF FATHER Abe Baumgardner

11. BIRTHPLACE OF FATHER Ohio
(State or Country)

12. MAIDEN NAME OF MOTHER Lizzie Hagg

13. BIRTHPLACE OF MOTHER Ohio
(State or Country)

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Abe Baumgardner
(Address) Aberdeen Idaho

15. Filed Dec 24 1913 McMackinnon
Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH December 23 1913
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from _____ 191____, to _____ 191____
that I last saw h_____ alive on _____ 191____
and that death occurred on the date stated above, at _____ M.
The CAUSE OF DEATH* was as follows:

Pneumonia.
There was no physician in attendance.

_____ (Duration) _____ yrs. _____ mos. 3 ds.
Contributory _____
(Secondary) _____
_____ (Duration) _____ yrs. _____ mos. _____ ds.
(Signed) _____ M. D.
_____ 19____ (Address) _____

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place _____ In the _____
of death _____ yrs. _____ mos. _____ ds. State _____ yrs. _____ mos. _____ ds.
Where was disease contracted, _____
If not at place of death? _____
Former or _____
usual residence. _____

19. PLACE OF BURIAL OR REMOVAL Mennon Cemetery DATE OF BURIAL Dec 25 1913

20. UNDERTAKER Abe Baumgardner ADDRESS Aberdeen Ida

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Form V. S. No. 5 20M.1-16-12

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH.

Registration District No. 50County of LewisPrimary Registration District No. 2129City of Ilo

(No. _____ St.)

File No. 6741Registered No. 9

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Alfred Hanson

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX

4. COLOR OR RACE

5. SINGLE, MARRIED, WIDOWED OR DIVORCED.

malewhitemarried
(Write the word.)

6. DATE OF BIRTH

Sept
(Month)30
(Day)1870
(Year)

7. AGE

43 yrs. 2 mos. 6 ds.

IF LESS than 1 day
how many hrs. or
..... mins.?

8. OCCUPATION

(a) Trade, profession or particular kind of work

Farmer

(b) General nature of industry business, or establishment in which employed (or employer)

X

9. BIRTHPLACE

(State or Country)

Burlington Iowa

10. NAME OF FATHER

Chas. Hanson

11. BIRTHPLACE OF FATHER

(State or Country)

Stockholm Sweden

12. MAIDEN NAME OF MOTHER

not known

13. BIRTHPLACE OF MOTHER

(State or Country)

Christanna Norway

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

Victor Hanson

(Address)

Ilo, Idaho

15.

Filed

dec 61913H. C. Parrish

Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH

dec
(Month)6
(Day)1913
(Year)

17. I HEREBY CERTIFY, That I attended deceased from

June 9 1913, to dec 6 1913,that I last saw him alive on dec 5 1913,and that death occurred on the date stated above, at 4:2 M.

The CAUSE OF DEATH* was as follows:

Sarcoma(Duration) 2 yrs. mos. ds.Contributory
(Secondary)(Duration) yrs. mos. ds.(Signed) H. C. Parrish M. D.dec-6 1913 (Address) Ilo, Idaho

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death yrs. mos. days. In the State yrs. mos. days.

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

Ilo. S. O. F. Cemeterydec 6 1913

20. UNDERTAKER

ADDRESS

Ilo Hdw & Imp CoIlo Idaho

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Form V. S. No. 5. 12½ M. 7-24-11

CERTIFICATE OF DEATH

1. PLACE OF DEATH. Registration District No. 50
County of Lewis Primary Registration District No. 2129
City of Reubens (No. _____, St.)

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics
File No. 6742
Registered No. 7

If death occurs away from usual residence, give facts called for under special information.

If death occurred in a hospital, institution or camp give its NAME instead of street and number.

2. FULL NAME

John William Webb

PERSONAL AND STATISTICAL PARTICULARS

3. SEX Male 4. COLOR OR RACE White 5. SINGLE, MARRIED, WIDOWED OR DIVORCED. Married
(Write the word.)

6. DATE OF BIRTH Nov. 7 1842
(Month) (Day) (Year)

7. AGE 71 yrs. 1 mos. 18 ds. IF LESS than 1 day how many hrs. or min?

8. OCCUPATION

(a) Trade, profession or particular kind of work. Farmer
(b) General nature of industry business or establishment in which employed (or employer)

9. BIRTHPLACE

(State or Country) Missouri

10. NAME OF FATHER

Edward Webb

11. BIRTHPLACE OF FATHER

(State or Country) Virginia

12. MAIDEN NAME OF MOTHER

Mary P. Still

13. BIRTHPLACE OF MOTHER

(State or Country) Virginia

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Emmett Webb
(Address) Reubens Idaho

15.

Filed Dec 26 1913 H. L. Parrish
Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH

Dec. 24 1913
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from 1911, to 1911

that I last saw him alive on Dec. 24 1913
and that death occurred on the date stated above, at 1 A.M.
The CAUSE OF DEATH* was as follows:

Regeneration of Heart

(Duration) yrs. mos. ds.
Contributory (Secondary)

(Duration) yrs. mos. ds.
(Signed) George Gignard M. D.
Dec 24 1913 (Address) Reubens Idaho

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place In the
of death yrs. mos. ds. State yrs. mos. ds.
Where was disease contracted,
If not at place of death?
Former or
usual residence.

19. PLACE OF BURIAL OR REMOVAL DATE OF BURIAL

Gifford Idaho Dec 27 1913

20. UNDERTAKER

ADDRESS

Stoddard Gifford Idaho

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Form V. S. No. 5 20M.1-16-12

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH

Registration District No. 50

County of Lewis

Primary Registration District No. 2129

City of Leo

(No. 10 St.)

File No. 6743

Registered No. 8

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

Alvin W. Work

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX

Male

4. COLOR OR RACE

White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED.

Single
(Write the word.)

6. DATE OF BIRTH

12 3 1913
(Month) (Day) (Year)

7. AGE

62 yrs. mos. ds.

IF LESS than 1 day
how many hrs. or
mins.?

8. OCCUPATION

(a) Trade, profession or particular kind of work

Farmer

(b) General nature of industry, business, or establishment in which employed (or employer)

9. BIRTHPLACE

(State or Country)

Not Known

10. NAME OF FATHER

Not Known

11. BIRTHPLACE OF FATHER

(State or Country)

Not Known

12. MAIDEN NAME OF MOTHER

Not Known

13. BIRTHPLACE OF MOTHER

(State or Country)

Not Known

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

(Address)

H. C. Garrison
Idaho

15.

Filed Dec 5 1913

H. C. Garrison

Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

Dec 3 1913
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from

Dec 2 1913, to Dec 3 1913,

that I last saw him alive on Dec 3 1913,

and that death occurred on the date stated above, at 10:10 P.M.

The CAUSE OF DEATH* was as follows:

apoplexy

(Duration) yrs. 2 mos. ds.

Contributory Pneumonia (Secondary)

(Duration) yrs. mos. 1 ds.

(Signed) H. C. Garrison, M. D.

12-5 1913 (Address) Idaho

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death.....yrs.....mos.....days. In the State.....yrs.....mos.....days.

Where was disease contracted if not at place of death?

Former or usual residence.....

19. PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

Ho. S. O. O. F. Cemetery Dec. 6 1913

20. UNDERTAKER

ADDRESS

Ho. S. O. O. F. Cemetery
Idaho

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Form V. S. No. 5 20M.1-16-12

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH.

Registration District No. 47County of LewisPrimary Registration District No. 2124City of Russell

(No. _____, _____ St.)

File No. 6744Registered No. 10

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME _____

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX

F

4. COLOR OR RACE

W

5. SINGLE, MARRIED, WIDOWED OR DIVORCED.

Married
(Write the word.)

6. DATE OF BIRTH

Feb121913

(Month)

(Day)

(Year)

7. AGE

9 yrs. 13 mos. 13 ds.IF LESS than 1 day
how many _____ hrs. or
_____ mins.?

8. OCCUPATION

(a) Trade, profession or particular kind of work

None

(b) General nature of industry, business, or establishment in which employed (or employer)

9. BIRTHPLACE

(State or Country)

Russell

10. NAME OF FATHER

Jesse Tyler

11. BIRTHPLACE OF FATHER

(State or Country)

Kansas

12. MAIDEN NAME OF MOTHER

Mamie Jackson

13. BIRTHPLACE OF MOTHER

(State or Country)

Ohio

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

Mary Tyler

(Address)

Russell Idaho

15.

Filed

1225191320 M Jones

Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH

12

(Month)

25

(Day)

1913

(Year)

17. I HEREBY CERTIFY, That I attended deceased from

Dec1913

to

Dec 251913that I last saw him alive on 191and that death occurred on the date stated above, at M.

The CAUSE OF DEATH* was as follows:

pyemia

(Duration) _____ yrs. _____ mos. _____ ds.

Contributory

Karman

(Secondary)

(Duration) _____ yrs. _____ mos. _____ ds.

(Signed)

Dr. Jefferys M.D.19

(Address)

Myers

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death _____ yrs. _____ mos. _____ days. In the State _____ yrs. _____ mos. _____ days.

Where was disease contracted if not at place of death?

Former or usual residence _____

19. PLACE OF BURIAL OR REMOVAL

Guthrie Ida

DATE OF BURIAL

12 26 1913

20. UNDERTAKER

None

ADDRESS

—

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Form V. S. No. 5 20M.1-16-12

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics
File No. **6745**

1. PLACE OF DEATH.

Registration District No. **29**County of **Idaho**Primary Registration District No. **2050**City of **C. W. A.**(No. **2050** St.)Registered No. **4**

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

m f Kelly

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX

Female White

4. COLOR OR RACE

5. SINGLE, MARRIED, WIDOWED OR DIVORCED.

(Write the word.)

6. DATE OF BIRTH

1913
(Month) **9** (Day) (Year)

7. AGE

..... yrs. mos. **9** ds.

IF LESS than 1 day
how many hrs. or
..... mins.?

8. OCCUPATION

(a) Trade, profession or particular kind of work

(b) General nature of industry, business, or establishment in which employed (or employer)

9. BIRTHPLACE

(State or Country)

Cover & Allen

10. NAME OF FATHER

m f Kelly

11. BIRTHPLACE OF FATHER

(State or Country)

Ireland

12. MAIDEN NAME OF MOTHER

Leta & mums

13. BIRTHPLACE OF MOTHER

(State or Country)

Montana

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

m f Kelly

(Address)

1110 Sherman

15.

Filed

Jan 4

191

M. J. McNamee

Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH

Nov 28 1913
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from
Nov 20 1913, to **Nov 28** 1913,
that I last saw her alive on **Nov 28** 1913,

and that death occurred on the date stated above, at **104 M.**

The CAUSE OF DEATH* was as follows:

Harmophilia

(Duration) **1** yrs. **3** mos. **3** ds.

Contributory (Secondary) **Jaundice**

(Duration) **1** yrs. **3** mos. **3** ds.

(Signed) **W. H. Holden** M. D.

11/29 1913 (Address) **Cover & Allen Idaho**

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death yrs. mos. days. In the State yrs. mos. days.

Where was disease contracted if not at place of death?

Former or usual residence.....

19. PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

St Thomas Cem**Nov 29 1913**

20. UNDERTAKER

ADDRESS

S J Lauer**city**

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Form V. S. No. 5 20M.1-16-12

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics
File No. 6747 1
Registered No. 1

1. PLACE OF DEATH.

Registration District No. 29County of BoolemanPrimary Registration District No. 2050City of Coeur d'Alene (No. _____ St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Geo. W. Moore

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX

4. COLOR OR RACE

5. SINGLE, MARRIED, WIDOWED OR DIVORCED.

(Write the word.)

6. DATE OF BIRTH

7. AGE

IF LESS than 1 day
how many hr. or
..... min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work
(b) General nature of industry, business, or establishment in which employed (or employer)

9. BIRTHPLACE

(State or Country)

10. NAME OF FATHER

11. BIRTHPLACE OF FATHER

(State or Country)

12. MAIDEN NAME OF MOTHER

13. BIRTHPLACE OF MOTHER

(State or Country)

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Mrs. J. W. Moore(Address) 616 Lake Side Coeur d'Alene

15.

Filed Jan. 4 19131913

Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH

(Month)

(Day)

(Year)

17. I HEREBY CERTIFY, That I attended deceased from Dec 25 1913, to Dec 29 1913, that I last saw him alive on Dec 28 1913and that death occurred on the date stated above, at 8.9 M.

The CAUSE OF DEATH* was as follows:

Chronic Arterial Rheumatism

(Duration)

yrs. _____

mos. _____

ds. _____

Contributory (Secondary)

Gastritis

(Duration)

yrs. _____

mos. _____

ds. _____

(Signed)

Jno. B. B. B. M. D.

19

(Address)

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MANNER OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death

yrs. _____

mos. _____

days. _____

In the State

yrs. _____

mos. _____

days. _____

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

Forest Cem.Dec. 31 1913

20. UNDERTAKER

ADDRESS

Cassidy & Nelson Coeur d'Alene

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Form V. S. No. 5 20M.1-16-12

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics
File No. 6748

1. PLACE OF DEATH. Registration District No. 29
County of Kootenai Primary Registration District No. 205-0
City of Coeur d'Alene (No. , St.)

Registered No. 2
If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

Aminia Irvine

PERSONAL AND STATISTICAL PARTICULARS

3. SEX Female 4. COLOR OR RACE white 5. SINGLE, MARRIED, WIDOWED OR DIVORCED. married
(Write the word.)

6. DATE OF BIRTH

1866
(Month) (Day) (Year)

7. AGE

47 yrs. mos. ds.

IF LESS than 1 day
how many hrs. or
mins.?

8. OCCUPATION

(a) Trade, profession or particular kind of work
(b) General nature of industry business, or establishment in which employed (or employer)

Wife

9. BIRTHPLACE

(State or Country)

New Brunswick

10. NAME OF FATHER

John Crabie

11. BIRTHPLACE OF FATHER

(State or Country)

Ireland

12. MAIDEN NAME OF MOTHER

Charlatti Ward

13. BIRTHPLACE OF MOTHER

(State or Country)

Ireland

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

Geo. Currell

(Address)

e. w. a.

15.

Filed

Jan 4 1913 J. M. Randall
Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH

Nov. 5 1913
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from Oct 17 1913, to Nov. 5 1913 that I last saw her alive on Nov. 5 1913 and that death occurred on the date stated above, at 9 P.M.

The CAUSE OF DEATH* was as follows:

Bright's Disease

(Duration) 5 yrs. mos. ds.

Contributory
(Secondary)

(Duration) yrs. mos. ds.

(Signed) Max Randall M. D.

Nov 6 1913 (Address) Coeur d'Alene Idaho

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death yrs. mos. days. In the State yrs. mos. days.

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL DATE OF BURIAL

St Thomas em 10 2 5 1913

20. UNDERTAKER

ADDRESS

J. J. Linn

e. w. a.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Form V. S. No. 5. 10M. 6-20-11.

CERTIFICATE OF DEATH

1. PLACE OF DEATH.

Registration District No.

County of CanyonPrimary Registration District No. 7City of Naupho

(No., St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

Anna Elizabeth Toft

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

File No. 6749

Registered No.

If death occurred in a hospital, institution or camp give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX

4. COLOR OR RACE 5. SINGLE, MARRIED, WIDOWED OR DIVORCED.

(Write the word.)

6. DATE OF BIRTH

Oct 8 1843
(Month) (Day) (Year)

7. AGE

70 yrs. 1 mos. 28 ds.

IF LESS than 1 day
how many hrs. or
..... min.?

8. OCCUPATION

- (a) Trade, profession, or particular kind of work
(b) General nature of industry, business, or establishment in which employed (or employer)

9. BIRTHPLACE

(State or Country)

Maine

10. NAME OF FATHER

Chas. Woodbury

11. BIRTHPLACE OF FATHER

(State or Country)

Dont know

12. MAIDEN NAME OF MOTHER

Elizabeth Morton

13. BIRTHPLACE OF MOTHER

(State or Country)

Dont know

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

Edw. Toft

(Address)

Naupho Ida

15.

Filed

Dec 8 1913P. D. Calauer

Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

Dec 7 1913
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from At times for two years past
1911 to 1913

that I last saw her alive on Dec 7 1913,
and that death occurred on the date stated above, at 11:30 A. M.

The CAUSE OF DEATH* was as follows:

Arteriosclerosis of liver and
General Debility

(Duration) long time yrs. mos. ds.

Contributory (Secondary)

(Duration) yrs. mos. ds.

(Signed) J. H. Murray M. D.

Dec 9 1913 (Address) Naupho Idaho

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place In the
of death yrs. mos. ds. State yrs. mos. ds.

Where was Disease contracted,

If not at place of death?

Former or

usual residence.

19. PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

Kohlerlawm Cem 12/10 1913

20. UNDERTAKER

ADDRESS

715 Robinson Naupho Ida

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Form V. S. No. 5. 10M. 6-20-11.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH.
County of Campan
City of Nampa

Registration District No. _____
Primary Registration District No. _____
(No. 12, 2)

File No. _____
Registered _____
Hospital, in _____ its NAME _____ and number.

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME W. D. Gardner

PERSONAL AND STATISTICAL PARTICULARS

3. SEX Male 4. COLOR OR RACE White 5. SINGLE, MARRIED, WIDOWED OR DIVORCED. Married
(Write the word.)

6. DATE OF BIRTH July 19 1830
(Month) (Day) (Year)

7. AGE 83 yrs. 4 mos. 18 ds. IF LESS than 1 day how many _____ hrs. or _____ min.

8. OCCUPATION
(a) Trade, profession or particular kind of work Farmer
(b) General nature of industry business or establishment in which employed (or employer)

9. BIRTHPLACE
(State or Country) Henry Co. Ky.

10. NAME OF FATHER Not known

11. BIRTHPLACE OF FATHER
(State or Country) Ky

12. MAIDEN NAME OF MOTHER —

13. BIRTHPLACE OF MOTHER
(State or Country) Not known

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) W. D. Gardner
(Address) Nampa Idaho

15. Filed Dec 9 1913 J. A. Calouga
Local Registrar

MEDICAL CERTIFICATE

16. DATE OF DEATH Dec 8 1913
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from 191____ to 191____

that I last saw h_____ alive on 191____

and that death occurred on the date stated above, at 8:20 A. M.

The CAUSE OF DEATH* was as follows:

General Debility

(Duration) _____ yrs. _____ mos. _____ ds.

Contributory (Secondary) _____

(Duration) _____ yrs. _____ mos. _____ ds.

(Signed) J. H. Murray M. D.

Dec 8 1913 (Address) Nampa Idaho

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death _____ yrs. _____ mos. _____ ds. State _____ yrs. _____ mos. _____ ds.

Where was disease contracted, _____

If not at place of death? _____

Former or usual residence _____

19. PLACE OF BURIAL OR REMOVAL Nampa Idaho

Koherslawn cemetery

20. UNDERTAKER W. H. Robinson

DATE OF BURIAL Dec 9 1913

ADDRESS Nampa Ida

Form V. S. No. 5. 10M. 6-20-11.

CERTIFICATE OF DEATH

 State of Idaho
 BOARD OF HEALTH
 Bureau of Vital Statistics

 1. PLACE OF DEATH.
 County of Canyon
 City of _____

 Registration District No. _____
 Primary Registration District No. _____
 (No. _____, _____ St.)

 File No. 6751
 Registered No. _____

If death occurs away from usual residence, give facts called for under special information.

 2. FULL NAME Mary Howard Hodgkinson

If death occurred in a hospital, institution or camp give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

 3. SEX Female 4. COLOR OR RACE White 5. SINGLE, MARRIED, WIDOWED OR DIVORCED. married
 (Write the word.)

6. DATE OF BIRTH

 _____ 191____
 (Month) (Day) (Year)

7. AGE

84 yrs. - mos. - ds.

 IF LESS than 1 day
 how many _____ hrs. or
 _____ min.?

8. OCCUPATION

 (a) Trade, profession, or particular kind of work Housewife

(b) General nature of industry business, or establishment in which employed (or employer)

9. BIRTHPLACE

(State or Country) Wales10. NAME OF FATHER William Howard

11. BIRTHPLACE OF FATHER

(State or Country) Wales12. MAIDEN NAME OF MOTHER Don't know

13. BIRTHPLACE OF MOTHER

(State or Country) Wales

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Thomas J. Hodgkinson(Address) Kuna Ida

15.

Filed Dec 10 1913
J. D. Calauer
 Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

12 — 9 1913
 (Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from

12/20/13 191____, to 12/9/13 191____

 that I last saw her alive on 12-6/13 191____,

 and that death occurred on the date stated above, at 12 M.

The CAUSE OF DEATH* was as follows:

Carcinoma Tongue

(Duration) _____ yrs. _____ mos. _____ ds.

Contributory (Secondary)

(Duration) _____ yrs. _____ mos. _____ ds.

(Signed) W. H. Johnson M. D.
12/9/13 19____ (Address) Baldwell Ida

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL,

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

 At place _____ In the _____
 of death _____ yrs. _____ mos. _____ ds. State _____ yrs. _____ mos. _____ ds.

Where was Disease contracted,

If not at place of death? _____

Former or

usual residence. _____

19. PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

Kohlerlaw Cemetery 12/9 1913

20. UNDERTAKER

ADDRESS

F. H. Robinson 79 E. Kuna Ida

Form V. S. No. 5. 10M. 6-20-11.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH.

Registration District No.

County of Canyon

Primary Registration District No.

City of Nampa(No. 9551-8 St.)File No. 6752

Registered No.

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

Elizabeth Charlotte Hardy

If death occurred in a hospital, institution or camp give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX

4. COLOR OR RACE 5. SINGLE, MARRIED, WIDOWED OR DIVORCED.

Female White Widowed
(Write the word.)

6. DATE OF BIRTH

May 31 1892
(Month) (Day) (Year)

7. AGE

71 yrs. 7 mos. 14 ds.IF LESS than 1 day
how many hrs. or
min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work
(b) General nature of industry business or establishment in which employed (or employer)Retired

9. BIRTHPLACE

(State or Country)

Belfast Ireland

10. NAME OF FATHER

Geo Cassidy

11. BIRTHPLACE OF FATHER

(State or Country)

Ireland

12. MAIDEN NAME OF MOTHER

Charlotte Holden

13. BIRTHPLACE OF MOTHER

(State or Country)

England

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

Mrs H. E. King

(Address)

Nampa Idaho

15.

Filed

Dec 15 1913S. A. Calver

Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

Dec 14 1913
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from

Sept 15 1913, to Dec 14 1913that I last saw him alive on Dec 13 1913,and that death occurred on the date stated above, at 8:53 P.M.

The CAUSE OF DEATH* was as follows:

Cancer which included the uterus the liver and possibly the stomach(Duration) 3 yrs. 3 mos. 3 ds.

Contributory (Secondary)

(Duration) 3 yrs. 3 mos. 3 ds.

(Signed)

J. H. Murray M. D.
Dec 15 1913 (Address) Nampa Idaho

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death yrs. mos. ds. State yrs. mos. ds.

Where was disease contracted,

If not at place of death?

Former or

usual residence

19. PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

Nampa Idaho Dec 15 1913
Kryhler lawn cemetery

20. UNDERTAKER

ADDRESS

Shellobarber Nampa Ida

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Form V. S. No. 5. 10M. 6-20-11.

CERTIFICATE OF DEATH

1. PLACE OF DEATH.

County of CanyonCity of Nauffa

If death occurs away from usual residence, give facts called for under special information.

Registration District No.

Primary Registration District No.

(No. Maloney St.)State of Idaho
BOARD OF HEALTH
Bureau of Vital StatisticsFile No. 6753

Registered No.

If death occurred in a hospital, institution or camp give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX

Male

4. COLOR OR RACE

White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED.

Married
(Write the word.)

6. DATE OF BIRTH

Don't know 1
(Month) (Day) (Year)

7. AGE

2 yrs. - mos. - ds. IF LESS than 1 day
how many hrs. or
..... min.?

8. OCCUPATION

(a) Trade, profession, or particular kind of work

House Keeping

(b) General nature of industry business, or establishment in which employed (or employer)

9. BIRTHPLACE

(State or Country)

Colo

10. NAME OF FATHER

Hugh O'Hara

11. BIRTHPLACE OF FATHER

(State or Country)

Ireland

12. MAIDEN NAME OF MOTHER

Anna Bryson

13. BIRTHPLACE OF MOTHER

(State or Country)

Ireland

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

(Address)

Hugh O'Hara

15.

Filed Dec 31 1913D.D. Calauer

Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

Dec 31 1913
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from

Dec 28 1913, to Dec 31 1913

that I last saw her alive on Dec 31 1913,

and that death occurred on the date stated above, at 3 PM,

The CAUSE OF DEATH* was as follows:

Post Partum eclampsia(Duration) yrs. mos. 2 ds.

Contributory (Secondary)

Pregnancy

(Duration) yrs. mos. ds.

(Signed) D.D. Calauer M. D.Dec 31 1913 (Address) Nauffa

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place

In the

of death yrs. mos. ds. State yrs. mos. ds.

Where was Disease contracted,

If not at place of death?

Former or

usual residence.

19. PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

Kahler LawnJan 2 1913

20. UNDERTAKER

ADDRESS

F.H. RobinsonNauffa

MARGIN RESERVED FOR BINDING
WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Form V. S. No. 5. 10M. 6-20-11.

CERTIFICATE OF DEATH

1. PLACE OF DEATH.

Registration District No.

County of Canyon

Primary Registration District No.

City of Nampa

(No. St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

Ed Williams

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics
File No. 6754

Registered No.

If death occurred in a hospital, institution or camp give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX

Male

4. COLOR OR RACE 5. SINGLE, MARRIED, WIDOWED OR DIVORCED.

White

Don't know
(Write the word.)

6. DATE OF BIRTH

Don't know

(Month) (Day) (Year)

7. AGE

Don't know

IF LESS than 1 day
how many hrs. or
..... min.?

yrs. mos. ds.

8. OCCUPATION

(a) Trade, profession, or particular kind of work

Don't know

(b) General nature of industry, business, or establishment in which employed (or employer)

9. BIRTHPLACE

(State or Country)

Don't know

10. NAME OF FATHER

11. BIRTHPLACE OF FATHER

(State or Country)

12. MAIDEN NAME OF MOTHER

13. BIRTHPLACE OF MOTHER

(State or Country)

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) F. H. Robinson

(Address)

Nampa Ida

15.

Filed 191

S. S. Calonge
Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

Dec 23 1913
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from

191 to 191
that I last saw him alive on 191

and that death occurred on the date stated above, at M.

The CAUSE OF DEATH* was as follows:

Suicide
(strychnine poisoning)

(Duration) yrs. mos. ds.

Contributory
(Secondary)

(Duration) yrs. mos. ds.

(Signed) F. H. Robinson Coroner

19 (Address) Nampa Ida

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place yrs. mos. ds. In the
of death yrs. mos. ds. State yrs. mos. ds.

Where was Disease contracted,

If not at place of death?

Former or

usual residence.

19. PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

Kollerlaun cem

12/30 1913

20. UNDERTAKER

ADDRESS

F. H. Robinson

Nampa Ida

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 18672

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Form V. S. No. 5. 10M. 6-20-11.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH. Registration District No.
County of Canyon Primary Registration District No.
City of Nampa (No., St.)

File No. 6756
Registered No.

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

Elizabeth Cummings

If death occurred in a hospital, institution or camp give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX Female 4. COLOR OR RACE White 5. SINGLE, MARRIED, WIDOWED OR DIVORCED. married
(Write the word.)

6. DATE OF BIRTH

Apr 4 1869
(Month) (Day) (Year)

7. AGE

44 yrs. 8 mos. 10 ds. IF LESS than 1 day
how many hrs. or min.?

8. OCCUPATION

(a) Trade, profession, or particular kind of work House wife
(b) General nature of industry, business, or establishment in which employed (or employer)

9. BIRTHPLACE

(State or Country) England

10. NAME OF FATHER

John Coates

11. BIRTHPLACE OF FATHER

(State or Country) England

12. MAIDEN NAME OF MOTHER

Don't know

13. BIRTHPLACE OF MOTHER

(State or Country) England

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) G. D. Cummings
(Address) Nampa Ida

15.

Filed Dec 15 1913 P. D. Colange
Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

Dec 14 1913
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from

April 1910, to Dec 13 1913
that I last saw her alive on Dec 13 1913

and that death occurred on the date stated above, at 230 P. M.

The CAUSE OF DEATH* was as follows:

Pulmonary tuberculosis

(Duration) 3+ yrs. — mos. — ds.

Contributory (Secondary)

(Duration) — yrs. — mos. — ds.

(Signed) H. P. Rose M. D.

Dec 16 1913 (Address) Nampa Ida

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place yrs. mos. ds. In the
of death yrs. mos. ds. State yrs. mos. ds.

Where was Disease contracted,

If not at place of death?

Former or

usual residence.

19. PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

Kokirlawn cem

12/16 1913

20. UNDERTAKER

ADDRESS

24 Robinson

Nampa Ida

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Form V. S. No. 5. 10M. 6-20-11.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH.

Registration District No.

County of Owyhee
City of Rural

Primary Registration District No. 7File No. 6757

Registered No.

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

Patricen Lincham

If death occurred in a hospital, institution or camp give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX

Male

4. COLOR OR RACE

White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED.

Married
(Write the word.)

6. DATE OF BIRTH

(7)
(Month)(7)
(Day)1837
(Year)

7. AGE

76 yrs.(7) mos.(7) ds.

IF LESS than 1 day
how many hrs. or
..... min.?

8. OCCUPATION

- (a) Trade, profession, or particular kind of work
(b) General nature of industry, business, or establishment in which employed (or employer)

Paucher

9. BIRTHPLACE

(State or Country)

Ireland

10. NAME OF FATHER

(7)

11. BIRTHPLACE OF FATHER

(State or Country)

(7)

12. MAIDEN NAME OF MOTHER

(7)

13. BIRTHPLACE OF MOTHER

(State or Country)

(7)

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

B. B. Shellabarger

(Address)

Nauppa, Ida

15.

Filed

Dec 2 1913B. B. Colouze

Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

(Month)

(Day)

1913
(Year)

17. I HEREBY CERTIFY That I attended deceased from

Deceased lived near
Prussia in Owyhee Co 1913
and that death occurred on the date stated above, at M.

The CAUSE OF DEATH* was as follows:

No physician attended him
Deceased was known
to be a sufferer from Bright's
disease Duration 7 yrs. 7 mos. 7 ds.

Contributory
(Secondary)

(7)

(Duration) (7) yrs. 7 mos. 7 ds.

(Signed) B. B. Colouze M. D.

(Address) No further data obtainable

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place In the
of death yrs. mos. ds. State yrs. mos. ds.

Where was Disease contracted,
If not at place of death?

Former or
usual residence

19. PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

Kohler LawnNov 26 1913

20. UNDERTAKER

ADDRESS

B. B. Shellabarger Nauppa

Deas. out of town and burial permit cannot
not be given until Dec 2. Permit granted by telephone

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Form V. S. No. 5. 10M. 6-20-11.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH.

Registration District No. 4County of CanyonPrimary Registration District No. 1008City of Payette

(No. _____, _____ St.)

File No. 6758Registered No. 106

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

George to Hanny Miller

If death occurred in a hospital, institution or camp give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX

Male

4. COLOR OR RACE

white

5. SINGLE, MARRIED, WIDOWED OR DIVORCED.

Married
(Write the word.)

6. DATE OF BIRTH

July

(Month)

27

(Day)

1874

(Year)

7. AGE

39 yrs. 4 mos. 8 ds.IF LESS than 1 day
how many hrs. or
..... min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work

Farmer

(b) General nature of industry business or establishment in which employed (or employer)

9. BIRTHPLACE

(State or Country)

Fayette County Iowa

10. NAME OF FATHER

H. W. Miller

11. BIRTHPLACE OF FATHER

(State or Country)

Michigan

12. MAIDEN NAME OF MOTHER

Elsie Robison

13. BIRTHPLACE OF MOTHER

(State or Country)

Iowa

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Mrs. Geo. C. Miller(Address) Payette Idaho

15.

Filed Dec 5 1913 J. C. Woodward
Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

December

(Month)

4

(Day)

1913

(Year)

17. I HEREBY CERTIFY, That I attended deceased from

Aug. 29 1913, to Dec. 3 1913that I last saw him alive on Dec. 3 1913and that death occurred on the date stated above, at 2 A. M.

The CAUSE OF DEATH* was as follows:

Pulmonary + Laryngeal Tuberculosis(Duration) 1 yrs. 6 mos. ds.

Contributory (Secondary)

(Duration) _____ yrs. _____ mos. _____ ds.

(Signed)

Dec 5 1913 (Address) Payette Ida

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL OR HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death _____ yrs. _____ mos. _____ ds. State _____ yrs. _____ mos. _____ ds.

Where was disease contracted,

If not at place of death?

Former or

usual residence.

19. PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

Payette Ida Dec 5 1913

20. UNDERTAKER

ADDRESS

Glenn C. Landon Payette Ida

MARGIN USED FOR BINDING
WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
N. B.—Every item of information should be carefully supplied. AGE should be state EXACTLY. PHYSICIAN should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Form V-S No. 5. 10M, 6-20-11

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH
County of Boise
City of Sweet

Registration District No. 4
Primary Registration District No. 1008
(No. 7, St.)

File No. 6759
Registered No. 7

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

T. J. Butler

If death occurred in a hospital, institution or camp give the NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX M. 4. COLOR OR RACE W. 5. SINGLE, MARRIED, WIDOWED, OR DIVORCED.
Widowed
(Write the word.)

6. DATE OF BIRTH April 13 1850
(Month) (Day) (Year)

7. AGE 63 yrs. 8 mos. — ds. IF LESS than 1 day how many hrs. or min.?

8. OCCUPATION
(a) Trade, profession, or particular kind of work Saddler
(b) General nature of industry business, or establishment in which employed (or employer) employer

9. BIRTHPLACE
(State or Country) Indiana

10. NAME OF FATHER Son does not know

11. BIRTHPLACE OF FATHER
(State or Country) —

12. MAIDEN NAME OF MOTHER not known

13. BIRTHPLACE OF MOTHER
(State or Country) Indiana

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) A. Skippen

(Address) Sweet

15. Filed Dec 14 1913
J. C. Woodward
Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH Dec. 12 1913
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from Sept 10 1913, to Dec. 12 1913
that I last saw him alive on Dec. 12 1913
and that death occurred on the date stated above, at 4 P. M.

The CAUSE OF DEATH* was as follows:
Bronchitis & Emphysema

(Duration) 3 yrs. 3 mos. 3 ds.
Contributory (Secondary) Cancer

(Duration) 3 yrs. 3 mos. 3 ds.
(Signed) Alfred Skippen M. D.
Dec. 12 1913 (Address) Sweet Ida

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place Pinhurst In the 346
of death. yrs. 2 mos. 2 ds. State Ida yrs. 346 mos. — ds.
Where was Disease contracted, Payette
If not at place of death?
Former or usual residence. Payette

19. PLACE OF BURIAL OR REMOVAL Payette Ida DATE OF BURIAL Dec 15 1913

20. UNDERTAKER H. A. Adair ADDRESS Payette Ida

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Form V. S. No. 5 20M.1-16-12

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH

County of *Payette*Registration District No. *4*Primary Registration District No. *1008*

City of _____

(No. _____)

St.) _____

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

*Lucenda Miller Bell*File No. *6760*Registered No. *108*

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX

Female

4. COLOR OR RACE

White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED.

Widow
(Write the word.)

6. DATE OF BIRTH

May 12 1887
(Month) (Day) (Year)

7. AGE

*81 yrs. 7 mos. ds.*IF LESS than 1 day
how many hrs. or mins.?

8. OCCUPATION

(a) Trade, profession or particular kind of work

Housewife

(b) General nature of industry business, or establishment in which employed (or employer)

9. BIRTHPLACE

(State or Country)

Cambridge Penn sylvania

10. NAME OF FATHER

Donald V Miller

11. BIRTHPLACE OF FATHER

(State or Country)

Harrisburg Penn

12. MAIDEN NAME OF MOTHER

Elizabeth Blair

13. BIRTHPLACE OF MOTHER

(State or Country)

Penn

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

Am Bell

(Address)

Payette

15.

Filed

*Dec 15 1913**J. C. Woodward*

Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

December 12 1913
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from

*Dec. 9 1913, to Dec. 12 1913,*that I last saw her alive on *December 12 1913,*and that death occurred on the date stated above, at *1 P. M.*

The CAUSE OF DEATH* was as follows:

Solar pneumonia(Duration) yrs. mos. *4* ds.

Contributory (Secondary)

(Duration) yrs. *6* mos. ds.

(Signed)

*C. H. Avery M. D.*19 (Address) *Payette Idaho*

*State the DISEASE CAUSING DEATH; or in death from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death.....yrs.....mos.....days. In the State.....yrs.....mos.....days.

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL DATE OF BURIAL

Payette Ida Dec. 15 1913

20. UNDERTAKER

ADDRESS

J. N. Adair Payette Ida

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Form V. S. No. 5. 10M. 6-20-11.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics
File No. **6761**

1. PLACE OF DEATH.

Registration District No. **4**

County of **Cassia**

Primary Registration District No. **1008**

City of **Payette**

(No. _____ St.)

Registered No. **109**

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME **Sarah Jane Ross**

If death occurred in a hospital, institution or camp give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX

4. COLOR OR RACE 5. SINGLE, MARRIED, WIDOWED OR DIVORCED.

Female **White**

Married
(Write the word.)

6. DATE OF BIRTH

July **17** **1844**
(Month) (Day) (Year)

7. AGE

6 yrs. **5** mos. **16** ds. IF LESS than 1 day how many _____ hrs. or _____ min.?

8. OCCUPATION

- (a) Trade, profession or particular kind of work
(b) General nature of industry, business or establishment in which employed (or employer)

Housewife

9. BIRTHPLACE

(State or Country)

New York

10. NAME OF FATHER

Abel Maibel

11. BIRTHPLACE OF FATHER

(State or Country)

unknown

12. MAIDEN NAME OF MOTHER

Jane Delaf

13. BIRTHPLACE OF MOTHER

(State or Country)

unknown

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

Mary Bennett

(Address)

Payette

15.

Filed **Dec 24 1913**

Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

_____ 191_____
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from _____ 191_____, to _____ 191_____,

that I last saw him _____ alive on _____ 191_____,

and that death occurred on the date stated above, at _____ M.

The CAUSE OF DEATH* was as follows:

_____ (Duration) _____ yrs. _____ mos. _____ ds.

Contributory (Secondary)

_____ (Duration) _____ yrs. _____ mos. _____ ds.

(Signed) _____ M. D.

Dec 24 1913 (Address) _____

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place _____ In the _____
of death _____ yrs. _____ mos. _____ ds. State _____ yrs. _____ mos. _____ ds.

Where was disease contracted.

If not at place of death?

Former or

usual residence.

19. PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

Payette Idaho

Dec 26 1913

20. UNDERTAKER

ADDRESS

Glen C Landon

Payette Ida

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Form V. S. No. 5. 10M. 6-20-11.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH.

Registration District No. 4County of BonanzaPrimary Registration District No. 1008City of Payette

(No. _____, St.)

File No. 6762Registered No. 110

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

Mary Ann Nelson

If death occurred in a hospital, institution or camp give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX

Female

4. COLOR OR RACE

White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED.

(Write the word.)

6. DATE OF BIRTH

July121862

(Month)

(Day)

(Year)

7. AGE

57 yrs. 3 mos. 22 ds.IF LESS than 1 day
how many _____ hrs. or
_____ min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work

Housewife

(b) General nature of industry business or establishment in which employed (or employer)

9. BIRTHPLACE

(State or Country)

Ill.

10. NAME OF FATHER

John English

11. BIRTHPLACE OF FATHER

(State or Country)

Don't know

12. MAIDEN NAME OF MOTHER

Susan Lockhart

13. BIRTHPLACE OF MOTHER

(State or Country)

Ill.

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

E. B. Nelson

(Address)

Payette Idaho

15.

Filed

Dec 24 1913J. C. Woodward
Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

Dec231913

(Month)

(Day)

(Year)

17. I HEREBY CERTIFY, That I attended deceased from

Dec 23, 1913, to Dec 23, 1913that I last saw him alive on Dec 1, 1913and that death occurred on the date stated above, at 2 P. M.

The CAUSE OF DEATH* was as follows:

Heart Disease

(Duration) _____ yrs. _____ mos. _____ ds.

Contributory
(Secondary)

(Duration) _____ yrs. _____ mos. _____ ds.

(Signed) _____ M. D.

12 27 1913 (Address) Payette Idaho

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death _____ yrs. _____ mos. _____ ds. State _____ yrs. _____ mos. _____ ds.

Where was disease contracted,
If not at place of death?
Former or usual residence _____

19. PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

Payette IdahoDec 24 1913

20. UNDERTAKER

ADDRESS

Glenn C. LandonPayette Idaho

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Form V. S. No. 5 20M.1-16-12

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH.

Registration District No. 4County of CanyonPrimary Registration District No. 1008File No. 6763City of Payette(No. 111)

(St.)

Registered No. 111

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Chimene August Berding

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX

Male

4. COLOR OR RACE

White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED.

Married
(Write the word.)

6. DATE OF BIRTH

Jan 8 1871
(Month) (Day) (Year)

7. AGE

42 yrs. 11 mos. 16 ds.IF LESS than 1 day
how many hrs. or
..... mins.?

8. OCCUPATION

(a) Trade, profession or particular kind of work

(b) General nature of industry business, or establishment in which employed (or employer)

Farmer Stock
Raiser

9. BIRTHPLACE

(State or Country)

California

10. NAME OF FATHER

Arnold Berding

11. BIRTHPLACE OF FATHER

(State or Country)

Germany

12. MAIDEN NAME OF MOTHER

Mary Huth

13. BIRTHPLACE OF MOTHER

(State or Country)

Germany

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

(Address)

Mrs. L. A. Berding
Payette

15.

Filed Dec 24 19133J. C. Woodward

Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH

Dec 24 1913
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from

191, to 191,
that I last saw him alive on 191,and that death occurred on the date stated above, at M.

The CAUSE OF DEATH* was as follows:

Gun shot wound
self in the chest
(Cornel Kordick)
(Duration) yrs. mos. ds.Contributory
(Secondary)(Duration) yrs. mos. ds.
(Signed) F. J. Robinson M. D.19. (Address) Payette, Idaho

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death yrs. mos. days. In the State yrs. mos. days.

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

Terrebonne Cal.Dec 28 1913

20. UNDERTAKER

ADDRESS

H. Adair Payette Idaho

Form No. 5 20M.1-16-12

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH.

Registration District No.

County of Bannock

Primary Registration District No.

City of _____(No. Michigale St.)File No. 346764Registered No. 703

If death occurs away from usual residence, give facts called for under special information.

2.

FULL NAME Mike Brunetto

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX

4. COLOR OR RACE

5. SINGLE, MARRIED, WIDOWED OR DIVORCED.

MaleWhiteMarried
(Write the word.)

6. DATE OF BIRTH

Exact date unknown 1874
(Month) (Day) (Year)

7. AGE

39 years known
yrs. mos. ds.IF LESS than 1 day
how many hrs. or mins.?

8. OCCUPATION

(a) Trade, profession or particular kind of work

(b) General nature of industry business, or establishment in which employed (or employer)

Miner

9. BIRTHPLACE

(State or Country)

California

10. NAME OF FATHER

Unknown

11. BIRTHPLACE OF FATHER

(State or Country)

Unknown

12. MAIDEN NAME OF MOTHER

Unknown

13. BIRTHPLACE OF MOTHER

(State or Country)

Unknown

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

Mrs. Michial Brunetto

(Address)

Bannock Co

15.

Filed

Nov 4, 1913

1913

Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH

Nov 2nd

(Month)

(Day)

1913

(Year)

17. I HEREBY CERTIFY, That I attended deceased from

June 1913, to June 1913that I last saw him alive on June 1913and that death occurred on the date stated above, at M.

The CAUSE OF DEATH* was as follows:

Pneumonia tuberculosis

(Duration)

3 yrs.2 mos.— ds.

Contributory

(Secondary)

(Duration)

— yrs.— mos.— ds.

(Signed)

O. B. S. S. S.

M. D.

11-3-1913 (Address)Pocatello Idaho

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place

of death

yrs.

mos.

days.

In the

State

yrs.

mos.

days.

Where was disease contracted if not at place of death?

Former or

usual residence

19. PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

1913

20. UNDERTAKER

ADDRESS

Local Registrar

Paul & SchumacherCity

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Form V. S. No. 5 20M.1-16-12

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH

Registration District No.

County of *Blaine*

Primary Registration District No.

City of *Pocatello*

(No. *531* *By Harrison* St.)

File No. *3 6765*

Registered No. *105*

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME *Mary Cathleen Dwyer*

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX *Female*

4. COLOR OR RACE

5. SINGLE, MARRIED, WIDOWED OR DIVORCED.

(Write the word.)

6. DATE OF BIRTH

Sept 5 1913
(Month) (Day) (Year)

7. AGE

1 yrs. 28 mos. ds.

IF LESS than 1 day
how many hrs. or mins.?

8. OCCUPATION

(a) Trade, profession or particular kind of work

(b) General nature of industry business, or establishment in which employed (or employer)

None

9. BIRTHPLACE

(State or Country)

Pocatello Idaho

10. NAME OF FATHER

John E. Dwyer

11. BIRTHPLACE OF FATHER

(State or Country)

Altoona Pa.

12. MAIDEN NAME OF MOTHER

Rose Francis Farnam

13. BIRTHPLACE OF MOTHER

(State or Country)

Montana

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

John E. Dwyer

(Address)

Pocatello

15.

Filed

Nov 2 1913

of place

Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH

Nov. 2 1913
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from *Oct 24 1913* to *Nov 2 1913* that I last saw her alive on *Nov 2 1913*

and that death occurred on the date stated above, at *M.*

The CAUSE OF DEATH* was as follows:

Pneumonia

(Duration) yrs. mos. *8* ds.

Contributory (Secondary)

(Duration) yrs. mos. ds.

(Signed)

H. A. Casette M. D.

Nov 2 1913 (Address) *Pocatello Idaho*

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death. yrs. mos. days. In the State. yrs. mos. days.

Where was disease contracted if not at place of death?

Former or usual residence.

19. PLACE OF BURIAL OR REMOVAL DATE OF BURIAL

St. Louis Cemetery Nov 3 1913

20. UNDERTAKER

ADDRESS

W. A. Wacker Pocatello

-SUPPLEMENTARY DEATH CERTIFICATE-

(Please reply on this sheet to
the registrar of Vital Statistics)

Death Certificate No. 6765

Name Mary Cathleen Dwyer

Date of Death Nov. 2, 1912

Cause of Death Lobar Pneumonia

Contributory Cause of death Exposure of babe & ill health of mother

(Sign here) H. A. Castle M.D.

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICI-
ANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact state-
ment of OCCUPATION is very important. See instructions on back of certificate.

Form V. S. No. 5 20M.1-16-12

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH. Registration District No.
County of Bannock Primary Registration District No.
City of Pocatello (No. 1132, N. Eighth ave. St.)

File No. 3 6766
Registered No. 91

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Mr. Currier

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX Male 4. COLOR OR RACE White 5. SINGLE, MARRIED, WID-
OWED OR DIVORCED. Married
(Write the word.)

6. DATE OF BIRTH Sept 20 1912
(Month) (Day) (Year)

7. AGE 1 yrs. - mos. 24 ds.
IF LESS than 1 day
how many hrs. or mins.?

8. OCCUPATION
(a) Trade, profession or particular kind of work None.
(b) General nature of industry business, or establishment in which employed (or employer)

9. BIRTHPLACE Pocatello
(State or Country)

10. NAME OF FATHER John Currier

11. BIRTHPLACE OF FATHER St. Louis Mo
(State or Country)

12. MAIDEN NAME OF MOTHER Minnie Hughes

13. BIRTHPLACE OF MOTHER Stall City Mo
(State or Country)

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) John Currier
(Address) Pocatello

15. Filed Oct 15, 1913 OT Street
Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH Oct 14 1913
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from Oct 12 1913 to Oct 14 1913
that I last saw him alive on Oct 14
and that death occurred on the date stated above, at 6 A. M.

The CAUSE OF DEATH* was as follows: Pneumonia

(Duration) yrs. mos. ds.

Contributory (Secondary)

(Duration) yrs. mos. ds.

(Signed) OT Street M. D.
Oct 15 1913 (Address) Pocatello Idaho

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death yrs. mos. days. In the State yrs. mos. days.

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL St. Paul Cemetery DATE OF BURIAL Oct 15 1913

20. UNDERTAKER W. M. Mather ADDRESS Pocatello

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Form V. S. No. 5 20M.1-16-12

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

File No. **3 6767**

Registered No. **107**

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

1. PLACE OF DEATH

Registration District No.

County of **Bannock**

Primary Registration District No.

City of **Pocatello**

(No. **455 N. Grant** St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME **Thie Elliott**

PERSONAL AND STATISTICAL PARTICULARS

3. SEX

Female

4. COLOR OR RACE

White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED

Married
(Write the word)

6. DATE OF BIRTH

Nov. 20 1877
(Month) (Day) (Year)

7. AGE

35 yrs. 11 mos. 12 ds.

IF LESS than 1 day
how many hrs. or mins.

8. OCCUPATION

(a) Trade, profession or particular kind of work

Housewife

(b) General nature of industry, business, or establishment in which employed (or employer)

9. BIRTHPLACE

(State or Country)

Minnesota

10. NAME OF FATHER

11. BIRTHPLACE OF FATHER

(State or Country)

12. MAIDEN NAME OF MOTHER

13. BIRTHPLACE OF MOTHER

(State or Country)

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

Arthur Elliott

(Address)

Pocatello

15.

Filed

Nov 1st

191

3 07 55

Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

Nov. 1 1913
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from **Nov. 1 1913** to **Nov 1st 1913**

that I last saw her alive on **Nov 1st 1913**

and that death occurred on the date stated above, at **9:20 P.M.**

The CAUSE OF DEATH* was as follows:

Gun shot wound (Suicide) of the breast

(Duration) yrs. mos. ds.

Contributory (Secondary)

(Duration) yrs. mos. ds.

(Signed) **Donald M. D.**

Nov 7 1913 (Address) **1211 N. 2nd St.**

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death.....yrs.....mos.....days. In the State.....yrs.....mos.....days.

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL DATE OF BURIAL

St. Clair Cemetery Nov 4 1913

20. UNDERTAKER

ADDRESS

M. M. Mackay Pocatello

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Form V. S. No. 5 20M.1-16-12

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

File No. 3 6768
Registered No. 108

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

1. PLACE OF DEATH

Registration District No.

County of

Primary Registration District No.

City of

(No. Railroad St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

PERSONAL AND STATISTICAL PARTICULARS

3. SEX

4. COLOR OR RACE

5. SINGLE, MARRIED, WIDOWED OR DIVORCED.

6. DATE OF BIRTH

7. AGE

IF LESS than 1 day
how many hrs. or
..... mins.?

8. OCCUPATION

- (a) Trade, profession or particular kind of work
(b) General nature of industry business, or establishment in which employed (or employer)

9. BIRTHPLACE

(State or Country)

10. NAME OF FATHER

11. BIRTHPLACE OF FATHER

(State or Country)

12. MAIDEN NAME OF MOTHER

13. BIRTHPLACE OF MOTHER

(State or Country)

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

(Address)

15.

Filed

191

Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH

17. I HEREBY CERTIFY, That I attended deceased from

that I last saw him alive on

and that death occurred on the date stated above, at M.

The CAUSE OF DEATH* was as follows:

(Duration) yrs. mos. ds.
Contributory
(Secondary)

(Signed) O. B. Steady M. D.
11-1-1913 (Address) Portland, Ore.

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death yrs. mos. days. In the State yrs. mos. days.

Where was disease contracted if not at place of death?

Former or usual residence.

19. PLACE OF BURIAL OR REMOVAL DATE OF BURIAL

20. UNDERTAKER ADDRESS

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Form V. S. No. 5 20M.1-16-12

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH
County of *Bannock*
City of *Pocatello*

Registration District No. _____
Primary Registration District No. _____
(No. *826*, *To Nam* St.)

File No. *3 6769*
Registered No. *109*

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME *Mary Alice Stephenson*

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

8. SEX *Female* 4. COLOR OR RACE *White* 5. SINGLE, MARRIED, WID-
OWED OR DIVORCED. *Single*
(Write the word.)

6. DATE OF BIRTH *June 12 1913*
(Month) (Day) (Year)

7. AGE *4 yrs. 25 mos. ds.* IF LESS than 1 day
how many hrs. or mins.?

8. OCCUPATION
(a) Trade, profession or particular kind of work *None*
(b) General nature of industry business, or establishment in which employed (or employer)

9. BIRTHPLACE *Pocatello*
(State or Country)

10. NAME OF FATHER *J. N. Stephenson*

11. BIRTHPLACE OF FATHER *Salt Lake City*
(State or Country)

12. MAIDEN NAME OF MOTHER *Josie M. Erickson*

13. BIRTHPLACE OF MOTHER *Provo Utah*
(State or Country)

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) *J. N. Stephenson*
(Address) *Pocatello*

15. Filed *Nov 7 1913* *O. P. H. H.*
Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH *Nov 7 1913*
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from *Nov 1 1913* to *Nov 7 1913*,
that I last saw her alive on *Nov 7 1913*,
and that death occurred on the date stated above, at *8:30 A.M.*

The CAUSE OF DEATH* was as follows:

Hydrocephalus
(Duration) _____ yrs. _____ mos. _____ ds.

Contributory (Secondary) _____
(Duration) _____ yrs. _____ mos. _____ ds.

(Signed) *Wm. H. D. Reese* M. D.
Nov 7 1913 (Address) *Provo Utah*

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death _____ yrs. _____ mos. _____ days. In the State _____ yrs. _____ mos. _____ days.

Where was disease contracted if not at place of death? _____

Former or usual residence _____

19. PLACE OF BURIAL OR REMOVAL *St. Lewis cemetery* DATE OF BURIAL *Nov 8 1913*

20. UNDERTAKER *W. H. Walter* ADDRESS *Pocatello Ida*

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Form V. S. No. 5 20M.1-16-12

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH
County of *Blaine*
City of *Soda Springs*
Registration District No. _____
Primary Registration District No. _____
(No. *Roadroad* St.)

File No. *36770*
Registered No. *110*

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME *Andrew J. Messa*

PERSONAL AND STATISTICAL PARTICULARS

3. SEX *Male* 4. COLOR OR RACE *White* 5. SINGLE, MARRIED, WIDOWED OR DIVORCED. *Single*
(Write the word.)

6. DATE OF BIRTH *May 15 1885*
(Month) (Day) (Year)

7. AGE *28 yrs. 5 mos. 16 ds.* IF LESS than 1 day how many hrs. or mins.?

8. OCCUPATION
(a) Trade, profession or particular kind of work *Rd Fireman*
(b) General nature of industry business, or establishment in which employed (or employer) _____

9. BIRTHPLACE *Kansas*
(State or Country)

10. NAME OF FATHER *C. J. Messa*

11. BIRTHPLACE OF FATHER *Indiana*
(State or Country)

12. MAIDEN NAME OF MOTHER *Ellen Pusey*

13. BIRTHPLACE OF MOTHER *Indiana*
(State or Country)

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) *C. J. Messa*
(Address) *Hawking Col.*

15. Filed *Nov 1st 1913* Local Registrar *O. H. Hester*

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH *Nov. 1st 1913*
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from *1913* to *1913*, that I last saw him alive on *1913*, and that death occurred on the date stated above, at *5:30* P. M.

The CAUSE OF DEATH* was as follows:

Railroad Accident

(Duration) yrs. mos. ds.
Contributory (Secondary) _____

(Signed) *O. H. Hester* M. D.

11-1-1913 (Address) *Pocatello Idaho*

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death yrs. mos. days. In the State yrs. mos. days.

Where was disease contracted if not at place of death? _____

Former or usual residence _____

19. PLACE OF BURIAL OR REMOVAL *St. Louis Cemetery* DATE OF BURIAL *Nov. 5 1913*

20. UNDERTAKER *H. H. Walker* ADDRESS *Pocatello Idaho*

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Form V. S. No. 5 20M.1-16-12

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH.

Registration District No.

County of

Primary Registration District No.

File No. 3 6771

City of

(No. 626, N. H. St.)

Registered No. 111

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

Mike Gates Jr.

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX

4. COLOR OR RACE

5. SINGLE, MARRIED, WIDOWED OR DIVORCED.

Male

Indian

(Write the word.)

6. DATE OF BIRTH

Sept 2 1898
(Month) (Day) (Year)

7. AGE

15 yrs. 2 mos. 6 ds.

IF LESS than 1 day
how many hrs. or mins?

8. OCCUPATION

(a) Trade, profession or particular kind of work

(b) General nature of industry business, or establishment in which employed (or employer)

School boy.

9. BIRTHPLACE

(State or Country)

Pocatello

10. NAME OF FATHER

Mike Gates

11. BIRTHPLACE OF FATHER

(State or Country)

Italy

12. MAIDEN NAME OF MOTHER

Rebecca Joseph.

13. BIRTHPLACE OF MOTHER

(State or Country)

Idaho

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

(Address)

Mike Gates
Pocatello Idaho

15.

Filed

Nov 9 1913
Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH

Nov. 8 1913
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from Nov. 5th 1913, to Nov. 8th 1913,

that I last saw him alive on Nov 8th 1913, and that death occurred on the date stated above, at 11 A.M.

The CAUSE OF DEATH* was as follows:

Lobar Pneumonia

(Duration) yrs. mos. 4 ds.

Contributory
(Secondary)

(Duration) yrs. mos. ds.

(Signed)

Nov 10 1913 (Address) Pocatello Idaho

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death... yrs... mos... days. In the State... yrs... mos... days.

Where was disease contracted if not at place of death?

Former or usual residence.

19. PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

St. Clair Cemetery Nov. 16 1913

20. UNDERTAKER

ADDRESS

W. W. Walker Pocatello Idaho

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Form V. S. No. 5 20M.1-16-12

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

File No. 3 6772

Registered No. 112

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

1. PLACE OF DEATH

Registration District No.

County of

Primary Registration District No.

City of

(No.

617, B. Harrison St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

Mary Nanda Rosquist

PERSONAL AND STATISTICAL PARTICULARS

3. SEX

Female

4. COLOR OR RACE

White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED.

Single
(Write the word.)

6. DATE OF BIRTH

Oct

13

1913

(Month)

(Day)

(Year)

7. AGE

— yrs. — mos. 27 ds.

IF LESS than 1 day
how many hrs. or
..... mins.?

8. OCCUPATION

(a) Trade, profession or particular kind of work

None

(b) General nature of industry business, or establishment in which employed (or employer)

9. BIRTHPLACE

(State or Country)

Pocatello

10. NAME OF FATHER

Aug Rosquist

11. BIRTHPLACE OF FATHER

(State or Country)

Sweden

12. MAIDEN NAME OF MOTHER

Sillie Jorgberg

13. BIRTHPLACE OF MOTHER

(State or Country)

Idaho

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

Aug Rosquist

(Address)

Pocatello

15.

Filed

Nov 9 1913

1913

of J. J. J. J.

Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH

Nov

9

1913

(Month)

(Day)

(Year)

17. I HEREBY CERTIFY, That I attended deceased from

Nov 9 1913, to Nov 9 1913,

that I last saw her alive on Nov 9 1913,

and that death occurred on the date stated above, at 11 P. M.

The CAUSE OF DEATH* was as follows:

Encephalitis

(Duration) yrs. mos. ds.

Contributory
(Secondary)

(Duration) yrs. mos. ds.

(Signed)

Wm. J. J. J. J. M. D.

(Address) Pocatello Idaho

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death yrs. mos. days. In the State yrs. mos. days.

Where was disease contracted if not at place of death?

Former or usual residence.

19. PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

St. Vincent Cemetery

1913

20. UNDERTAKER

ADDRESS

Wm. J. J. J. J.

Pocatello Idaho

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Form V. S. No. 5. 10M. 6-20-11.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH.

Registration District No. _____

County of Bannock
City of Orford

Primary Registration District No. _____

(No. On Ranch St.)

File No. 36774

Registered No. 114

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

Landon A. Andrews

If death occurred in a hospital, institution or camp give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX

Male

4. COLOR OR RACE White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED.

Married
(Write the word)

6. DATE OF BIRTH

Jan

(Month)

(Day)

1853
(Year)

7. AGE

60 yrs.

11 mos.

ds.

IF LESS than 1 day
how many hrs. or
min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work
(b) General nature of industry business or establishment in which employed (or employer)

Rancher.

9. BIRTHPLACE

(State or Country)

Utah

10. NAME OF FATHER

Wiley Andrews

11. BIRTHPLACE OF FATHER

(State or Country)

Kennecott

12. MAIDEN NAME OF MOTHER

13. BIRTHPLACE OF MOTHER

(State or Country)

Kennecott

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

Landon A. Andrews

(Address)

Orford Ida

15.

Filed

Dec 1, 1913

Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

Nov

(Month)

28

(Day)

1913
(Year)

17. I HEREBY CERTIFY, That I attended deceased from

1913

to

1913

that I last saw him alive on 1913

and that death occurred on the date stated above, at M.

The CAUSE OF DEATH* was as follows:

Crushed to death by hayrack falling on him

(Duration) yrs. mos. ds.

Contributory
(Secondary)

(Duration) yrs. mos. ds.

(Signed)

Dr. J. H. Corcoran, M. D.
Dec 4, 1913 (Address) Pocatello Idaho

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and 2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place

In the

of death yrs. mos. ds. State yrs. mos. ds.

Where was disease contracted,

If not at place of death?

Former or

usual residence.

19. PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

Orford Ida

1913

20. UNDERTAKER

ADDRESS

M. Maerker

Pocatello Ida

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Form V. S. No. 5 20M.1-16-12

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH _____ Registration District No. 1085
County of Twins Falls Primary Registration District No. _____
City of Twins Falls (No. _____ St.)

File No. 6775

Registered No. _____

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Edythe Gayl Jones

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX Female 4. COLOR OR RACE white 5. SINGLE, MARRIED, WIDOWED OR DIVORCED single

6. DATE OF BIRTH Oct 27 1913
(Month) (Day) (Year)

7. AGE _____ yrs. _____ mos. 5 ds.
IF LESS than 1 day how many _____ hrs. or _____ mins.?

8. OCCUPATION

- (a) Trade, profession or particular kind of work
(b) General nature of industry, business, or establishment in which employed (or employer)

9. BIRTHPLACE

(State or Country) Idaho10. NAME OF FATHER Harry W. Jones11. BIRTHPLACE OF FATHER Iowa

(State or Country)

12. MAIDEN NAME OF MOTHER Edna G. Bachus13. BIRTHPLACE OF MOTHER Iowa

(State or Country)

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Harry W. Jones(Address) Twins Falls

15.

Filed 11-1191 3Local Registrar John H. Ogden

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH

Nov 1 1913
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from

Oct 27 1913, to Nov 1 1913

that I last saw her alive on Oct 31 1913

and that death occurred on the date stated above, at 6 a.m.

The CAUSE OF DEATH* was as follows:

Intestinal obstruction

(Duration) _____ yrs. _____ mos. 1 ds.

Contributory
(Secondary)

(Duration) _____ yrs. _____ mos. _____ ds.

(Signed) Har Wilson

M. D.

Nov 1 1913 (Address) Twins Falls, Idaho

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death _____ yrs. _____ mos. _____ days. In the State _____ yrs. _____ mos. _____ days.

Where was disease contracted if not at place of death?

Former or usual residence.

19. PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

Twins Falls Nov 1 1913

20. UNDERTAKER

ADDRESS

H. J. Grossman Twins Falls

Form V. S. No. 5 20M.1-16-12

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics1. PLACE OF DEATH
County of Twin Falls Registration District No. 1085
City of " " Primary Registration District No. " "
(No. " " St. " ")File No. 6776
Registered No. " "

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Narvon T. Davis

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX Male 4. COLOR OR RACE White 5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.)6. DATE OF BIRTH July 4th 1899
(Month) (Day) (Year)7. AGE 14 yrs. 3 mos. 29 ds.IF LESS than 1 day
how many hrs. or
..... mins.?8. OCCUPATION School boy(a) Trade, profession or particular kind of work
(b) General nature of industry, business, or establishment in which employed (or employer)9. BIRTHPLACE Missouri

(State or Country)

10. NAME OF FATHER A. H. Davis11. BIRTHPLACE OF FATHER Ohio

(State or Country)

12. MAIDEN NAME OF MOTHER Lulu G. Barber13. BIRTHPLACE OF MOTHER Missouri

(State or Country)

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) A. H. Davis(Address) Tiler

15.

Filed 11-3 1913Local Registrar John W. Bughla

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH November 2nd 1913
(Month) (Day) (Year)17. I HEREBY CERTIFY, That I attended deceased from Nov 1 1913, to Nov 2 1913,
that I last saw him alive on Nov 2nd 1913,
and that death occurred on the date stated above, at 10 P.M.The CAUSE OF DEATH* was as follows: appendicitis(Duration) yrs. mos. 7 ds.Contributory
(Secondary)

(Duration) yrs. mos. ds.

(Signed) J. B. Bughla M. D.11/3 1913 (Address) Twin Falls - Idaho

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death yrs. mos. days. In the State yrs. mos. days.

Where was disease contracted if not at place of death?

Former or usual residence.....

19. PLACE OF BURIAL OR REMOVAL TilerDATE OF BURIAL 11-4 191320. UNDERTAKER C. J. CrosbyADDRESS Twin Falls

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Form V. S. No. 5 20M.1-16-12

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH Registration District No. 1085
County of Blaine Primary Registration District No. _____
City of Idaho Falls (No. _____ St.)

File No. 6778
Registered No. _____

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Sarah Fredricks

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX Female 4. COLOR OR RACE White 5. SINGLE, MARRIED, WIDOWED OR DIVORCED. Widow (Print the word.)

6. DATE OF BIRTH June 15 1841
(Month) (Day) (Year)

7. AGE 72 yrs. 4 mos. 11 ds. IF LESS than 1 day how many hrs. or mins.?

8. OCCUPATION
(a) Trade, profession or particular kind of work retired house wife
(b) General nature of industry, business, or establishment in which employed (or employer)

9. BIRTHPLACE (State or Country) Canada

10. NAME OF FATHER William McGee

11. BIRTHPLACE OF FATHER (State or Country) not known

12. MAIDEN NAME OF MOTHER " "

13. BIRTHPLACE OF MOTHER (State or Country) " "

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE (Informant) Benjamin Gardner

(Address) Murrough Ida

15. Filed Nov. 8 1913 Idaho Falls Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH Nov 6 1913
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from Nov 1 1913, to Nov 7 1913, that I last saw him alive on Nov 7 1913, and that death occurred on the date stated above, at 12:00 P.M.
The CAUSE OF DEATH* was as follows:
Senility

(Duration) yrs. mos. ds.

Contributory (Secondary)

(Duration) yrs. mos. ds.

(Signed) W. B. Boyd M. D.

19 (Address)

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death yrs. mos. days. In the State yrs. mos. days.

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL DATE OF BURIAL

Idaho Falls Nov. 8 1913

20. UNDERTAKER ADDRESS

Idaho Falls

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Form V. S. No. 5 20M.1-16-12

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH

Registration District No. 1085

County of

Primary Registration District No.

City of

(No.

St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

File No.

Registered No.

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX

4. COLOR OR RACE

5. SINGLE, MARRIED, WIDOWED OR DIVORCED.

6. DATE OF BIRTH

7. AGE

IF LESS than 1 day
how many hrs. or
..... mins.?

8. OCCUPATION

(a) Trade, profession or
particular kind of work(b) General nature of industry
business, or establishment in
which employed (or employer)

9. BIRTHPLACE

(State or Country)

10. NAME OF
FATHER11. BIRTHPLACE
OF FATHER

(State or Country)

12. MAIDEN NAME
OF MOTHER13. BIRTHPLACE
OF MOTHER

(State or Country)

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

(Address)

15.

Filed

1913

Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

17. I HEREBY CERTIFY, That I attended deceased from

that I last saw her alive on

and that death occurred on the date stated above, at 2:30 P.M.

The CAUSE OF DEATH* was as follows:

Abscess of left lung
caused by blocking of left
bronchus by mucus
(Duration) yrs. mos. 15 ds.Contributory
(Secondary)

(Signed) M. D.

Was 30 1913 (Address) Twin Falls Idaho

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL OR HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death yrs. mos. days. In the State yrs. mos. days.

Where was disease contracted, if not at place of death?

Former or usual residence.

19. PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

20. UNDERTAKER

ADDRESS

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Form V. S. No. 5. 12½ M. 7-24-11

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH. Registration District No. 122
County of Shoshone Primary Registration District No. _____
City of Avery (No. _____, _____ St.)

File No. 6780

Registered No. _____

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

Mary Lally

If death occurred in a hospital, institution or camp give its NAME instead of street and number

PERSONAL AND STATISTICAL PARTICULARS

3. SEX 4. COLOR OR RACE 5. SINGLE, MARRIED, WIDOWED OR DIVORCED.

Female White Single
(Write the word.)

6. DATE OF BIRTH December 12 1909
(Month) (Day) (Year)

7. AGE 3 yrs. 11 mos. 2 ds. IF LESS than 1 day
how many _____ hrs. or _____ min?

8. OCCUPATION

- (a) Trade, profession or particular kind of work
(b) General nature of industry business or establishment in which employed (or employer)

9. BIRTHPLACE (State or Country) Caliente Nevada

10. NAME OF FATHER William Lally

11. BIRTHPLACE OF FATHER (State or Country) Ireland

12. MAIDEN NAME OF MOTHER Mary Duffey

13. BIRTHPLACE OF MOTHER (State or Country) Ireland

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) W. Lally
(Address) Avery Ida

15. Filed Nov 20 1913 W. Mowery
Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

November 14 1913
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased Nov 10th 1913, to Nov 14 1913

that I last saw her alive on Nov 14 and that death occurred on the date stated above, at 52

The CAUSE OF DEATH* was as follows:

acute gastro-enteritis

(Duration) _____ yrs. _____ mos. 6

Contributory (Secondary) _____

(Duration) _____ yrs. _____ mos. _____

(Signed) L. J. Smith
Nov 14 1913 (Address) Avery Ida

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state MEANS OF INJURY; (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place _____ In the _____
of death _____ yrs. _____ mos. _____ ds. State _____ yrs. _____ mos. _____

Where was disease contracted, If not at place of death? _____

Former or usual residence _____

19. PLACE OF BURIAL OR REMOVAL DATE OF BURIAL

Spokane Wash Nov 16 1913

20. UNDERTAKER ADDRESS

Mulcahy St. Marys Ida

CERTIFICATE OF DEATH.

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH.

Registration District No.

County of

Primary Registration District No.

City of

(No. St.)

File No.

Registered No. **6781**

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

Thomas Andrews

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX

4. COLOR OR RACE

5. SINGLE, MARRIED, WIDOWED OR DIVORCED.

*Male**White**Married*
(Write the word.)

6. DATE OF BIRTH.

Sept 22 1839
(Month) (Day) (Year)

7. AGE

*74 Yrs. 2 Mos. 16 ds.*IF LESS than 1 day
how many hrs. or
..... min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work...
(b) General nature of industry, business, or establishment in which employed (or employer).....*Farmer*

9. BIRTHPLACE

(State or Country)

England

10. NAME OF FATHER

William Andrews

11. BIRTHPLACE OF FATHER

(State or Country)

England

12. MAIDEN NAME OF MOTHER

Lewis

13. BIRTHPLACE OF MOTHER

(State or Country)

England

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant)

G. W. Andrews

(Address)

Panna, Ida

15.

Filed

12/1

191

*3**R. J. Reuer*

Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

Dec 7 1913
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from

Found dead in bed 191

that I last saw h..... alive on 191

and that death occurred on the date stated above, at M.

The CAUSE OF DEATH* was as follows:

Write Pneumonia?

(Duration) Yrs. mos. ds.

Contributory
(Secondary)

(Duration) Yrs. mos. ds.

(Signed) *William E. Dally* M. D.

19 (Address)

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death.....yrs.....mos.....days In the State.....yrs.....mos.....days

Where was disease contracted if not at place of death?.....

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

*Panna, Ida**12/1 1913*

20. UNDERTAKER

ADDRESS

*Black & White**Panna*

CERTIFICATE OF DEATH.

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH.

Registration District No.

County of Canyon
City of Parma

Primary Registration District No.

(No. St.)

File No.

Registered No. 6782If death occurs away from
usual residence, give facts
called for under special
information.

2. FULL NAME

Henry T. ShawIf death occurred in a hos-
pital, institution or camp,
give its NAME instead of
street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX

Male

4. COLOR OR RACE

White5. SINGLE, MARRIED, WID-
OWED OR DIVORCED.Married
(Write the word.)

6. DATE OF BIRTH.

Sept - 15 1871
(Month) (Day) (Year)

7. AGE

47 Yrs. 2 Mos. 21 ds.IF LESS than 1 day
how many hrs. or
..... min.?

8. OCCUPATION

(a) Trade, profession or
particular kind of work...
(b) General nature of in-
dustry, business, or estab-
lishment in which employ-
ed (or employer).....Stockman
Sheep dealer

9. BIRTHPLACE

(State or Country)

Iowa10. NAME OF
FATHERWm B. Shaw11. BIRTHPLACE
OF FATHER.

(State or Country)

Missouri12. MAIDEN NAME
OF MOTHERMary Lewis13. BIRTHPLACE
OF MOTHER

(State or Country)

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant)

Mrs Marcella Shaw

(Address)

Parma Ida

15.

Filed

12/7193R. R. Shaw

Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

Dec - 4 1913
(Month) (Day) (Year)17. I HEREBY CERTIFY, That I attended deceased from
date 191... to Dec 4 1913.that I last saw him alive on Dec 4 1913,
and that death occurred on the date stated above, at 9:30 P. M.

The CAUSE OF DEATH* was as follows:

ruptured compensation of
heart(Duration) one day Yrs. mos. ds.Contributory
(Secondary)none

(Duration) Yrs. mos. ds.

(Signed) William E. M. D.Dec 19/3 (Address) Parma, Idaho*State the DISEASE* CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1)
MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.18. LENGTH OF RESIDENCE (For Hospitals, Institutions,
Transients or Recent Residents.)

At place of death.....yrs.....mos.....days In the State.....yrs.....mos.....days

Where was disease contracted
if not at place of death?.....Former or
usual residence

19. PLACE OF BURIAL OR REMOVAL

Parma Ida

DATE OF BURIAL

12/7 1913

20. UNDERTAKER

Shaw & Co

ADDRESS

Parma

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS
should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement
of OCCUPATION is very important. See instructions on back of certificate.

MARGIN RESERVED FOR BINDING

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Form V. S. No. 5. 12½M.7-24-11

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH
County of Boer Lake
City of Bloomington

Registration District No. 53
Primary Registration District No. 2132
(No., St.)

File No. 6819
Registered No.

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Christian Carl Jensen

If death occurred in a hospital, institution or camp give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX male 4. COLOR OR RACE white 5. SINGLE, MARRIED, WIDOWED OR DIVORCED. married
(Write the word.)

6. DATE OF BIRTH march 9 1847
(Month) (Day) (Year)

7. AGE 66 yrs. 5 mos. 16 ds. IF LESS than 1 day how many hrs. or min?

8. OCCUPATION
(a) Trade, profession or particular kind of work. mason + farming
(b) General nature of industry business or establishment in which employed (or employer)

9. BIRTHPLACE (State or Country) Denmark

10. NAME OF FATHER unknown

11. BIRTHPLACE OF FATHER (State or Country) Denmark

12. MAIDEN NAME OF MOTHER unknown

13. BIRTHPLACE OF MOTHER (State or Country) Denmark

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Mrs. C.C. Jensen
(Address) Bloomington

15. August 27 1913 W. L. Rich
Filed Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH Aug 25 1913
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from Feb 15 1913, to Aug 23 1913
that I last saw him alive on Aug 23 1913
and that death occurred on the date stated above, at 2:20 P. M.

The CAUSE OF DEATH* was as follows:

Apoplexy + paralysis

(Duration) yrs. 6 mos. ds.
Contributory arterio-sclerosis
(Secondary)

(Duration) 2 yrs. mos. ds.
(Signed) Dr. A. Hottel M. D.
Aug 25 1913 (Address) Bloomington

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; (2) whether ACCIDENTAL, SUICIDAL OR HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place In the
of death yrs. mos. ds. State yrs. mos. ds.
Where was disease contracted,
If not at place of death?
Former or
usual residence

19. PLACE OF BURIAL OR REMOVAL DATE OF BURIAL
Bloomington Aug 27 1913

20. UNDERTAKER ADDRESS
J. Jacobsen Bloomington

WRITE PLAINLY, WITH UNFADING INK.—THIS IS A PERMANENT RECORD.
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

FORM V. S. No. 5-25 M. 1-16-13

CERTIFICATE OF DEATH.

1. PLACE OF DEATH.

County of Oneida
City of Malad

If death occurs away from usual residence, give facts called for under special information.

Registration District No. 26
Primary Registration District No. 2069
(No. _____ St.)

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

File No. 6822
Registered No. 87

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME

Ellen S Price

PERSONAL AND STATISTICAL PARTICULARS

3. SEX

Female

4. COLOR OR RACE

White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED.

Married
(Write the word.)

6. DATE OF BIRTH.

May 26 1887
(Month) (Day) (Year)

7. AGE

26 Yrs. 6 Mos. 26 ds.

IF LESS than 1 day
how many.....hrs. or
.....min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work...
(b) General nature of industry, business, or establishment in which employed (or employer).....

Housewife

9. BIRTHPLACE

(State or Country)

Harriman Ut.

10. NAME OF FATHER

Edwin Reese

11. BIRTHPLACE OF FATHER

(State or Country)

Wales

12. MAIDEN NAME OF MOTHER

Mary A. J. Farmer

13. BIRTHPLACE OF MOTHER

(State or Country)

Salt Lake City Ut.

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant)

Mary A. J. Reese

(Address)

Emmett Idaho

15.

Filed

12-24

1913

D C Ray

Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

Dec 22 1913
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from

Dec 1 1913 to Dec 22 1913
that I last saw her alive on Dec 21 1913

and that death occurred on the date stated above, at 3 1/2 M.

The CAUSE OF DEATH* was as follows:

Pneumonia

(Duration) Yrs. mos. 4 ds.

Contributory (Secondary) Chronic Bronchitis

(Duration) 3 yrs. 2 mos. ds.

(Signed) D C Ray M. D.

12-23-13 (Address) Malad City Idaho

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death.....yrs.....mos.....days. In the State.....yrs.....mos.....days

Where was disease contracted if not at place of death?.....

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

Malad Idaho Dec 24 1913

20. UNDERTAKER

ADDRESS

W. S. Johnson Malad Ida.

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Form V. S. No. 5 20M.1-16-12

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH

Registration District No. 26

County of Oneida

Primary Registration District No. 2069

City of Malad

(No. _____ St.)

File No. 6823

Registered No. 86

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

Anna Nelson

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX

4. COLOR OR RACE

5. SINGLE, MARRIED, WIDOWED OR DIVORCED.

fe

white

(Write the word.)

6. DATE OF BIRTH

10 24 1913
(Month) (Day) (Year)

7. AGE

2 yrs. 15 mos. 15 ds.

IF LESS than 1 day
how many _____ hrs. or
_____ mins.?

8. OCCUPATION

(a) Trade, profession or particular kind of work

none

(b) General nature of industry, business, or establishment in which employed (or employer)

9. BIRTHPLACE

(State or Country)

Idaho

10. NAME OF FATHER

David Nelson

11. BIRTHPLACE OF FATHER

(State or Country)

Utah

12. MAIDEN NAME OF MOTHER

Katherine Pierce

13. BIRTHPLACE OF MOTHER

(State or Country)

Idaho

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

John Pierce

(Address)

15.

Filed 12-10 1914

W C Ray

Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH

Dec 9 1913
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from

Dec 9 1913 to Dec 9 1913

that I last saw her alive on Dec 8 1913

and that death occurred on the date stated above, at 11 AM.

The CAUSE OF DEATH* was as follows:

acute gastric fuleritis

(Duration) _____ yrs. _____ mos. 3 ds.

Contributory
(Secondary)

(Duration) _____ yrs. _____ mos. _____ ds.

(Signed) W C Ray M. D.

12-10-14 (Address) Malad city

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death.....yrs.....mos.....days. In the State.....yrs.....mos.....days.

Where was disease contracted if not at place of death?.....

Former or usual residence.....

19. PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

St John

12-13 1913

20. UNDERTAKER,

ADDRESS

W C Johnson

Malad

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Form V. S. No. 5 20M.1-16-12

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics
File No. **6826**
Registered No. **19**

1. PLACE OF DEATH. Registration District No. **86**
County of **Washington** Primary Registration District No. **2112**
City of **Weiser** (No. _____, St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME **Baby Erickson**

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX **Female** 4. COLOR OR RACE **White** 5. SINGLE, MARRIED, WIDOWED OR DIVORCED. **Single**
(Write the word.)

6. DATE OF BIRTH **Oct - 13 - 1913**
(Month) (Day) (Year)

7. AGE **yrs. 2 mos. 6 ds.**
IF LESS than 1 day how many hrs. or mins.?

8. OCCUPATION
(a) Trade, profession or particular kind of work **none**
(b) General nature of industry business, or establishment in which employed (or employer)

9. BIRTHPLACE **Weiser Idaho**
(State or Country)

10. NAME OF FATHER **Andy Erickson**

11. BIRTHPLACE OF FATHER **Sweden**
(State or Country)

12. MAIDEN NAME OF MOTHER **Emma Rambo**

13. BIRTHPLACE OF MOTHER **State of Oregon**
(State or Country)

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) **Andy Erickson**
(Address) **Weiser Ida**

15. Filed **Dec 20th** 1913 **D. R. Hamrick**
Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH **Dec - 20 - 1913**
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from **October 13 1913**, to **December 20 1913**, that I last saw her alive on **Oct 13 1913**, and that death occurred on the date stated above, at **3:30 A.M.**

The CAUSE OF DEATH* was as follows:

Spina Bifida

(Duration) yrs. mos. ds.
Contributory (Secondary) **none**

(Duration) yrs. 3 mos. ds.
(Signed) **James A. Young** M. D.
12/20 1913 (Address) **Weiser, Ida.**

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death yrs. mos. days. In the State yrs. mos. days.
Where was disease contracted if not at place of death?
Former or usual residence.

19. PLACE OF BURIAL OR REMOVAL **Galloway Cemetery** DATE OF BURIAL **12/21 1913**

20. UNDERTAKER **R. W. Bowen** ADDRESS **Weiser, Ida.**

Form V. S. No. 5 20M.1-16-12

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics1. PLACE OF DEATH.
County of Washington
City of WenatcheeRegistration District No. 86
Primary Registration District No. 1010
(No. 11-st East St.)File No. 6827
Registered No. 151

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

Henry Gibbons

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX Male 4. COLOR OR RACE White 5. SINGLE, MARRIED, WIDOWED OR DIVORCED. Single
(Write the word.)

6. DATE OF BIRTH

April - 1 - 1840
(Month) (Day) (Year)

7. AGE

70 yrs. 8 mos. — ds.IF LESS than 1 day
how many hrs. or
..... mins.?

8. OCCUPATION

(a) Trade, profession or particular kind of work
(b) General nature of industry business, or establishment in which employed (or employer)Farmer

9. BIRTHPLACE

(State or Country)

Castile Co., New York

10. NAME OF FATHER

Gibbons

11. BIRTHPLACE OF FATHER

(State or Country)

Ireland

12. MAIDEN NAME OF MOTHER

13. BIRTHPLACE OF MOTHER

(State or Country)

Ireland

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

(Address)

Mrs Maude Graham
Wenatchee, Ida

15.

Filed

Dec 4th 1913 M. R. Hamilton
Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH

Dec - 2 - 1913
(Month) (Day) (Year)17. I HEREBY CERTIFY, That I attended deceased from Sept 1913, to Dec 2nd 1913, that I last saw him alive on Dec 1st 1913, and that death occurred on the date stated above, at 9 P.M.

The CAUSE OF DEATH* was as follows:

Apoplexy

(Duration) yrs. mos. ds.

Contributory
(Secondary)

(Duration) yrs. mos. ds.

(Signed) M. R. Hamilton

M. D.

12/3 1913 (Address) Wenatchee, Idaho

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death yrs. mos. days. In the State yrs. mos. days.

Where was disease contracted if not at place of death?

Former or usual residence.....

19. PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

Wenatchee, Ida. 12/5 1913

20. UNDERTAKER

ADDRESS

A. G. Cordell Wenatchee, Ida.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Form V. S. No. 5. 12½M. 7-24-11

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics
File No. **6828**
Registered No. **20**

1. PLACE OF DEATH. Registration District No. **96**
County of **Washington** Primary Registration District No. **2112**
City of **Missoula** (No. **9 miles up Manns Creek St.**)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

Patrick Lynch

If death occurred in a hospital, institution or camp give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX **Male** 4. COLOR OR RACE **White** 5. SINGLE, MARRIED, WIDOWED OR DIVORCED. **Married**
(Write the word.)

6. DATE OF BIRTH **March - 17 - 1830**
(Month) (Day) (Year)

7. AGE **83** yrs. **9** mos. **13** ds. IF LESS than 1 day how many.....hrs. or.....min?

8. OCCUPATION

- (a) Trade, profession or particular kind of work.
(b) General nature of industry business or establishment in which employed (or employer)

Farmer

9. BIRTHPLACE
(State or Country)

Ireland

10. NAME OF FATHER

Michael Lynch

11. BIRTHPLACE OF FATHER
(State or Country)

Ireland

12. MAIDEN NAME OF MOTHER

Margaret Terkin

13. BIRTHPLACE OF MOTHER
(State or Country)

Ireland

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) **William Lynch**
(Address) **Missoula Ida**

15.

Filed **Dec 31** 1913 **D. R. Hannah**
Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH **Dec - 30 - 1913**
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from **12/10** 1913, to **12/10** 1913

that I last saw him alive on **12/10** 1913 and that death occurred on the date stated above, at **8 P. M.**

The CAUSE OF DEATH* was as follows:

Old age + chronic intestinal putrefaction complicating chronic gastric catarrh
(Duration) **8 or more yrs.** ds.

Contributory **Age**
(Secondary) (Duration) **—** yrs. **—** mos. **—** ds.

(Signed) **D. T. Anderson** M. D.
12/31 1913, (Address) **Missoula**

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; (2) whether ACCIDENTAL, SUICIDAL OR HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place In the
of death.....yrs.....mos.....ds. State.....yrs.....mos.....ds.
Where was disease contracted,
If not at place of death?
Former or usual residence

19. PLACE OF BURIAL OR REMOVAL DATE OF BURIAL

Missoula, Idaho **Jan - 1 - 1914**
20. UNDERTAKER **A. G. Ordell** ADDRESS **Missoula, Ida.**

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Form V. S. No. 5. 12½ M. 7-24-11

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics
File No. **6831**
Registered No.

1. PLACE OF DEATH. Registration District No.
County of Power Primary Registration District No.
City of Rockland (No. St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Elisabeth Bailey

If death occurred in a hospital, institution or camp give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX Female 4. COLOR OR RACE White 5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.)

6. DATE OF BIRTH February 12 1861
(Month) (Day) (Year)

7. AGE 52 yrs 9 mos 11 ds. IF LESS than 1 day how many hrs. or min?

8. OCCUPATION

(a) Trade, profession or particular kind of work. Housewife
(b) General nature of industry business or establishment in which employed (or employer)

9. BIRTHPLACE

(State or Country) Wisconsin

10. NAME OF FATHER

Martin L. Bremagham

11. BIRTHPLACE OF FATHER

(State or Country) New York

12. MAIDEN NAME OF MOTHER

Mary Tompkins

13. BIRTHPLACE OF MOTHER

(State or Country) New York

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) J. E. Bailey
(Address) Rockland, Ida.

15. Nov 26 1913 R. F. Hoob
Filed Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH November 25 1913
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from September 9 1913, to November 25 1913 that I last saw him alive on November 21 1913 and that death occurred on the date stated above, at 11 A.M.

The CAUSE OF DEATH* was as follows:

Typhoid fever

(Duration) yrs. 2 mos. ds.
Contributory (Secondary) Hypostatic pneumonia
(Duration) yrs. mos. ds.
(Signed) V. G. Leary M. D.
November 26 1913 (Address) Rockland, Idaho

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place In the
of death yrs. mos. ds. State yrs. mos. ds.
Where was disease contracted,
If not at place of death?
Former or usual residence.

19. PLACE OF BURIAL OR REMOVAL DATE OF BURIAL

Rockland 11/26 1913
20. UNDERTAKER ADDRESS
Roy Russell Pocatello

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Form V. S. No. 5 20M.1-16-12

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics
File No. **6832**

1. PLACE OF DEATH

Registration District No. **79**County of **Bonner**Primary Registration District No. **2156**City of **Meadow Creek**

(No. _____, _____ St.)

Registered No. _____

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

Hiram Nichols Calder

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX

4. COLOR OR RACE

5. SINGLE, MARRIED, WIDOWED OR DIVORCED.

married
(Write the word.)

6. DATE OF BIRTH

Sept 25th**1852**

(Month)

(Day)

(Year)

7. AGE

61 yrs. **2** mos. **21** ds.IF LESS than 1 day
how many _____ hrs. or
_____ mins.?

8. OCCUPATION

(a) Trade, profession or particular kind of work

Stenographer & Rancher

(b) General nature of industry business, or establishment in which employed (or employer)

9. BIRTHPLACE

(State or Country)

Ill

10. NAME OF FATHER

Hiram Calder

11. BIRTHPLACE OF FATHER

(State or Country)

Scotland

12. MAIDEN NAME OF MOTHER

not certain

13. BIRTHPLACE OF MOTHER

(State or Country)

Scotland

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

Hilig Calder

(Address)

Spokane Wn

15.

Filed

Dec. 31 - 1913**S. E. Mc**

Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

Dec**16****1913**

(Month)

(Day)

(Year)

17. I HEREBY CERTIFY, That I attended deceased from

191

to

191

that I last saw h. alive on

191and that death occurred on the date stated above, at **10:30 A.M.**

The CAUSE OF DEATH* was as follows:

**Death without medical attendance.
(Probable cerebral hemorrhage.)
(Arrived two hours after death.)**

(Duration)

yrs.

mos.

ds.

Contributory

(Secondary)

(Duration)

yrs.

mos.

ds.

(Signed)

L. J. Stauffer

M. D.

Dec 31 1913. (Address) **Bonnors Ferry, Idaho**

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death

yrs.

mos.

days

In the State

yrs.

mos.

days

Where was disease contracted if not at place of death?

Former or usual residence

Spokane, Wash.

19. PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

Portland Ore**See 23rd 1913**

20. UNDERTAKER

ADDRESS

Gilman Co**Spokane Wn****Bonner**

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Form V. S. No. 5 20M.1-16-12

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics
File No. **6833**

1. PLACE OF DEATH.

Registration District No. **11**County of **Bannock**Primary Registration District No. **2048**City of **Chesleyfield**

(No. _____ St.)

Registered No. **1**

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME **Kimball Rigby**

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX **m**4. COLOR OR RACE **w**

5. SINGLE, MARRIED, WIDOWED OR DIVORCED.

Single
(Write the word.)

6. DATE OF BIRTH

Oct**14****1909**

(Month)

(Day)

(Year)

7. AGE

4 yrs. **1** mos. **22** ds.IF LESS than 1 day
how many _____ hrs. or
_____ mins.?

8. OCCUPATION

(a) Trade, profession or particular kind of work

none

(b) General nature of industry business, or establishment in which employed (or employer)

9. BIRTHPLACE

(State or Country)

Chesleyfield

10. NAME OF FATHER

Alfred Rigby

11. BIRTHPLACE OF FATHER

(State or Country)

Utah

12. MAIDEN NAME OF MOTHER

Lillian Wright

13. BIRTHPLACE OF MOTHER

(State or Country)

Utah

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

Alfred Rigby

(Address)

Chesleyfield

15.

Filed

Jan 14, 1914

Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH

Dec**9****1913**

(Month)

(Day)

(Year)

17. I HEREBY CERTIFY, That I attended deceased from

Dec 5**1913**

to

Dec 8**1913**that I last saw him alive on **Dec 8** **1913**and that death occurred on the date stated above, at **5 P.** M.

The CAUSE OF DEATH* was as follows:

Pseudo-membranous**Scarlatinal****tracheo-pneumonia**

(Duration)

yrs.

mos.

6 ds.

Contributory

Scarlet Fever

(Secondary)

(Duration)

yrs.

mos.

2 wks ds.

(Signed)

Russell J. Smith M. D.**Dec 10, 1913**

(Address)

Bannock

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place

of death.....yrs.....mos.....days.

In the

State.....yrs.....mos.....days.

Where was disease contracted if not at place of death?

Former or usual residence.....

19. PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

Bannock**Dec 11, 1913**

20. UNDERTAKER

ADDRESS

H. C. Johnson**Bannock**

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Form V. S. No. 5. 12½M.7-24-11

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics
File No. 6835
Registered No. 5

1. PLACE OF DEATH. Registration District No. 11
County of Bannock Primary Registration District No. 2048
City of Perry (No. _____, _____ St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Joseph Lanner

If death occurred in a hospital, institution or camp give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX Boy 4. COLOR OR RACE White 5. SINGLE, MARRIED, WIDOWED OR DIVORCED. Baby
(Write the word.)

6. DATE OF BIRTH Oct 26 1913
(Month) (Day) (Year)

7. AGE _____ yrs. _____ mos. 21 ds. IF LESS than 1 day how many _____ hrs. or _____ min?

8. OCCUPATION None
(a) Trade, profession or particular kind of work.
(b) General nature of industry business or establishment in which employed (or employer)

9. BIRTHPLACE Perry Idaho
(State or Country)

10. NAME OF FATHER Lahn Alma Lanner

11. BIRTHPLACE OF FATHER Tuella Utah
(State or Country)

12. MAIDEN NAME OF MOTHER Delila Warner

13. BIRTHPLACE OF MOTHER Benjamin Utah
(State or Country)

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE (Informant) Mary Longgreen
(Address) Treasureton Idaho

15. Filed Jan 19 1914 E. E. Roney Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH Nov 15 1913
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from 191____, to 191____

that I last saw h. _____ alive on 191____

and that death occurred on the date stated above, at _____ M.

The CAUSE OF DEATH* was as follows:

Ignited Lanner
Heart Disease

_____ (Duration) _____ yrs. _____ mos. _____ ds.

Contributory (Secondary) _____

_____ (Duration) _____ yrs. _____ mos. _____ ds.

(Signed) E. E. Roney M. D.
Jan 19 1914 (Address) Idaho

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place _____ In the _____
of death _____ yrs. _____ mos. _____ ds. State _____ yrs. _____ mos. _____ ds.

Where was disease contracted, If not at place of death? _____

Former or usual residence _____

19. PLACE OF BURIAL OR REMOVAL DATE OF BURIAL

Perry Idaho Nov 16 1913

20. UNDERTAKER ADDRESS

J. Lanner Idaho

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Form V. S. No. 5 20M.1-16-12

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH.

Registration District No. 11

County of

Primary Registration District No. 2048

City of

(No. St.)

File No. 6837

Registered No. 3

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Thomas J. Harrison

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX *m* 4. COLOR OR RACE *w* 5. SINGLE, MARRIED, WIDOWED OR DIVORCED *married*
(Write the word.)

6. DATE OF BIRTH *Oct 24 1850*
(Month) (Day) (Year)

7. AGE *63* yrs. *1* mos. *6* ds.
IF LESS than 1 day how many hrs. or mins.?

8. OCCUPATION
(a) Trade, profession or particular kind of work *Stonemason*
(b) General nature of industry business, or establishment in which employed (or employer)

9. BIRTHPLACE *England*
(State or Country)

10. NAME OF FATHER *Ralph Harrison*

11. BIRTHPLACE OF FATHER *England*
(State or Country)

12. MAIDEN NAME OF MOTHER *Mary Jane Edwards*

13. BIRTHPLACE OF MOTHER *England*
(State or Country)

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) *Ralph Harrison*
(Address) *Bancroft, Ida*

15. Filed *Jan 14 1914* *E. E. Kacy*
Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH *Nov 30 1913*
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That ~~I attended~~ deceased ~~from~~ *1913* to *1913*,
that I last saw him ~~alive on~~ *1913*,
and that death occurred on the date stated above, at *6 P.M.*

The CAUSE OF DEATH* was as follows:

Diabetes

(Duration) *2* yrs. mos. ds.
Contributory *Coma*
(Secondary)

(Duration) yrs. mos. ds.
(Signed) *R. J. Smith* M. D.
19..... (Address) *Bancroft, Ida*

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death yrs. mos. days. In the State yrs. mos. days.

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL *Bancroft* DATE OF BURIAL *Dec 4 1914*

20. UNDERTAKER *R. C. Johnson* ADDRESS *Bancroft*

Form V. S. No. 5 20M.1-16-12

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH

Registration District No.

County of

Primary Registration District No.

City of

(No. 752 2nd Ave. St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

File No.

Registered No.

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX

4. COLOR OR RACE

5. SINGLE, MARRIED, WIDOWED OR DIVORCED

6. DATE OF BIRTH

7. AGE

IF LESS than 1 day
how many hrs. or
..... mins.?

8. OCCUPATION

(a) Trade, profession or particular kind of work

(b) General nature of industry business, or establishment in which employed (or employer)

9. BIRTHPLACE

(State or Country)

10. NAME OF FATHER

11. BIRTHPLACE OF FATHER

(State or Country)

12. MAIDEN NAME OF MOTHER

13. BIRTHPLACE OF MOTHER

(State or Country)

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

(Address)

15.

Filed

1913

Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

17. I HEREBY CERTIFY, That I attended deceased from

that I last saw him alive on

and that death occurred on the date stated above, at.....M.

The CAUSE OF DEATH* was as follows:

(Duration) yrs. mos. ds.

Contributory (Secondary)

(Duration) yrs. mos. ds.

(Signed)

M. D. (Address)

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death yrs. mos. days. In the State yrs. mos. days.

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL DATE OF BURIAL

20. UNDERTAKER

ADDRESS

MARGIN RESERVED FOR BINDING

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Form V. S. No. 5 20M.1-16-12

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics
File No. 3 6839
Registered No. 119

1. PLACE OF DEATH. Registration District No. _____
County of Bannock Primary Registration District No. _____
City of Pocatello (No. 440 N Buchanan St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Frederick Brown

PERSONAL AND STATISTICAL PARTICULARS

3. SEX Male 4. COLOR OR RACE White 5. SINGLE, MARRIED, WIDOWED OR DIVORCED. married
(Write the word.)

6. DATE OF BIRTH Exact date unknown 885
(Month) (Day) (Year)

7. AGE 28 yrs. near as known mos. ds. IF LESS than 1 day many hrs. or

8. OCCUPATION Labourer
(a) Trade, profession or particular kind of work.
(b) General nature of industry business, or establishment in which employed (or employer)

9. BIRTHPLACE H. Cariloria
(State or Country)

10. NAME OF FATHER Jack Brown

11. BIRTHPLACE OF FATHER unknown
(State or Country)

12. MAIDEN NAME OF MOTHER unknown

13. BIRTHPLACE OF MOTHER unknown
(State or Country)

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) D. V. Puffer
(Address) City

15. Filed Dec 8 1913 J. B. Steady
Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH Dec 8 1913
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from Nov 28 1913 to Dec 8 1913,
that I last saw him alive on Dec 7 1913
and that death occurred on the date stated above, at 7 A.M.

The CAUSE OF DEATH* was as follows:
Pneumonia

(Duration) yrs. mos. 9 ds.
Contributory alcoholism
(Secondary)
(Signed) H. A. Castle M. D.
Dec 8 1913 (Address) Pocatello Idaho

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death. yrs. mos. days. In the State. yrs. mos. days.
Where was disease contracted if not at place of death?
Former or usual residence.

19. PLACE OF BURIAL OR REMOVAL Alexandria N. C. DATE OF BURIAL Dec 12 1913.
20. UNDERTAKER W. B. Steady ADDRESS City

Form V. S. No. 5 20M.1-16-12

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH.

Registration District No.

County of

Primary Registration District No.

City of

(No. 229 S. Fairfield St.)

File No.

Registered No.

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX

4. COLOR OR RACE

5. SINGLE, MARRIED, WIDOWED OR DIVORCED.

6. DATE OF BIRTH

7. AGE

IF LESS than 1 day
how many hrs. or
mins.?

8. OCCUPATION

- (a) Trade, profession or particular kind of work
-
- (b) General nature of industry, business, or establishment in which employed (or employer)

9. BIRTHPLACE

(State or Country)

10. NAME OF FATHER

11. BIRTHPLACE OF FATHER

(State or Country)

12. MAIDEN NAME OF MOTHER

13. BIRTHPLACE OF MOTHER

(State or Country)

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

(Address)

15.

Filed

191

Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH

17. I HEREBY CERTIFY, That I attended deceased from

Dec 7 1913, to Dec 8 1913,

that I last saw him alive on Dec 7 1913,

and that death occurred on the date stated above, at 8:30 P. M.

The CAUSE OF DEATH* was as follows:

(Duration) yrs. mos. ds.

Contributory
(Secondary)

(Duration) yrs. mos. ds.

(Signed) M. D.

(Address)

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death.....yrs.....mos.....days. In the State.....yrs.....mos.....days.

Where was disease contracted if not at place of death?

Former or usual residence.....

19. PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

20. UNDERTAKER

ADDRESS

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Form V. S. No. 5 20M.1-16-12

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

File No. 3 6841Registered No. 117

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

1. PLACE OF DEATH.

Registration District No.

County of Bannock

Primary Registration District No.

City of Pocatello(No. 17, North Harrison St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME L. A. Rayle

PERSONAL AND STATISTICAL PARTICULARS

3. SEX

4. COLOR OR RACE

5. SINGLE, MARRIED, WIDOWED OR DIVORCED.

femaleWhiteMarried
(Write the word.)

6. DATE OF BIRTH

Jan 14 1866
(Month) (Day) (Year)

7. AGE

47 yrs. 10 mos. 22 ds.

IF LESS than 1 day
how many hrs. or
..... mins.?

8. OCCUPATION

(a) Trade, profession or particular kind of work

(b) General nature of industry business, or establishment in which employed (or employer)

Wife

9. BIRTHPLACE

(State or Country)

Indiana

10. NAME OF FATHER

William Langans

11. BIRTHPLACE OF FATHER

(State or Country)

Ireland

12. MAIDEN NAME OF MOTHER

Welch

13. BIRTHPLACE OF MOTHER

(State or Country)

York State

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

(Address)

L. A. Rayle
17 North Harrison Ave

15.

Filed Dec 8, 19131913W. J. Seed
Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH

1261913

(Month)

(Day)

(Year)

17. I HEREBY CERTIFY, That I attended deceased from

May 1913, to Dec. 6 1913,that I last saw her alive on Dec. 6 1913,and that death occurred on the date stated above, at 4:40 PM.

The CAUSE OF DEATH* was as follows:

Carcinoma cervix uteri(Duration) 1 yrs. mos. ds.Contributory
(Secondary)(Duration) 1 yrs. mos. ds.

(Signed)

12/8 1913 (Address) Pocatello Idaho

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death yrs. mos. days. In the State yrs. mos. days.

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

Mountain View Dec-8- 1913

20. UNDERTAKER

ADDRESS

Heranford Schumacher city

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Form V. S. No. 5 20M.1-16-12

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH

Registration District No.

County of

Primary Registration District No.

City of

(No. 1049, St. Lincoln St.)

File No.

Registered No.

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX

4. COLOR OR RACE

5. SINGLE, MARRIED, WIDOWED OR DIVORCED.

6. DATE OF BIRTH

7. AGE

IF LESS than 1 day
how many hrs. or
mins.

8. OCCUPATION

(a) Trade, profession or particular kind of work
(b) General nature of industry business, or establishment in which employed (or employer)

9. BIRTHPLACE

(State or Country)

10. NAME OF FATHER

11. BIRTHPLACE OF FATHER

(State or Country)

12. MAIDEN NAME OF MOTHER

13. BIRTHPLACE OF MOTHER

(State or Country)

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

(Address)

15.

Filed

191

Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

17. I HEREBY CERTIFY, That I attended deceased from

that I last saw him alive on

and that death occurred on the date stated above, at

The CAUSE OF DEATH* was as follows:

(Duration) yrs. mos. ds.

Contributory Exposure 18 mile ride

(Secondary) in wagon 6 hrs, during crisis

(Duration) yrs. mos. ds.

(Signed) W. J. Howard, M. D.

12/10 1913 (Address) Pocatello, Idaho

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death yrs. mos. days. In the State yrs. mos. days.

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

20. UNDERTAKER

ADDRESS

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Form V. S. No. 5 20M.1-16-12

CERTIFICATE OF DEATH

 State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

File No. 288 6843

Registered No. _____

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

1. PLACE OF DEATH.

Registration District No. _____

County of AdaPrimary Registration District No. 1004City of Boise(No. 713 1/2 - 7 - 8 St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Clorothy Laverna Williams

PERSONAL AND STATISTICAL PARTICULARS

3. SEX

4. COLOR OR RACE

5. SINGLE, MARRIED, WIDOWED OR DIVORCED.

Female WhiteMarried
(Write the word.)

6. DATE OF BIRTH

Nov. 28 1913
(Month) (Day) (Year)

7. AGE

 _____ yrs. _____ mos. 5 ds.

 IF LESS than 1 day
how many _____ hrs. or
_____ mins.

8. OCCUPATION

 (a) Trade, profession or particular kind of work
(b) General nature of industry, business, or establishment in which employed (or employer)
House

9. BIRTHPLACE

(State or Country)

Boise Idaho

10. NAME OF FATHER

George Williams

11. BIRTHPLACE OF FATHER

(State or Country)

Idaho

12. MAIDEN NAME OF MOTHER

Ora Roberts

13. BIRTHPLACE OF MOTHER

(State or Country)

Kansas

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

Geo. L. Williams

(Address)

713 1/2 - 7 - 8

15.

Filed 12 - 3

1913

W. Parker

Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH

Dec. 3 1913
(Month) (Day) (Year)

 17. I HEREBY CERTIFY, That I attended deceased from Nov 28 1913, to Dec. 3 1913,

 that I last saw her alive on Dec 3 1913,

 and that death occurred on the date stated above, at 4:15 M.

The CAUSE OF DEATH* was as follows:

Convulsions

(Duration) _____ yrs. _____ mos. _____ ds.

Contributory (Secondary)

Cerebral Hemorrhage

(Duration) _____ yrs. _____ mos. _____ ds.

(Signed)

John B. Smith M. D.(Address) Boise Idaho

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death _____ yrs. _____ mos. _____ days. In the State _____ yrs. _____ mos. _____ days.

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

Mount Hill Cemetery Dec 3 1913

20. UNDERTAKER

ADDRESS

Fry & Summers Boise Idaho

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Form V. S. No. 5 20M.1-16-12

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics
File No. 289 6844
Registered No. 227

1. PLACE OF DEATH.

Registration District No. 2County of AdaPrimary Registration District No. 1044City of Boise(No. 112 E Banuock St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Edward Chester

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX

Male

4. COLOR OR RACE

White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED.

Single
(Write the word.)

6. DATE OF BIRTH

Don't know1875

(Month)

(Day)

(Year)

7. AGE

38

yrs. — mos. — ds.

IF LESS than 1 day
how many hrs. or
mins.?

8. OCCUPATION

(a) Trade, profession or particular kind of work

miner

(b) General nature of industry business, or establishment in which employed (or employer)

9. BIRTHPLACE

(State or Country)

Kansas City Mo

10. NAME OF FATHER

Don't know

11. BIRTHPLACE OF FATHER

(State or Country)

Don't know

12. MAIDEN NAME OF MOTHER

Don't know

13. BIRTHPLACE OF MOTHER

(State or Country)

Don't know

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

Dorothy Selby

(Address)

Boise

15.

Filed 12-61913W. J. Barker

Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH

Dec 2nd

(Month)

(Day)

1913

17. I HEREBY CERTIFY, That I attended deceased from

April 1st 1913, to Dec 1st 1913that I last saw him alive on Dec 1st 1913and that death occurred on the date stated above, at 5 A.M.

The CAUSE OF DEATH* was as follows:

Pulmonary Tuberculosis(Duration) 1 yrs. — mos. — ds.

Contributory (Secondary)

Empyema(Duration) 1 yrs. — mos. — ds.

(Signed)

R. E. Selby

M. D.

19

(Address)

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place

of death...yrs....mos. 5 days.

In the

State...yrs....mos....days.

Where was disease contracted if not at place of death?

Boise

Former or usual residence

Near Boise 4 yrs

PLACE OF BURIAL OR REMOVAL DATE OF BURIAL

Mountain View Cemetery Co. Mo. 12/6 1913

20. UNDERTAKER

ADDRESS

Schubert & Widensadun Boise

MARGIN RESERVED FOR BINDING
WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Form V. S. No. 5 20M.1-16-12

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics
File No. 290 6845
Registered No. 290 6845

PLACE OF DEATH

Registration District No. 2

County of Ada

Primary Registration District No. 1004

City of Boise

(No. 1010, Franklin St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

James K Loree

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX

Male

4. COLOR OR RACE

White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED.

Married
(Write the word.)

6. DATE OF BIRTH

Sept 5 1852
(Month) (Day) (Year)

7. AGE

61 yrs. 2 mos. 28 ds.

IF LESS than 1 day
how many hrs. or
..... mins.

8. OCCUPATION

(a) Trade, profession or particular kind of work

Hardware Dealer

(b) General nature of industry business, or establishment in which employed (or employer)

9. BIRTHPLACE

(State or Country)

Michigan

10. NAME OF FATHER

Nathan Loree

11. BIRTHPLACE OF FATHER

(State or Country)

Penn.

12. MAIDEN NAME OF MOTHER

Unknown

13. BIRTHPLACE OF MOTHER

(State or Country)

Unknown

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

Maria Loree

(Address)

1010 Franklin St.

15.

Filed

12-4

1913

W. S. Parker

Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

Dec 3 1913
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from Dec 3 1913, to Dec 3 1913

that I last saw him alive on Dec 3 1913

and that death occurred on the date stated above, at 8:40 AM

The CAUSE OF DEATH* was as follows:

Cerebral apoplexy

(Duration) yrs. mos. ds.

Contributory
(Secondary)

arterio sclerosis

(Duration) yrs. mos. ds.

(Signed)

Jos. R. Numbers M. D.

Dec 3 1913 (Address) Boise, Idaho

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place

of death yrs. mos. days.

In the

State yrs. mos. days.

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

Marion Hill Cemetery

Dec 4 1913

20. UNDERTAKER

ADDRESS

Schubert & Widengrad

Boise

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Form V. S. No. 5 20M.1-16-12

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH.

Registration District No. 2County of AdaPrimary Registration District No. 1004City of Boise(No. 1106, E. Jefferson St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Walter B. BushFile No. 296Registered No. 6846

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX

4. COLOR OR RACE

5. SINGLE, MARRIED, WIDOWED OR DIVORCED.

6. DATE OF BIRTH

7. AGE

3 yrs. 3 mos. 6 ds.IF LESS than 1 day
how many hrs. or
..... mins.?

8. OCCUPATION

(a) Trade, profession or particular kind of work

(b) General nature of industry business, or establishment in which employed (or employer)

9. BIRTHPLACE

(State or Country)

10. NAME OF FATHER

11. BIRTHPLACE OF FATHER

(State or Country)

12. MAIDEN NAME OF MOTHER

13. BIRTHPLACE OF MOTHER

(State or Country)

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

(Address)

15.

Filed 12 - 4 1913

Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH

Dec41913

(Month)

(Day)

(Year)

17. I HEREBY CERTIFY, That I attended deceased from

Nov 1913, to Dec 3 1913,that I last saw him alive on Dec 3 1913,and that death occurred on the date stated above, at 2 A.M.

The CAUSE OF DEATH* was as follows:

Colitis

(Duration)

yrs.

mos.

ds.

Contributory

(Secondary)

(Duration)

yrs.

mos.

ds.

(Signed)

1913 1913 (Address) Boise, Ida.

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place

of death yrs. mos. days.

In the

State yrs. mos. days.

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

Harris Hill Cemetery12/4 1913

20. UNDERTAKER

ADDRESS

Schreiber & SiderupBoise, Idaho

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Form V. S. No. 5 20M.1-16-12

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH

Registration District No. 7

County of Ada

Primary Registration District No. 1004

File No. 294

City of Boise

(No. 410, State Idaho St.)

Registered No. 6847

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Pursey Althea Lewis

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX

Female

4. COLOR OR RACE

White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED.

Married
(Write the word.)

6. DATE OF BIRTH

Jan 8 1855
(Month) (Day) (Year)

7. AGE

58 yrs. 10 mos. 3 ds.

IF LESS than 1 day
how many hrs. or mins.?

8. OCCUPATION

(a) Trade, profession or particular kind of work

Housekeeper

(b) General nature of industry business, or establishment in which employed (or employer)

9. BIRTHPLACE

(State or Country)

Oregon

10. NAME OF FATHER

David Powers

11. BIRTHPLACE OF FATHER

(State or Country)

Louis Bush

12. MAIDEN NAME OF MOTHER

Laura

13. BIRTHPLACE OF MOTHER

(State or Country)

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

(Address)

J. V. Lewis
Eagle Boise

15.

Filed 12-5 1913 M. S. Parker
Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH

Dec 4 1913
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from

Nov 6 1913 to Dec 4 1913

that I last saw her alive on Dec 4 1913

and that death occurred on the date stated above, at 10 P. M.

The CAUSE OF DEATH* was as follows:

Lobar pneumonia-bilateral

(Duration) yrs. mos. ds.

Contributory Acute hemorrhagic pericarditis
(Secondary)

(Duration) yrs. mos. ds.

(Signed) Maurice Henry Johnson M. D.

12/5 1913 (Address) Boise, Idaho

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death Staphouse Hosp yrs. mos. days. In the State yrs. mos. days.

Where was disease contracted if not at place of death?

Former or usual residence Eagle, Idaho

19. PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

Marion Hill Cemetery 7/6 1913

20. UNDERTAKER

ADDRESS

Schreibers Undertaker Boise Idaho

MARGIN RESERVED FOR BINDING
WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Form V. S. No. 5 20M.1-16-12

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH.

Registration District No. 7

County of Latah

Primary Registration District No. 1004

City of Boise

(No. 916 Fort St.)

File No. 295 6848

Registered No. _____

If death occurs away from usual residence, give facts called for under special instruction.

2. FULL NAME

Emilia Kaufman

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX

4. COLOR OR RACE

5. SINGLE, MARRIED, WIDOWED OR DIVORCED

Female White

Married
(Write the word.)

6. DATE OF BIRTH

June 21 1839
(Month) (Day) (Year)

7. AGE

74 yrs. 5 mos. 14 ds.

IF LESS than 1 day
how many hrs. or
..... mins.?

8. OCCUPATION

(a) Trade, profession or particular kind of work

Housework

(b) General nature of industry business, or establishment in which employed (or employer)

9. BIRTHPLACE

(State or Country)

Germany

10. NAME OF FATHER

Earnest B. Rothman

11. BIRTHPLACE OF FATHER

(State or Country)

France

12. MAIDEN NAME OF MOTHER

Rose T. Lawrence

13. BIRTHPLACE OF MOTHER

(State or Country)

France

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

Mr. G. B. Bloomquist

(Address)

Boise, Idaho

15.

Filed 12-6 1913

W. B. Parker

Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH

Dec. 5 1913
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from

Oct 1 1913 to Dec 5 1913

that I last saw him alive on Dec 5 1913

and that death occurred on the date stated above, at 1 P.M.

The CAUSE OF DEATH* was as follows:

Senility

(Duration) yrs. mos. ds.

Contributory arterio sclerosis
(Secondary)

(Duration) yrs. mos. ds.

(Signed) J. S. Springer M. D.

Dec 5 1913 (Address) Boise

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death yrs. mos. days. In the State yrs. mos. days.

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

Morris Hill

Dec. 7 1913

20. UNDERTAKER

ADDRESS

Jay & Summers

Boise, Idaho

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Form V. S. No. 5 20M.1-16-12

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics
File No. 296 6849
Registered No. _____

1. PLACE OF DEATH.

Registration District No. 2

County of Ada

Primary Registration District No. 1004

City of Boise

(No. 1806, Ridenbaugh St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

Helary L. La Rand

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX

4. COLOR OR RACE

5. SINGLE, MARRIED, WIDOWED OR DIVORCED.

Female, White

Single
(Write the word.)

6. DATE OF BIRTH

Oct. 10 1872
(Month) (Day) (Year)

7. AGE

41 yrs. 1 mos. 25 ds.

IF LESS than 1 day
how many hrs. or
..... mins.?

8. OCCUPATION

(a) Trade, profession or particular kind of work

(b) General nature of industry, business, or establishment in which employed (or employer)

Housework

9. BIRTHPLACE

(State or Country)

Wisconsin

10. NAME OF FATHER

C. J. Rand

11. BIRTHPLACE OF FATHER

(State or Country)

West Va.

12. MAIDEN NAME OF MOTHER

Nancy Hicks

13. BIRTHPLACE OF MOTHER

(State or Country)

Canada

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

(Address)

C. J. Rand
Boise, Ida.

15.

Filed 12-8 1913

M. S. Parker
Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

Dec 5 1913
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from

Nov. 30 1913 to Dec 5 1913

that I last saw him alive on Dec 4 1913

and that death occurred on the date stated above, at 9 a. m.

The CAUSE OF DEATH* was as follows:

Pneumonia (Toxic)

(Duration) yrs. mos. ds.

Contributory (Secondary)

Chronic Rheumatism with heart disease

(Duration) yrs. mos. ds.

(Signed)

12-6 1913 (Address) Boise

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death yrs. mos. days. In the State yrs. mos. days.

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

Morris Hill Cemetery

Dec. 7 1913

20. UNDERTAKER

ADDRESS

J. J. Summers

Boise, Ida.

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Form V. S. No. 5 20M.1-16-12

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics
File No. 297 6850
Registered No. _____

1. PLACE OF DEATH

Registration District No. 2

County of Ada

Primary Registration District No. 1004

City of Boise

(No. 410, State _____ St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Charles Oster

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX

Male

4. COLOR OR RACE

White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED.

Married
(Write the word.)

6. DATE OF BIRTH

December 29 1887
(Month) (Day) (Year)

7. AGE

85 yrs. 11 mos. 9 ds.

IF LESS than 1 day
how many _____ hrs. or
_____ mins.

8. OCCUPATION

(a) Trade, profession or particular kind of work

Sculptor

(b) General nature of industry business, or establishment in which employed (or employer)

9. BIRTHPLACE

(State or Country)

Baden, Germany

10. NAME OF FATHER

Unknown

11. BIRTHPLACE OF FATHER

(State or Country)

Germany

12. MAIDEN NAME OF MOTHER

Unknown

13. BIRTHPLACE OF MOTHER

(State or Country)

Germany

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

John P. Adelman

(Address)

221 West Jeff St. Boise Ida

15.

Filed

12-8

1913

W. S. Parker

Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH

Dec. 8 1913
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from

Nov 2 1913, to Dec 6 1913,

that I last saw him alive on Dec 5 1913,

and that death occurred on the date stated above, at M.

The CAUSE OF DEATH* was as follows:

Apoplexy

(Duration) _____ yrs. _____ mos. _____ ds.

Contributory
(Secondary)

(Duration) _____ yrs. _____ mos. _____ ds.

(Signed)

Ed. Coates M. D.

19

(Address)

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place St. Alphonsus Hospital in the
of death _____ yrs. _____ mos. 33 days. State _____ yrs. _____ mos. _____ days.

Where was disease contracted if not at place of death?

Former or usual residence 618 State St. Boise Ida

19. PLACE OF BURIAL OR REMOVAL DATE OF BURIAL

Monro Hill Cemetery Dec. 9 1913

20. UNDERTAKER

ADDRESS

Schier & Hidenfaden Boise

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Form V. S. No. 5 20M.1-16-12

Cancer

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH.

Registrar's Office No. 2

County of Ada

Primary District No. 1004

City of Boise

(No. 1004 N. 194 St.)

File No. 298 6851

Registered No.

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

John Noble

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX

Male

4. COLOR OR RACE

White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED.

Married
(Write the word.)

6. DATE OF BIRTH

Sept 11 1833
(Month) (Day) (Year)

7. AGE

80 yrs. 2 mos. 27 ds.

IF LESS than 1 day
how many hrs. or mins.?

8. OCCUPATION

(a) Trade, profession or particular kind of work

Retired

(b) General nature of industry business, or establishment in which employed (or employer)

9. BIRTHPLACE

(State or Country)

Cornwall Canada

10. NAME OF FATHER

Jacob Noble

11. BIRTHPLACE OF FATHER

(State or Country)

Vermont

12. MAIDEN NAME OF MOTHER

Catherine Farling

13. BIRTHPLACE OF MOTHER

(State or Country)

Canada

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

(Address)

15.

Filed

12-10

1913

M. S. Parker

Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH

Dec 8 1913
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from

about Oct 30 1913 to Dec 8 1913

that I last saw him alive on Dec 5 1913

and that death occurred on the date stated above, at 6 P. M.

The CAUSE OF DEATH* was as follows:

Senility

(Duration) yrs. mos. ds.

Contributory (Secondary)

Cancer of rectum

(Duration) yrs. mos. ds.

(Signed)

J. S. Springer M. D.
Dec 9 1913 (Address) Boise

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death.....yrs.....mos.....days. In the State.....yrs.....mos.....days.

Where was disease contracted if not at place of death?

Former or usual residence.

19. PLACE OF BURIAL OR REMOVAL DATE OF BURIAL

Morris Hill Cemetery 12/10 1913

20. UNDERTAKER

ADDRESS

Schreibers Sidewalk Boise

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Form V. S. No. 5 20M.1-16-12

CERTIFICATE OF DEATH

1. PLACE OF DEATH.

County of Ada
City of Boise

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

Registration District No. 2

Primary Registration District No. 1004

(No. 716 1/2 Main St.)

F. C. Brown

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

File No. 300 6853

Registered No. _____

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX

Male

4. COLOR OR RACE

White

5. SINGLE, MARRIED, ID-OWED OR DIVORCED.

Married
(Write the word.)

6. DATE OF BIRTH

Aug 21 1875
(Month) (Day) (Year)

7. AGE

38 yrs. 4 mos. 17 ds.

IF LESS than 1 day
how many hrs. or
..... mins.?

8. OCCUPATION

(a) Trade, profession or particular kind of work

Contractor

(b) General nature of industry business, or establishment in which employed (or employer)

9. BIRTHPLACE

(State or Country)

Ref.

10. NAME OF FATHER

Mr. C. C. Brown

11. BIRTHPLACE OF FATHER

(State or Country)

Am.

12. MAIDEN NAME OF MOTHER

Martha Gardner

13. BIRTHPLACE OF MOTHER

(State or Country)

Am.

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

Mrs. F. C. Brown

(Address)

Caldwell

15.

Filed 12 - 11 1913

McParker

Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH

Dec. 9 1913
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from

death 1913 to Dec. 9 1913
that I last saw him alive about 1913

and that death occurred on the date stated above, at Boise

The CAUSE OF DEATH* was as follows:

Inquest pending as to cause of death

(Duration) yrs. mos. ds.

Contributory
(Secondary)

(Duration) yrs. mos. ds.

(Signed) Adolph Schmitz Boise
19..... (Address) Boise

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death yrs. mos. days. In the State yrs. mos. days.

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

Morris Hill Cemetery Dec. 12 1913

20. UNDERTAKER

ADDRESS

Schmitz & Hidenfaden Boise

Form V. S. No. 5 20M.1-16-12

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH.

Registration District No. 2County of AdaPrimary Registration District No. 1004City of Bonne(No. 1210, East Jefferson St.)File No. 392-6854

Registered No. _____

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Joseph Henry Clavison

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX

4. COLOR OR RACE

5. SINGLE, MARRIED, WIDOWED OR DIVORCED.

Male WhiteSingle
(Write the word.)

6. DATE OF BIRTH

May 25 1897
(Month) (Day) (Year)

7. AGE

16 yrs. 6 mos. 14 ds.

IF LESS than 1 day
how many hrs. or
..... mins?

8. OCCUPATION

(a) Trade, profession or particular kind of work

(b) General nature of industry business, or establishment in which employed (or employer)

Employer in
Saw mill

9. BIRTHPLACE

(State or Country)

Nebraska

10. NAME OF FATHER

W. H. Clavison

11. BIRTHPLACE OF FATHER

(State or Country)

Indiana

12. MAIDEN NAME OF MOTHER

Eugene Humphrey

13. BIRTHPLACE OF MOTHER

(State or Country)

Indiana

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

J. H. Clavison(Address) 1210 E. Jeff St

15.

Filed 12-12 1913M. S. Parker

Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH

12 12 1913
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from

12/11 1913, to 12/12 1913that I last saw him alive on 12/11 1913and that death occurred on the date stated above, at 10:09 M.

The CAUSE OF DEATH* was as follows:

Shock. Leg crushed by
tree falling on him(Duration) yrs. mos. 2 ds.

Contributory

(Secondary)

(Duration) yrs. mos. ds.

(Signed) Fred A. Tilling Jr M. D.12/13 1913 (Address) Tulsa

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death yrs. mos. days. In the State yrs. mos. days.

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

Morris Hill Cemetery Dec 14 1913

20. UNDERTAKER

ADDRESS

Jay & Summers Bonne Id.

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Form V. S. No. 5 20M.1-16-12

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics
File No. 3036855
Registered No. _____

1. PLACE OF DEATH.

Registration District No. 2

County of Ada

Primary Registration District No. 1004

City of Boise

(No. 716 1/2 Main St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Fred Wallis

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX

4. COLOR OR RACE

5. SINGLE, MARRIED, WIDOWED OR DIVORCED.

Male

White

Single
(Write in word.)

6. DATE OF BIRTH

Not obtainable

(Month)

(Day)

(Year)

7. AGE

about 45 years

..... yrs.

..... mos.

..... ds.

IF LESS than 1 day
how many hrs. or
..... mins.?

8. OCCUPATION

(a) Trade, profession or particular kind of work

Laborer

(b) General nature of industry business, or establishment in which employed (or employer)

9. BIRTHPLACE

(State or Country)

Salem Mo.

10. NAME OF FATHER

Not obtainable

11. BIRTHPLACE OF FATHER

(State or Country)

a

q

12. MAIDEN NAME OF MOTHER

a

a

13. BIRTHPLACE OF MOTHER

(State or Country)

a

a

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

Adolph Schreiber

(Address)

15.

Filed 12-13

1913

W. B. Parker

Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

Dec.

9th

1913

(Month)

(Day)

(Year)

17. I HEREBY CERTIFY, That I attended deceased from

dead

1913

Dec.

1913

that I last saw h alive on Dec. 9th 1913

and that death occurred on the date stated above, at 4 M.

The CAUSE OF DEATH* was as follows:

Inquest pending cause of death

(Duration)

yrs.

mos.

ds.

Contributory

(Secondary)

(Duration)

yrs.

mos.

ds.

(Signed)

Adolph Schreiber

19

(Address)

Boise

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death

yrs.

mos.

days.

In the State

yrs.

mos.

days.

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

Monis Hill Cemetery

Dec. 14 1913

20. UNDERTAKER

ADDRESS

Schreiber & Widengaden

Boise

RECORDING INK—THIS IS A PERMANENT RECORD. Entries should be carefully supplied. AGE should be stated EXACTLY. PHYSICIAN'S CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact state-
MENT is very important. See instructions on back of certificate.

Form V. S. No. 5 20M.1-16-12

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH

Registration District No. 2

County of Ada

Primary Registration District No. 1004

City of Boise

(No. St. Alphonsus Hosp. St.)

File No. 2436856

Registered No. 304

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Albert B. Cummings

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX

4. COLOR OR RACE

5. SINGLE, MARRIED, WID-
OWED OR DIVORCED

Male, White

married
(Write the word.)

6. DATE OF BIRTH

Not obtainable 1830
(Month) (Day) (Year)

7. AGE

83 yrs. mos. ds.

IF LESS than 1 day
how many hrs. or
..... mins.?

8. OCCUPATION

(a) Trade, profession or
particular kind of work
(b) General nature of industry
business, or establishment in
which employed (or employer)

Carpenter

9. BIRTHPLACE

(State or Country)

Ohio

10. NAME OF
FATHER

Not obtainable

11. BIRTHPLACE
OF FATHER

(State or Country)

Not obtainable

12. MAIDEN NAME
OF MOTHER

Not obtainable

13. BIRTHPLACE
OF MOTHER

(State or Country)

Not obtainable

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

Howard Campbell

(Address)

1301 S. 4th

12-15

1913

M. Parker

Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

Dec 15 1913
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from

Oct 11 1913, to Dec 16 1913

that I last saw him alive on Dec 16 1913

and that death occurred on the day above, at 11 P

The CAUSE OF DEATH* was as follows:

Septic infection from
operation on bladder

(Duration) yrs. mos. ds.

Contributory
(Secondary)

(Duration) yrs. mos. ds.

(Signed) E. S. O'Connell M. D.

19 (Address)

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death yrs. mos. days. In the State yrs. mos. days.

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

Belleview Idg

Dec 18 1913

20. UNDERTAKER

ADDRESS

J. & S. Cummings

Boise Idg

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Form V. S. No. 5 20M.1-16-12

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics
File No. 306 6858
Registered No. _____

1. PLACE OF DEATH

Registration District No. 2County of AdaPrimary Registration District No. 1004City of Boise(No. 1313, No. 5th St. St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME William A Roice

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX

4. COLOR OR RACE

5. SINGLE, MARRIED, WIDOWED OR DIVORCED.

MaleWhiteSingle (Write in word.)

6. DATE OF BIRTH

Oct191853

(Month)

(Day)

(Year)

7. AGE

60 yrs. 1 mos. 26 ds.IF LESS than 1 day
how many hrs. or
..... mins.?

8. OCCUPATION

(a) Trade, profession or particular kind of work

(b) General nature of industry business, or establishment in which employed (or employer)

Librarian

9. BIRTHPLACE

(State or Country)

New York

10. NAME OF FATHER

Not obtainable

11. BIRTHPLACE OF FATHER

(State or Country)

Not obtainable

12. MAIDEN NAME OF MOTHER

Not obtainable

13. BIRTHPLACE OF MOTHER

(State or Country)

Not obtainable

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

(Address)

Albert Slater
Boise Idaho

15.

Filed 12 — 18 1913W. D. Parker

Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH

12171913

(Month)

(Day)

(Year)

17. I HEREBY CERTIFY, That I attended deceased from

1913, to Dec 17 1913that I last saw him alive on Dec 7 1913and that death occurred on the date stated above, at 2 P. M.

The CAUSE OF DEATH* was as follows:

Septic meningitis
Embolus from

(Duration) yrs. mos. ds.

Contributory (Secondary)

Endocarditis

(Duration) yrs. mos. ds.

(Signed)

Fred J. Fenniger M. D.12/18 1913

(Address)

Idaho

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death yrs. mos. days. In the State yrs. mos. days.

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

Morris Hill CemeteryDec 18 1913

20. UNDERTAKER

ADDRESS

Fry & Summers Boise Idaho

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Form V. S. No. 5 20M.1-16-12

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics
File No. 306859
Registered No.

1. PLACE OF DEATH.

Registration District No. 2

County of Ada

Primary Registration District No. 1004

City of Boise

(No. 1611 N. 7th St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

Honorah Job

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX

F.

4. COLOR OR RACE

White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED.

Married
(Write the word.)

6. DATE OF BIRTH

July 12th 1871
(Month) (Day) (Year)

7. AGE

42 yrs. 5 mos. 7 ds.

IF LESS than 1 day
how many hrs. or
..... mins.?

8. OCCUPATION

(a) Trade, profession or particular kind of work

Housekeeper

(b) General nature of industry business, or establishment in which employed (or employer)

9. BIRTHPLACE

(State or Country)

Montana.

10. NAME OF FATHER

Thos. Linehan

11. BIRTHPLACE OF FATHER

(State or Country)

Ireland.

12. MAIDEN NAME OF MOTHER

Margaret Linehan

13. BIRTHPLACE OF MOTHER

(State or Country)

American

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

Jonathan Job

(Address)

Challis, Idaho.

15.

Filed 12-20 1913

M. S. Parker

Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH

Dec 19th 1913
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from

Oct 2nd 1913, to Dec 19th 1913that I last saw her alive on Dec 18th 1913and that death occurred on the date stated above, at 10¹⁵ AM.

The CAUSE OF DEATH* was as follows:

Myocarditis

(Duration) yrs. mos. ds.

Contributory
(Secondary)

(Duration) yrs. mos. ds.

(Signed)

M. D.

12/19/13 (Address) Boise, Ida.

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death yrs. mos. days. In the State yrs. mos. days.

Where was disease contracted if not at place of death?

Former or usual residence.

19. PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

Challis Idaho.

12/21 1913

20. UNDERTAKER

ADDRESS

Schreiber & Sidenfader

Boise, Idaho

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Form V. S. No. 5 20M.1-16-12

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics
File No. 3486860
Registered No. _____

1. PLACE OF DEATH.

Registration District No. _____

County of AdaPrimary Registration District No. 1004City of Boise(No. 1208, Port St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Matilda J. Black

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX

Female

4. COLOR OR RACE

white

5. SINGLE, MARRIED, WIDOWED OR DIVORCED.

Divorced
(Write the word.)

6. DATE OF BIRTH

June271857

(Month)

(Day)

(Year)

7. AGE

56 yrs. 5 mos. 23 ds.IF LESS than 1 day
how many hrs. or
..... mins.?

8. OCCUPATION

(a) Trade, profession or

particular kind of work retired

(b) General nature of industry

business, or establishment in

which employed (or employer)

9. BIRTHPLACE

(State or Country) Ut Pleasant Iowa

10. NAME OF FATHER

Nathaniel Harrison

11. BIRTHPLACE OF FATHER

(State or Country) Quincy West Virginia

12. MAIDEN NAME OF MOTHER

Sarah Jane Long

13. BIRTHPLACE OF MOTHER

(State or Country) Illinois

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Alvin J. Hall(Address) Boise, Idaho

15.

Filed 12-20 1913M. S. Parker

Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH

Dec191913

(Month)

(Day)

(Year)

17. I HEREBY CERTIFY, That I attended deceased from

Aug 81913, toDec 191913,

that I last saw her alive on

Dec 181913,and that death occurred on the date stated above, at 3 A.M.

The CAUSE OF DEATH* was as follows:

Probably carcinoma of liverAutopsy refused

(Duration)

yrs.

mos.

ds.

Contributory

(Secondary)

(Duration)

yrs.

mos.

ds.

(Signed) M. H. Falkner

M. D.

140 1913(Address) Boise, Idaho

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place

of death.....yrs.....mos.....days.

In the

State.....yrs.....mos.....days.

Where was disease contracted
if not at place of death?.....

Former or

usual residence.....

19. PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

Morris Hill Cemetery12/191913

20. UNDERTAKER

ADDRESS

Schreiber & VidengadenBoise, Idaho

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Form V. S. No. 5 20M.1-16-12

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics
File No. 6861
Registered No. 309

1. PLACE OF DEATH.

Registration District No. 2County of AdaPrimary Registration District No. 1004City of Boise(No. Boise & R. Dr. St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

Thomas Means

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX

Male

4. COLOR OR RACE

White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED.

Married

(Write the word.)

6. DATE OF BIRTH

Aug 28 1834
(Month) (Day) (Year)

7. AGE

79 yrs. 3 mos. 22 ds.

IF LESS than 1 day
how many hrs. or
..... mins.?

8. OCCUPATION

(a) Trade, profession or particular kind of work
(b) General nature of industry, business, or establishment in which employed (or employer)

Retired

9. BIRTHPLACE

(State or Country)

Iowa

10. NAME OF FATHER

Not obtainable

11. BIRTHPLACE OF FATHER

(State or Country)

Germany

12. MAIDEN NAME OF MOTHER

Not obtainable

13. BIRTHPLACE OF MOTHER

(State or Country)

" "

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

L. V. Means

(Address)

Boise, Ida.

15.

Filed 12-22 1913

M. Parker

Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH

12 19 1913
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from 12-17 1913, to 12-19 1913.

that I last saw him alive on 12-19 1913.

and that death occurred on the date stated above, at 11 P.M.

The CAUSE OF DEATH* was as follows:

Bright's disease - Interstitial nephritis

(Duration) 2 yrs. mos. ds.

Contributory
(Secondary)

(Duration) yrs. mos. ds.

(Signed)

M. T. Sullivan M. D.

142 1913 (Address) Boise, Ida.

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death yrs. mos. days. In the State yrs. mos. days.

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

Morris Hill (Cor. Plod. Morris Hill) Dec. 23 1913

20. UNDERTAKER

ADDRESS

Schreiber & Sons Boise

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Form V. S. No. 5 20M.1-16-12

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH.

Registration District No. 2County of AdaPrimary Registration District No. 1004City of Boise(No. Boise

St.)

File No. 3406801Registered No. 216862

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

John A. Honck

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX

male

4. COLOR OR RACE

white

5. SINGLE, MARRIED, WIDOWED OR DIVORCED.

married
(Write the word.)

6. DATE OF BIRTH

Nov.1890

(Month)

(Day)

(Year)

7. AGE

43 yrs.

mos.

ds.

IF LESS than 1 day
how many hrs. or
..... mins.?

8. OCCUPATION

- (a) Trade, profession or particular kind of work
(b) General nature of industry business, or establishment in which employed (or employer)

Painter

9. BIRTHPLACE

(State or Country)

Ohio

10. NAME OF FATHER

Frederick Honck

11. BIRTHPLACE OF FATHER

(State or Country)

Germany

12. MAIDEN NAME OF MOTHER

Augusta Scholt

13. BIRTHPLACE OF MOTHER

(State or Country)

Germany

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

R. M. McCracken

(Address)

Boise Ida

15.

Filed 12-23

1913

M. S. Parker

Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH

Dec23rd

1913

(Month)

(Day)

(Year)

17. I HEREBY CERTIFY, That I attended deceased from

Oct 10th

1913 to

Dec 22

1913

that I last saw him alive on Dec 22 1913.and that death occurred on the date stated above, at M.

The CAUSE OF DEATH* was as follows:

Sarcoma

(Duration)

yrs.

mos.

ds.

Contributory

(Secondary)

(Duration)

yrs.

mos.

ds.

(Signed)

J. S. Baugh

M. D.

Dec 23 1913

(Address)

Boise

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place

of death

yrs.

mos.

days.

In the

State

yrs.

mos.

days.

Where was disease contracted if not at place of death?

Former or

usual residence

19. PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

Morris Hill Cemetery12/24 1913

20. UNDERTAKER

ADDRESS

Vickrey & SchenckBoisevagile

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Form V. S. No. 5 20M.1-16-12

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics
File No. 314 6863
Registered No. _____

1. PLACE OF DEATH.

Registration District No. 2County of AdaPrimary Registration District No. 1004City of Boise(No. 612, W. State St.)

If death occurs away from usual residence, give facts called for under special information.

2.

FULL NAME

Edward Gard Percy

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX

M

4. COLOR OR RACE

W

5. SINGLE, MARRIED, WIDOWED OR DIVORCED.

Married
(Write the word.)

6. DATE OF BIRTH

Aug.1839

(Month)

(Day)

(Year)

7. AGE

74 yrs.

mos.

ds.

IF LESS than 1 day
how many hrs. or
..... mins.?

8. OCCUPATION

(a) Trade, profession or particular kind of work

Rancher

(b) General nature of industry business, or establishment in which employed (or employer)

9. BIRTHPLACE

(State or Country)

Yorkshire Eng

10. NAME OF FATHER

Joe Percy

11. BIRTHPLACE OF FATHER

(State or Country)

England

12. MAIDEN NAME OF MOTHER

not obtainable

13. BIRTHPLACE OF MOTHER

(State or Country)

not obtainable

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

A L Percy

(Address)

Highland Valley, Ada Co.

15.

Filed 12-231913M. Starker

Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH

Dec221913

(Month)

(Day)

(Year)

17. I HEREBY CERTIFY, That I attended deceased from

Dec 211913

to

Dec 221913that I last saw him alive on Dec 22 1913and that death occurred on the date stated above, at 10 P.M.

The CAUSE OF DEATH* was as follows:

mitral regurgitation

(Duration)

yrs.

mos.

ds.

Contributory (Secondary)

nephritis-chronic

(Duration)

yrs.

mos.

ds.

(Signed)

M. W. Hallman M.D.12/23 1913

(Address)

Boise, Idaho

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death

..... yrs. mos. days.

In the State

..... yrs. mos. days.

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

Harriet Hill Cemetery12/241913

20. UNDERTAKER

ADDRESS

Schreiber & Sidergaden Boise, IdahoHallman

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Form V. S. No. 5 20M.1-16-12

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics
File No. 312-6864

1. PLACE OF DEATH

Registration District No. 2

County of Ada

Primary Registration District No. 1004

City of Boise

(No. 410, State Idaho St.)

Registered No. _____

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Johnnie Greenstreet

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX M

4. COLOR OR RACE W.

5. SINGLE, MARRIED, WIDOWED OR DIVORCED Single
(Write the word.)

6. DATE OF BIRTH Sept 1898
(Month) (Day) (Year)

7. AGE 15 yrs. - 0 mos. - 0 ds.

IF LESS than 1 day
how many hrs. or
..... mins.

8. OCCUPATION

- (a) Trade, profession or particular kind of work
(b) General nature of industry, business, or establishment in which employed (or employer)

Student

9. BIRTHPLACE

(State or Country)

Ada County, Idaho

10. NAME OF FATHER

John W. Greenstreet

11. BIRTHPLACE OF FATHER

(State or Country)

Macon Co. Mo.

12. MAIDEN NAME OF MOTHER

Minnie Lewis

13. BIRTHPLACE OF MOTHER

(State or Country)

Ada Co. Idaho

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

Mrs Fannie M. Faley

(Address)

Rupert, Idaho

15.

Filed 12-26 1913

M. Parker

Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH Dec 26 1913
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from Dec 24 1913, to Dec 26 1913, that I last saw him alive on Dec 26 1913, and that death occurred on the date stated above, at 4 P. M.

The CAUSE OF DEATH* was as follows:

Empyema - right chest

(Duration) yrs. 7 mos. ds.

Contributory (Secondary)

(Duration) yrs. mos. ds.

(Signed) Maurice Henry Zallman M. D.

12/26/1913 (Address) Boise, Idaho

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Guest Residents.) St. Alphonsus Hosp.

At place of death mos. 3 days. State yrs. mos. days.

Where was disease contracted if not at place of death?

Former or usual residence

Rupert, Idaho

19. PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

Rupert, Idaho 12/26 1913

20. UNDERTAKER

ADDRESS

Schreiber & Siderfaden Boise Idaho

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Form V. S. No. 5 20M.1-16-12

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics
File No. 316865

PLACE OF DEATH.

Registration District No. 2

County of Idaho

Primary Registration District No. 1004

City of Boise

(No 704, N 7th St.)

Registered No. _____

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Therese Ruth Baker

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX Female

4. COLOR OR RACE W.

5. SINGLE, MARRIED, WIDOWED OR DIVORCED. Single
(Write the word.)

6. DATE OF BIRTH Dec 26 1913
(Month) (Day) (Year)

7. AGE _____ yrs. _____ mos. _____ ds.

IF LESS than 1 day
how many _____ hrs. or
_____ mins.

8. OCCUPATION

(a) Trade, profession or particular kind of work _____

(b) General nature of industry, business, or establishment in which employed (or employer) _____

9. BIRTHPLACE

(State or Country) Boise Ida

10. NAME OF FATHER George Baker

11. BIRTHPLACE OF FATHER Idaho
(State or Country)

12. MAIDEN NAME OF MOTHER Lana. Moford

13. BIRTHPLACE OF MOTHER Idaho
(State or Country)

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Rev. Boller

(Address) Boise Idaho

15.

Filed 12-27 1913

W. S. Parker

Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH Dec 26 1913
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from Dec 26 1913, to Dec 26 1913, that I last saw her alive on Dec 26 1913, and that death occurred on the date stated above, at 4:30 PM.

The CAUSE OF DEATH* was as follows:

Some obstruction to respiration, supposed to be due pressure on cord and attempt to breathe in utero
(Duration) _____ yrs. _____ mos. _____ ds.

Contributory (Secondary) _____

(Duration) _____ yrs. _____ mos. _____ ds.

(Signed) J. M. Taylor M. D.

Dec 26 1913 (Address) Boise Idaho

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death _____ yrs. _____ mos. _____ days. In the State _____ yrs. _____ mos. _____ days.

Where was disease contracted if not at place of death? _____

Former or usual residence _____

19. PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

Mountain Hill

Dec 27 1913

20. UNDERTAKER

ADDRESS

Try & Samsone

Boise Idaho

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Form V. S. No. 5 20M.1-16-12

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics
File No. 314 6866
Registered No. _____

1. PLACE OF DEATH.

Registration District No. 2

County of Ada

Primary Registration District No. 1004

City of Boise

(No. 1115 E. State St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Margorie Jane Weinkauf

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX Female 4. COLOR OR RACE white 5. SINGLE, MARRIED, WIDOWED OR DIVORCED. Single (e. word.)

6. DATE OF BIRTH Dec 3 1913
(Month) (Day) (Year)

7. AGE _____ yrs. _____ mos. 23 ds.
IF LESS than 1 day how many _____ hrs. or _____ mins.

8. OCCUPATION
(a) Trade, profession or particular kind of work _____
(b) General nature of industry business, or establishment in which employed (or employer) _____

9. BIRTHPLACE
(State or Country) Boise Idaho

10. NAME OF FATHER Chas Weinkauf

11. BIRTHPLACE OF FATHER
(State or Country) Wisconsin

12. MAIDEN NAME OF MOTHER Jennie Sipias

13. BIRTHPLACE OF MOTHER
(State or Country) Pennsylvania

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Chas Weinkauf
(Address) 1115 E. State St.

15. Filed 12-27 1913 W. A. Parker
Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH Dec 27 1913
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from time of birth 1913, to Dec 26 1913, that I last saw him alive on Dec 26 1913, and that death occurred on the date stated above, at 6 M.

The CAUSE OF DEATH* was as follows:

Purpura Hemorrhagica

(Duration) _____ yrs. _____ mos. _____ ds.
Contributory Congestive weakness —
(Secondary)

(Duration) _____ yrs. _____ mos. _____ ds.
(Signed) John Bank M. D.
19 _____ (Address) Boise Ida

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death. _____ yrs. _____ mos. _____ days. In the State. _____ yrs. _____ mos. _____ days.

Where was disease contracted if not at place of death? _____

Former or usual residence. _____

19. PLACE OF BURIAL OR REMOVAL DATE OF BURIAL

Morris Hill Cemetery Dec 28 1913

20. UNDERTAKER ADDRESS

Try Summers Boise

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Form V. S. No. 5 20M.1-16-12

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics
File No. 315 6867

1. PLACE OF DEATH.

Registration District No. 2County of AdaPrimary Registration District No. 1004City of Boise(No. 112 E. Hancock St.)

Registered No. _____

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Anna L. Evans

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX

4. COLOR OR RACE

5. SINGLE, MARRIED, WIDOWED OR DIVORCED.

Female WhiteMarried
(Write the word.)

6. DATE OF BIRTH

Feb. 1 1869
(Month) (Day) (Year)

7. AGE

44 yrs. 10 mos. 25 ds.

IF LESS than 1 day
how many hrs. or
..... mins.?

8. OCCUPATION

(a) Trade, profession or particular kind of work

Housekeeper

(b) General nature of industry business, or establishment in which employed (or employer)

9. BIRTHPLACE

(State or Country)

Iowa

10. NAME OF FATHER

W. T. Read

11. BIRTHPLACE OF FATHER

(State or Country)

Am.

12. MAIDEN NAME OF MOTHER

Josephine Bibb

13. BIRTHPLACE OF MOTHER

(State or Country)

Am.

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

Fred L. Evans

(Address)

Greenleaf Ida

15.

Filed 12-27 19131913M. Parker

Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH

Dec 26 1913
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from Dec 18 1913, to Dec 26 1913, that I last saw h. g. alive on Dec 26 1913, and that death occurred on the date stated above, at 7¹⁵ A.M.
The CAUSE OF DEATH* was as follows:

Sickle's Infection(Duration) yrs. mos. 5 ds.

Contributory (Secondary)

(Duration) yrs. mos. ds.

(Signed)

James B. Stewart M. D.

19

(Address)

Boise Idaho

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents)

At place of death yrs. mos. days. In the State yrs. mos. days.

Where was disease contracted if not at place of death?

Former or usual residence

Greenleaf Idaho

19. PLACE OF BURIAL OR REMOVAL DATE OF BURIAL

Miss Hill Cemetery 7-25 1913

20. UNDERTAKER

ADDRESS

Schreiber & Videnfader Boise Idaho
Stewart

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Form V. S. No. 5 20M.1-16-12

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH.

Registration District No. 73County of BonervillePrimary Registration District No. 2156City of Idaho Falls

(No. _____ St.)

File No. 6875Registered No. 1

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

Marie South

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX

4. COLOR OR RACE

5. SINGLE, MARRIED, WIDOWED OR DIVORCED.

FemaleWhiteSingle
(Write the word.)

6. DATE OF BIRTH

Aug 3 1913
(Month) (Day) (Year)

7. AGE

X yrs. 4 mos. 16 ds.IF LESS than 1 day
how many hrs. or
..... mins.?

8. OCCUPATION

(a) Trade, profession or particular kind of work

(b) General nature of industry, business, or establishment in which employed (or employer)

None

9. BIRTHPLACE

(State or Country)

Idaho

10. NAME OF FATHER

Otis South

11. BIRTHPLACE OF FATHER

(State or Country)

Mo

12. MAIDEN NAME OF MOTHER

Nellie Down

13. BIRTHPLACE OF MOTHER

(State or Country)

Iowa

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

Otis South

(Address)

Idaho Falls, Idaho

15.

Filed

12/221913J. E. Bennett
dep. Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH

Dec 20 1913
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from

Dec 17 1913, to Dec 19 1913that I last saw him alive on Dec 19 1913and that death occurred on the date stated above, at 9:30 A.

The CAUSE OF DEATH* was as follows:

Pneumonia

(Duration) yrs. mos. ds.

Contributory
(Secondary)

(Duration) yrs. mos. ds.

(Signed) A. R. Soderquist M. D.12/22 1913 (Address) Idaho Falls, Idaho

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death yrs. mos. days. In the State yrs. mos. days.

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

Idaho FallsDec 1913

20. UNDERTAKER

ADDRESS

G. H. HuntIdaho Falls

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

PLACE OF DEATH		Idaho WASHINGTON STATE BOARD OF HEALTH		Record No. <u>61-2141</u>
County of <u>Latah</u>		BUREAU OF VITAL STATISTICS		File No. <u>6886</u>
City or Town of <u>Viola Idaho</u>		CERTIFICATE OF DEATH		Registered No. <u>7</u>
Registration Dist. No. _____		(No. _____)		St.; _____ Ward)
<p>[If death occurs away from USUAL RESIDENCE give facts called for under "Special Information"]</p>		<p>Full Name <u>John William Lynch</u></p>		<p>[If death occurred in a Hospital or Institution give its NAME instead of street and number.]</p>
PERSONAL AND STATISTICAL PARTICULARS			MEDICAL CERTIFICATE OF DEATH	
3 SEX <u>Male</u>	4 COLOR OR RACE <u>White</u>	5 SINGLE, MARRIED, WIDOWED, OR DIVORCED <u>Married</u> (Write the word)		16 DATE OF DEATH <u>Dec 31st</u> , 191 <u>3</u> (Month) (Day) (Year)
6 DATE OF BIRTH <u>Nov 5, 1849</u> (Month) (Day) (Year)			17 I HEREBY CERTIFY, That I attended deceased from _____, 191____, to _____, 191____, that I last saw him alive on <u>Dec 30</u> , 191 <u>3</u> , and that death occurred, on the date stated above, at _____ m. The CAUSE OF DEATH* was as follows: <u>Cancer of Throat</u>	
7 AGE <u>64</u> yrs. <u>1</u> mos. <u>26</u> ds. If LESS than 1 day, _____ hrs. or _____ min. ?				
8 OCCUPATION (a) Trade, profession, or particular kind of work. <u>Farmer</u> (b) General nature of industry, business or establishment in which employed (or employer) _____				
9 BIRTHPLACE (State or country) <u>Iowa</u>				
PARENTS	10 NAME OF FATHER <u>Patrick Lynch</u>		Contributory (SECONDARY) _____ (Duration) _____ yrs. _____ mos. _____ ds.	
	11 BIRTHPLACE OF FATHER (State or country) _____		(Signed) _____ 191____ (Address) <u>W. M. Hagedorn</u>	
	12 MAIDEN NAME OF MOTHER <u>Harris</u>		*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.	
	13 BIRTHPLACE OF MOTHER (State or country) _____		18 LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS) At place of death _____ yrs. _____ mos. _____ ds. In the State _____ yrs. _____ mos. _____ ds. Where was disease contracted, if not at place of death? _____ Former or usual residence _____	
14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE (Informant) <u>J. R. Lynch</u> (Address) <u>Viola Idaho</u>				
15 Filled <u>Jan 22</u> , 191 <u>4</u> REGISTRAR				
19 PLACE OF BURIAL OR REMOVAL <u>Viola</u>			DATE OF BURIAL <u>Jan 2nd</u> , 191 <u>3</u>	
20 UNDERTAKER <u>C. L. Shaw</u>			ADDRESS <u>Caloune</u>	

Buried without permit—
Wm. Hagedorn
Idaho License #59

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Form V. S. No. 5 20M.1-16-12

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH

Registration District No.

County of

Primary Registration District No.

City of

(No.)

St.)

If death occurs away from usual residence, give facts called for under special information.

2.

FULL NAME

John Fitcher

Registered No.

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX

4. COLOR OR RACE

5. SINGLE, MARRIED, WIDOWED OR DIVORCED.

male

white

Married
(Write the word.)

6. DATE OF BIRTH

June 14 1894
(Month) (Day) (Year)

7. AGE

69 yrs. 4 mos. 25 ds.

IF LESS than 1 day
how many hrs. or mins.?

8. OCCUPATION

(a) Trade, profession or particular kind of work

(b) General nature of industry, business, or establishment in which employed (or employer)

Farmer

9. BIRTHPLACE

(State or Country)

Germany

10. NAME OF FATHER

un known

11. BIRTHPLACE OF FATHER

(State or Country)

Germany

12. MAIDEN NAME OF MOTHER

dont know

13. BIRTHPLACE OF MOTHER

(State or Country)

dont know

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

E. E. Fisher

(Address)

Buhl Idaho

15.

Filed 1-14 1913

Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

Dec 8 1913
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from

Dec 4th 1913, to Dec 6th 1913,

that I last saw him alive on Dec 6th 1913,

and that death occurred on the date stated above, at 11 P.M.

The CAUSE OF DEATH* was as follows:

Pneumonia

(Duration) yrs. mos. 7 ds.

Contributory

(Secondary)

(Duration) yrs. mos. ds.

(Signed)

A. J. McPherson M. D.

12/8/13 (Address) Buhl Idaho

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death.....yrs.....mos.....days. In the State.....yrs.....mos.....days.

Where was disease contracted if not at place of death?.....

Former or usual residence.....

19. PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

Buhl Cemetery

Dec 9 1913

20. UNDERTAKER

ADDRESS

H. B. Evans

Buhl

-SUPPLEMENTARY DEATH CERTIFICATE-

(Please reply on this sheet to
the registrar of Vital Statistics)

Death Certificate No. 6889

Name John Fitcher

Date of Death Dec. 7, 1913

Cause of Death Lobar Pneumonia

Contributory Cause of death

(Sign here)

A. J. McCarty

M.D.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Form V. S. No. 5. 10M. 6-20-11.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital StatisticsFile No. **6904**

Registered No. _____

If death occurred in a hospital, institution or camp give its NAME instead of street and number.

1. PLACE OF DEATH.
County of Campan
City of EmmettRegistration District No. 5011
Primary Registration District No. _____
(No. _____ St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

John Tyler

PERSONAL AND STATISTICAL PARTICULARS

3. SEX male 4. COLOR OR RACE white 5. SINGLE, MARRIED, WIDOWED OR DIVORCED. married
(Write the word.)6. DATE OF BIRTH March 28 1841
(Month) (Day) (Year)7. AGE 72 yrs. 8 mos. 24 ds. IF LESS than 1 day how many hrs. or min.?8. OCCUPATION
(a) Trade, profession, or particular kind of work Farmer
(b) General nature of industry business, or establishment in which employed (or employer) _____9. BIRTHPLACE
(State or Country) New York10. NAME OF FATHER Joseph Tyler11. BIRTHPLACE OF FATHER
(State or Country) New York12. MAIDEN NAME OF MOTHER Barbara King
Don't know13. BIRTHPLACE OF MOTHER
(State or Country) France

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) J. W. Tyler
(Address) Emmett Idaho

15. _____

Filed 1-10 1914 J. G. Reynolds
Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH Dec 22 1913
(Month) (Day) (Year)17. I HEREBY CERTIFY, That I attended deceased from Dec 22 1913
Did not see him alive 1913that I last saw him alive on _____ 1913,
and that death occurred on the date stated above, at 6 a. M.

The CAUSE OF DEATH* was as follows:

From the history and from the feel of arteries with probably resulted from heart failure
(Duration) _____ yrs. _____ mos. _____ ds.Contributory (Secondary) Arterio-sclerosis(Duration) 1 yrs. _____ mos. _____ ds.
(Signed) R. G. Cummings M. D.
Dec 22 1913 (Address) Emmett

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place _____ In the _____
of death _____ yrs. _____ mos. _____ ds. State _____ yrs. _____ mos. _____ ds.
Where was Disease contracted, _____
If not at place of death? _____
Former or _____
usual residence. _____19. PLACE OF BURIAL OR REMOVAL Emmett Cemetery DATE OF BURIAL Dec 24 191320. UNDERTAKER C. S. Bucknum ADDRESS Emmett

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Form V. S. No. 5. 10M. 6-20-11.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics
File No. **6905**
Registered No.

1. PLACE OF DEATH.
County of Canyon
City of Letha

Registration District No. 2810
Primary Registration District No. 1010
(No. St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Cynthia Clarissa Frint

If death occurred in a hospital, institution or camp give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX female 4. COLOR OR RACE white 5. SINGLE, MARRIED, WIDOWED OR DIVORCED. single
(Write the word.)

6. DATE OF BIRTH July 7 1899
(Month) (Day) (Year)

7. AGE 14 yrs. 5 mos. 24 ds.
IF LESS than 1 day how many hrs. or min.?

8. OCCUPATION
(a) Trade, profession, or particular kind of work at school
(b) General nature of industry, business, or establishment in which employed (or employer)

9. BIRTHPLACE
(State or Country) Kansas

10. NAME OF FATHER Norman H. Frint

11. BIRTHPLACE OF FATHER
(State or Country) Illinois

12. MAIDEN NAME OF MOTHER Sarah Elizabeth Newell

13. BIRTHPLACE OF MOTHER
(State or Country) Kansas

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) N. H. Frint
(Address) Letha, Idaho

15. Filed 1-10-1914 J. J. Reynolds
Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH Dec 31 1913
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from Dec 2 1913, to Dec 29 1913, that I last saw her alive on Dec 29 1913, and that death occurred on the date stated above, at am.

The CAUSE OF DEATH* was as follows:
Acute dilatation of heart

(Duration) yrs. mos. 25 ds.
Contributory (Secondary) Probably a myocarditis

(Duration) yrs. mos. ds.
(Signed) R. B. Cummings M. D.
Dec 31 1913 (Address) Emmett

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL,

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place yrs. mos. ds. In the State yrs. mos. ds.

Where was Disease contracted, If not at place of death?
Former or usual residence.

19. PLACE OF BURIAL OR REMOVAL Bramwell Cemetery DATE OF BURIAL Jan 1 1914

20. UNDERTAKER C. B. Bucknum ADDRESS Emmett

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Form V. S. No. 5 20M.1-16-12

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH

Registration District No.

109

County of

Custer

Primary Registration District No.

2187

City of

Maerday

(No.

St.)

File No.

6918

Registered No.

7

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

Dorannah McMonley

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX

F

4. COLOR OR RACE

wh

5. SINGLE, MARRIED, WIDOWED OR DIVORCED.

Married

(Write the word.)

6. DATE OF BIRTH

12

6

1839

(Month)

(Day)

(Year)

7. AGE

74

yrs.

18

mos.

ds.

IF LESS than 1 day
how many hrs. or
mins.?

8. OCCUPATION

(a) Trade, profession or particular kind of work

Housewife

(b) General nature of industry business, or establishment in which employed (or employer)

9. BIRTHPLACE

(State or Country)

North Town, Canada

10. NAME OF FATHER

James Good

11. BIRTHPLACE OF FATHER

(State or Country)

Ireland

12. MAIDEN NAME OF MOTHER

Catherine Taylor

13. BIRTHPLACE OF MOTHER

(State or Country)

Ireland

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

Mrs M. H. Warren

(Address)

Maerday

15.

Filed

1/9

1914

F. P. Richards

Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

12

24

1913

(Month)

(Day)

(Year)

17. I HEREBY CERTIFY, That I attended deceased from

12/23

1913,

to

12/24

1913,

that I last saw her alive on

12/24

1913

and that death occurred on the date stated above, at 12 P.M.

The CAUSE OF DEATH* was as follows:

(Duration)

yrs.

mos.

ds.

Contributory
(Secondary)

Chronic Nephritis

(Duration)

yrs.

mos.

ds.

(Signed)

H. P. Richards

M. D.

12/24

1913

(Address)

Maerday

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place

of death

yrs.

mos.

days.

In the

State

yrs.

mos.

days.

Where was disease contracted

if not at place of death?

Former or

usual residence

19. PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

Maerday

12/27

1913

20. UNDERTAKER

ADDRESS

E. J. Pien

Blaineport

MARGIN RESERVED FOR BINDING

WHITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. PHYSICIAN'S NAME, PLACE, DATE, TIME, AND SIGNATURE SHOULD BE STATED EXACTLY. EXACT STATEMENT OF OCCUPATION IS VERY IMPORTANT. See instructions on back of certificate.

Form V. S. No. 5 20M.1-16-12

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics
File No. **6932**

1. PLACE OF DEATH *Home* Registration District No. *99*
County of *Lincoln* Primary Registration District No. *2177*
City of *Marysville* (No. _____ St.)

Registered No. _____
If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME *Olevis S. Shaw*

PERSONAL AND STATISTICAL PARTICULARS

3. SEX *Male* 4. COLOR OR RACE *White* 5. SINGLE, MARRIED, WIDOWED OR DIVORCED *Married*
(Write the word.)

6. DATE OF BIRTH *March 24 1869*
(Month) (Day) (Year)

7. AGE *44 yrs. 8 mos. 28 ds.*
IF LESS than 1 day how many _____ hrs. or _____ mins.?

8. OCCUPATION *Blacksmith*
(a) Trade, profession or particular kind of work
(b) General nature of industry, business, or establishment in which employed (or employer)

9. BIRTHPLACE *Indiana*
(State or Country)

10. NAME OF FATHER *John Shaw*

11. BIRTHPLACE OF FATHER *Indiana*
(State or Country)

12. MAIDEN NAME OF MOTHER *Mary Anthony*

13. BIRTHPLACE OF MOTHER *Indiana*
(State or Country)

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) *Wm. S. Shaw*
(Address) *Marysville*

15. Filed *July 9 1914* Local Registrar *W. S. Shaw*

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH *December 21st 1913*
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from _____ 191____, to _____ 191____, that I last saw him alive on _____ 191____, and that death occurred on the date stated above, at *930 a.m.*

The CAUSE OF DEATH* was as follows:
Accidentally shot himself while hunting. Killed instantly.
(Duration) *6* yrs. *6* mos. *6* ds.

Contributory (Secondary) _____
(Duration) _____ yrs. _____ mos. _____ ds.
(Signed) *W. C. Himmell* M. D.
12/22 1913 (Address) *Marysville*

*State the DISEASE CAUSING DEATH; or in death from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death _____ yrs. _____ mos. _____ days. In the State _____ yrs. _____ mos. _____ days.
Where was disease contracted if not at place of death? _____
Former or usual residence _____

19. PLACE OF BURIAL OR REMOVAL *St. Anthony's* DATE OF BURIAL *12/24 1913*

20. UNDERTAKER *J. P. Brown* ADDRESS *Ripley*

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Form V. S. No. 5 20M.1-16-12

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH

Registration District No.

County of

Primary Registration District No.

City of

(No.

St.)

File No.

Registered No.

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX

4. COLOR OR RACE

5. SINGLE, MARRIED, WIDOWED OR DIVORCED

male

white

married
(write the word.)

6. DATE OF BIRTH

7. AGE

51

— yrs. — mos. — ds.

IF LESS than 1 day
how many hrs. or mins.?

8. OCCUPATION

(a) Trade, profession or particular kind of work

miner

(b) General nature of industry business, or establishment in which employed (or employer)

9. BIRTHPLACE

(State or Country)

not given

10. NAME OF FATHER

11. BIRTHPLACE OF FATHER

(State or Country)

12. MAIDEN NAME OF MOTHER

13. BIRTHPLACE OF MOTHER

(State or Country)

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

(Address)

15.

Filed

Jan 19 1914

1914

W. C. Mowrey
Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH

Jan 17 1913
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from

191, to 191,

that I last saw h. alive on 191,

and that death occurred on the date stated above, at 4:00 P. M.

The CAUSE OF DEATH* was as follows:

Fracture Skull

(Duration) yrs. mos. ds.

Contributory (Secondary)

Shock

(Duration) yrs. mos. ds.

(Signed)

Chas. R. Mowrey
Wallace, Idaho

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death. yrs. mos. days. In the State. yrs. mos. days.

Where was disease contracted if not at place of death?

Former or usual residence.

19. PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

Hereford Texas Aug 20 1914

20. UNDERTAKER

ADDRESS

Cruce & Wooten Wallace, Idaho

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Form V. S. No. 5 20M.1-16-12

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH

Registration District No. 96County of LatahPrimary Registration District No. 100?City of Lewiston(No. Hospital St.)File No. 6952Registered No. 7

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Tramie Ellen Truizer

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX M4. COLOR OR RACE W5. SINGLE, MARRIED, WID-
OWED OR DIVORCED.
married
(Write the word.)

6. DATE OF BIRTH

Jan (Month)8 (Day)1 (Year)

7. AGE

32 yrs. 3 mos. 3 ds.IF LESS than 1 day
how many hrs. or
..... mins.?

8. OCCUPATION

(a) Trade, profession or
particular kind of work(b) General nature of industry
business, or establishment in
which employed (or employer)Housewife

9. BIRTHPLACE

(State or Country)

Virginia10. NAME OF
FATHERJ. W. Billips11. BIRTHPLACE
OF FATHER

(State or Country)

Virginia12. MAIDEN NAME
OF MOTHERKate Farmer13. BIRTHPLACE
OF MOTHER

(State or Country)

Virginia

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

(Address)

Lewiston

15.

Filed Feb. 10191 4Local Registrar L. Perkins

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH

(Month)

(Day)

191 3
(Year)

17. I HEREBY CERTIFY, That I attended deceased from

Jan 9th 191 4 to Jan 12th 191 4that I last saw him alive on Jan 11th 191 4and that death occurred on the date stated above, at 2:45 P.M.

The CAUSE OF DEATH was as follows:

Illness Paralysis
as result of operation

(Duration)

yrs.

mos.

ds.

Contributory
(Secondary)Peritonitis

(Duration)

yrs.

mos.

ds.

(Signed)

J. P. Thomas

M. D.

1-18-1914 (Address)

Lewiston

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place

of death

yrs.

In the

State

yrs.

mos.

days.

Where was disease contracted

if not at place of death?

Former or

usual residence

19. PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

Nez Perce IdaJan. 191 19

20. UNDERTAKER

ADDRESS

Chas. S. S. S.Lewiston

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Form V. S. No. 5 20M.1-16-12

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics
File No. 6951
Registered No. 11

1. PLACE OF DEATH. Registration District No. 117
County of Boesia Primary Registration District No. 2196
City of Burley (No. , St.)
If death occurs away from usual residence, give facts called for under special information. 2. FULL NAME Margarette Ann Potter

PERSONAL AND STATISTICAL PARTICULARS

3. SEX Female 4. COLOR OR RACE white 5. SINGLE, MARRIED, WIDOWED OR DIVORCED. widowed

6. DATE OF BIRTH Oct. 29 1898
(Month) (Day) (Year)

7. AGE 25 yrs. 1 mos. 11 ds.
IF LESS than 1 day how many hrs. or mins.?

8. OCCUPATION
(a) Trade, profession or particular kind of work. Housewife
(b) General nature of industry business, or dtablissement in which employed (or employer)

9. BIRTHPLACE
(State or Country) Van Wert Co. Ohio

10. NAME OF FATHER Jacob W. Johns

11. BIRTHPLACE OF FATHER
(State or Country) Unknown

12. MAIDEN NAME OF MOTHER

13. BIRTHPLACE OF MOTHER
(State or Country)

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) H. J. Slater
(Address) Burley Idaho.

15. Filed Dec 5 1913 R. T. Irons Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH December 3 1913
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from Nov 20 1913, to Dec 3 1913, that I last saw her alive on Dec 3 1913, and that death occurred on the date stated above, at 10 PM.

The CAUSE OF DEATH* was as follows:
Pyemia from suppurating gall bladder
(Duration) yrs. mos. 30 ds.

Contributory Gallstones
(Secondary)
(Duration) yrs. mos. ds.

(Signed) J. M. Minter M. D.
Dec 5 1913 (Address) Burley Idaho

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death. yrs. mos. days. In the State. yrs. mos. days.

Where was disease contracted if not at place of death?

Former or usual residence.

19. PLACE OF BURIAL OR REMOVAL DATE OF BURIAL

Van Wert Ohio Dec 9 1913
20. UNDERTAKER ADDRESS

L. B. Gallagher Burley Idaho

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Form V. S. No. 5 20M.1-16-12

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH.

Registration District No. 35County of LincolnPrimary Registration District No. 2016City of Shoshone

(No. _____, _____ St.)

File No. 2696Registered No. 2696

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Alexander Murro

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX male 4. COLOR OR RACE white 5. SINGLE, MARRIED, WIDOWED OR DIVORCED. married
(Write the word.)

6. DATE OF BIRTH

(Month) _____ (Day) 1 (Year) _____
7. AGE 76 years IF LESS than 1 day
how many _____ hrs. or _____ mins.
_____ yrs. _____ mos. _____ ds.

8. OCCUPATION

(a) Trade, profession or particular kind of work
(b) General nature of industry, business, or establishment in which employed (or employer)stomach

9. BIRTHPLACE

(State or Country)

Scotland

10. NAME OF FATHER

don Know

11. BIRTHPLACE OF FATHER

(State or Country)

Scotland

12. MAIDEN NAME OF MOTHER

unknown

13. BIRTHPLACE OF MOTHER

(State or Country)

Scotland

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Alexander Reid

(Address) _____

15.

Filed Nov 3 1913 C. H. Keller

Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH

(Month) 10 (Day) 26 (Year) 191317. I HEREBY CERTIFY, That I attended deceased from Oct 26 1913, to Nov 1 1913,
that I last saw him alive on Oct 31 1913,
and that death occurred on the date stated above, at 3 PM.

The CAUSE OF DEATH* was as follows:

Acute Dilatation Heart caused by injury of stones falling on
heart.

(Duration) _____ yrs. _____ mos. _____ ds.

Contributory (Secondary) injury while at work

(Duration) _____ yrs. _____ mos. _____ ds.

(Signed) _____ M. D.

Nov 1, 1913 (Address) Shoshone Idaho

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death _____ yrs. _____ mos. _____ days. In the State _____ yrs. _____ mos. _____ days.

Where was disease contracted if not at place of death? _____

Former or usual residence _____

19. PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

Shoshone Idaho Nov 3 1913

20. UNDERTAKER

ADDRESS

C. H. Keller Shoshone

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
 N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Form V. S. No. 5. 10M. 6-20-11.

CERTIFICATE OF DEATH

 State of Idaho
 BOARD OF HEALTH
 Bureau of Vital Statistics

1. PLACE OF DEATH.

Registration District No. 3County of LincolnPrimary Registration District No. 2016City of Shoshone

(No., St.)

File No. 6963Registered No. 22

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

no name

If death occurred in a hospital, institution or camp give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX

male

4. COLOR OR RACE 5. SINGLE, MARRIED, WIDOWED OR DIVORCED.

whiteno
(Write the word.)

6. DATE OF BIRTH

Oct-23 1913

(Month)

(Day)

(Year)

7. AGE

6 weeks
 IF LESS than 1 day
 how many hrs. or
 min.?

8. OCCUPATION

 (a) Trade, profession, or particular kind of work
 (b) General nature of industry business, or establishment in which employed (or employer)
none

9. BIRTHPLACE

(State or Country)

Shoshone Idaho

10. NAME OF FATHER

Chas Burgess

11. BIRTHPLACE OF FATHER

(State or Country)

Iowa

12. MAIDEN NAME OF MOTHER

Carrie Kenarton

13. BIRTHPLACE OF MOTHER

(State or Country)

Neb

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

Chas Burgess

(Address)

15.

Filed

Oct 24 1913C. F. Zeller

Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

Oct 23

(Month)

23

(Day)

1913

(Year)

17. I HEREBY CERTIFY, That I attended deceased from

Oct 22 1913, to Oct 28 1913that I last saw h. alive on Oct 27 1913

and that death occurred on the date stated above, at M.

The CAUSE OF DEATH* was as follows:

Maesure(Duration) yrs. 1 mos. 14 ds.

Contributory (Secondary)

(Duration) yrs. mos. ds.

(Signed) M. D.

19 (Address)

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place

In the

of death yrs. mos. ds. State yrs. mos. ds.

Where was Disease contracted,

If not at place of death?

Former or

usual residence

19. PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

ShoshoneOct-24 1913

20. UNDERTAKER

ADDRESS

O. J. BrumanShoshone

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics1. PLACE OF DEATH.
County of Lynne
City of ShoshoneRegistration District No. 5Primary Registration District No. 2016File No. 6961Registered No. 29

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

Ruth Edna Shattz

If death occurred in a hospital, institution or camp give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX Female 4. COLOR OR RACE white 5. SINGLE, MARRIED, WIDOWED OR DIVORCED. married
(Write the word.)6. DATE OF BIRTH Jan 4 1892
(Month) (Day) (Year)7. AGE 21 years
IF LESS than 1 day
how many.....hrs. or
.....min.?

8. OCCUPATION

(a) Trade, profession, or particular kind of work
(b) General nature of industry business, or establishment in which employed (or employer)Housewife9. BIRTHPLACE
(State or Country)Wyoming State

10. NAME OF FATHER

R E McAllister11. BIRTHPLACE OF FATHER
(State or Country)Canada

12. MAIDEN NAME OF MOTHER

Dora Owens13. BIRTHPLACE OF MOTHER
(State or Country)Illinois

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Henry Schatz

(Address)

Shoshone, Idaho

15.

Filed Aug 15 1913 C. F. Zeller
Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

Aug 14 1913
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from

Aug 11 1913, to Aug 14 1913that I last saw her alive on Aug 14 1913and that death occurred on the date stated above, at 3:30 A.M.

The CAUSE OF DEATH* was as follows:

Acute ascending Paralysis(Duration) yrs. mos. 4 ds.Contributory
(Secondary)

(Duration) yrs. mos. ds.

(Signed)

Chas. F. Zeller M. D.7/15/13 (Address) Shoshone, Idaho

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place In the
of death yrs. mos. ds. State yrs. mos. ds.

Where was Disease contracted,

If not at place of death?

Former or

usual residence.

19. PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

Laramie Wyo 1913

20. UNDERTAKER

ADDRESS

O J Brimmer Shoshone

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Form V. S. No. 5. 10M. 6-20-11.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH.

Registration District No. 5County of LincolnPrimary Registration District No. 2016City of Richfield

(No. _____ St.)

File No. 6967Registered No. 24

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

Josephine B. Eastwood

If death occurred in a hospital, institution or camp give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX

Female

4. COLOR OR RACE 5. SINGLE, MARRIED, WIDOWED OR DIVORCED.

Wht.Widow
(Write the word.)

6. DATE OF BIRTH

Feb.

(Month)

6th

(Day)

1899

(Year)

7. AGE

74 yrs. 10 mos. 27 ds.IF LESS than 1 day
how many _____ hrs. or
_____ min.

8. OCCUPATION

(a) Trade, profession or particular kind of work

Housekeeper

(b) General nature of industry business or establishment in which employed (or employer)

9. BIRTHPLACE

(State or Country)

Ill.

10. NAME OF FATHER

Frank Morning

11. BIRTHPLACE OF FATHER

(State or Country)

Kentucky

12. MAIDEN NAME OF MOTHER

13. BIRTHPLACE OF MOTHER

(State or Country)

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

L. W. Eastwood

(Address)

Richfield

15.

Filed

Dec. 31 1913C. F. Zeller

Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

December 30

(Month)

(Day)

1913

(Year)

17. I HEREBY CERTIFY, That I attended deceased from

Aug

1913, to

Dec 30

1913

that I last saw h. l. r. alive on 11 am Dec 1913,and that death occurred on the date stated above, at 1 P. M.

The CAUSE OF DEATH* was as follows:

Pneumonia(Duration) _____ yrs. _____ mos. 4 ds.

Contributory (Secondary)

Asthma(Duration) 10 yrs. 9 mos. 4 ds.(Signed) R. A. Harris M. D.Jan 1 1914 (Address) Richfield

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and 2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death _____ yrs. _____ mos. _____ ds. In the State _____ yrs. _____ mos. _____ ds.

Where was disease contracted.

If not at place of death?

Former or

usual residence.

19. PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

Hailey1-2-1914

20. UNDERTAKER

ADDRESS

Ralph HarrisHailey

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Form V. S. No. 5. 10M. 6-20-11.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

File No. 6965

Registered No. 30

If death occurred in a hospital, institution or camp give its NAME instead of street and number.

1. PLACE OF DEATH.

Registration District No. 5

County of Lincoln

Primary Registration District No. 2016

City of Shoshone

(No. , St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME no name

PERSONAL AND STATISTICAL PARTICULARS

3. SEX

male

4. COLOR OR RACE 5. SINGLE, MARRIED, WIDOWED OR DIVORCED.

white

single
(Write the word.)

6. DATE OF BIRTH

Sept. 9

1913

(Month)

(Day)

(Year)

7. AGE

Died in utero

IF LESS than 1 day
how many hrs. or min.?

8. OCCUPATION

(a) Trade, profession, or particular kind of work

nurse

(b) General nature of industry business, or establishment in which employed (or employer)

9. BIRTHPLACE

(State or Country)

Shoshone Idaho

10. NAME OF FATHER

Claude Myers

11. BIRTHPLACE OF FATHER

(State or Country)

Idaho

12. MAIDEN NAME OF MOTHER

Merilla Myers

13. BIRTHPLACE OF MOTHER

(State or Country)

Price Utah

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

(Address)

C. F. Zeller
Shoshone Idaho

15.

Filed Sept. 20 1913

C. F. Zeller

Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

Sept.

9

1913

(Month)

(Day)

(Year)

17. I HEREBY CERTIFY, That I attended deceased from

Sept. 9

1913

to Sept. 9

1913

that I last saw him alive on 191

and that death occurred on the date stated above, at M.

The CAUSE OF DEATH* was as follows:

Died in utero
Premature separation of Placenta

(Duration) yrs. mos. ds.

Contributory
(Secondary)

(Duration) yrs. mos. ds.

(Signed) C. F. Zeller M. D.

Sept. 9 1913 (Address) Shoshone Idaho

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place

In the

of death. yrs. mos. ds. State. yrs. mos. ds.

Where was Disease contracted,

If not at place of death?

Former or

usual residence.

19. PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

Shoshone

Sept. 10 1913

20. UNDERTAKER

ADDRESS

O. J. Burman

Shoshone

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Form V. S. No. 5. 10M. 6-20-11.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics
File No. 6976
Registered No. 87
If death occurred in a hospital, institution or camp give its NAME instead of street and number.

1. PLACE OF DEATH. Registration District No. 8
County of Lincoln Primary Registration District No. 2076
City of Shoshone (No. _____ St.)
If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Robert H. Parker

PERSONAL AND STATISTICAL PARTICULARS

3. SEX male 4. COLOR OR RACE white 5. SINGLE, MARRIED, WIDOWED OR DIVORCED. widower
(Write the word.)

6. DATE OF BIRTH July 10 1893
(Month) (Day) (Year)

7. AGE 80 yrs. 1 mos. 26 ds. IF LESS than 1 day how many hrs. or min.?

8. OCCUPATION
(a) Trade, profession, or particular kind of work Builder
(b) General nature of industry business, or establishment in which employed (or employer)

9. BIRTHPLACE (State or Country) Nova Scotia

10. NAME OF FATHER Stephen Parker

11. BIRTHPLACE OF FATHER (State or Country) Nova Scotia

12. MAIDEN NAME OF MOTHER Ryan

13. BIRTHPLACE OF MOTHER (State or Country) Unknown

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) H. W. Parker
(Address) Twin Falls, Ida

15. Filed Sept. 5 1913 C. F. Heller
Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH Sept 4 1913
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from Aug 76 1913, to Sept 4 1913, that I last saw h. in alive on Sept 4 1913, and that death occurred on the date stated above, at 3:30 P. M.

The CAUSE OF DEATH* was as follows:
Pneumonia

(Duration) _____ yrs. _____ mos. _____ ds.
Contributory (Secondary) Exposure and cold

(Duration) _____ yrs. _____ mos. _____ ds.
(Signed) C. F. Heller M. D.
Sept 4 1913 (Address) Shoshone

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place _____ In the _____
of death _____ yrs. _____ mos. _____ ds. State _____ yrs. _____ mos. _____ ds.
Where was Disease contracted,
If not at place of death?
Former or
usual residence.

19. PLACE OF BURIAL OR REMOVAL Salt Lake Mar 9/5/13 1913
DATE OF BURIAL

20. UNDERTAKER O. J. Bruman ADDRESS Shoshone

MARGIN RESERVED FOR BINDING
WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Form V. S. No. 5. 10M. 6-20-11.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH.
County of Lincoln
City of Shoshone

Registration District No. 5
Primary Registration District No. 2016
(No. _____, _____ St.)

File No. 6971
Registered No. 38

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME no name

If death occurred in a hospital, institution or camp give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX male 4. COLOR OR RACE white 5. SINGLE, MARRIED, WIDOWED OR DIVORCED.

(Write the word.)

6. DATE OF BIRTH July 11
(Month) (Day) 3 days (Year)

7. AGE 3 days
IF LESS than 1 day how many _____ hrs. or _____ min.?

8. OCCUPATION
(a) Trade, profession, or particular kind of work nour
(b) General nature of industry business, or establishment in which employed (or employer) _____

9. BIRTHPLACE Shoshone
(State or Country)

10. NAME OF FATHER H B Jones

11. BIRTHPLACE OF FATHER Idaho
(State or Country)

12. MAIDEN NAME OF MOTHER Hattie Carson

13. BIRTHPLACE OF MOTHER Id
(State or Country)

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) H. B. Jones
(Address) Shoshone Idaho

15. Filed 7/13 1913 C. F. Zeller
Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH
July 12 1913
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from July 11 1913, to July 12 1913
that I last saw him alive on July 12 1913

and that death occurred on the date stated above, at _____ M.

The CAUSE OF DEATH* was as follows:

Premature Infant

(Duration) _____ yrs. _____ mos. _____ ds.

Contributory
(Secondary)

(Duration) _____ yrs. _____ mos. _____ ds.

(Signed) C. F. Zeller M. D.
July 12 1913 (Address) Shoshone, Idaho

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL,

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place _____ In the _____
of death. _____ yrs. _____ mos. _____ ds. State. _____ yrs. _____ mos. _____ ds.

Where was Disease contracted,

If not at place of death?

Former or

usual residence.

19. PLACE OF BURIAL OR REMOVAL DATE OF BURIAL

Shoshone Cemetery

7/13 1913

20. UNDERTAKER ADDRESS

O. J. Berrian

Shoshone

Form V. S. No. 5. 10M. 6-20-11.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics1. PLACE OF DEATH.
County of Latah
City of ShoshoneRegistration District No. 8
Primary Registration District No. 2076
(No. _____, _____ St.)File No. 6972
Registered No. _____

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

John J. Jir

If death occurred in a hospital, institution or camp give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX Female 4. COLOR OR RACE white 5. SINGLE, MARRIED, WIDOWED OR DIVORCED. W
(Write the word.)

6. DATE OF BIRTH

June 3 1913
(Month) (Day) (Year)7. AGE 3 yearsIF LESS than 1 day
how many _____ hrs. or _____ min.

8. OCCUPATION

(a) Trade, profession, or particular kind of work
(b) General nature of industry business, or establishment in which employed (or employer)none

9. BIRTHPLACE

(State or Country)

Magie dam

10. NAME OF FATHER

Ben Jir

11. BIRTHPLACE OF FATHER

(State or Country)

Utah

12. MAIDEN NAME OF MOTHER

Sara Kuster

13. BIRTHPLACE OF MOTHER

(State or Country)

Utah

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

Thos H. C. Alessa

(Address)

Richford

15.

Filed

June 5 1913 C. F. Zeller
Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

June 3 1913
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from

1913, to 1913that I last saw him alive on 1913,

and that death occurred on the date stated above, at _____ M.

The CAUSE OF DEATH* was as follows:

Accidental Drowning
Big Wood River
(Duration) _____ yrs. _____ mos. _____ ds.

Contributory (Secondary)

(Duration) _____ yrs. _____ mos. _____ ds.

(Signed) _____ M. D.

19. (Address) _____

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions Transients or Recent Residents.)

At place _____ In the _____
of death _____ yrs. _____ mos. _____ ds. State _____ yrs. _____ mos. _____ ds.Where was Disease contracted,
If not at place of death? _____Former or
usual residence _____

19. PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

Shoshone, Idaho June 5 1913

20. UNDERTAKER

ADDRESS

O. J. Brennan Shoshone

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Form V, S. No. 5 20M.1-16-12

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH.

Registration District No.

County of CanyonPrimary Registration District No. 7City of Nampa

(No., St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

RossFile No. 6993

Registered No.

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX

female

4. COLOR OR RACE

white

5. SINGLE, MARRIED, WIDOWED OR DIVORCED.

single
(Write the word.)

6. DATE OF BIRTH

Nov 26 1913
(Month) (Day) (Year)

7. AGE

0 yrs. 0 mos. 6 1/2 ds.

IF LESS than 1 day
how many hrs.

8. OCCUPATION

- (a) Trade, profession or particular kind of work
(b) General nature of industry, business, or establishment in which employed (or employer)

9. BIRTHPLACE

(State or Country)

Nampa Ida

10. NAME OF FATHER

H. P. Ross

11. BIRTHPLACE OF FATHER

(State or Country)

Canada

12. MAIDEN NAME OF MOTHER

Clara C. Ross

13. BIRTHPLACE OF MOTHER

(State or Country)

Minnesota

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

H. P. Ross

(Address)

Nampa

15.

Filed

Dec 30 1913 P. D. Calonge
Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH

Dec 3 1913
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from

Nov 26 1913, to Dec 30 1913,

that I last saw her alive on Dec 30 1913,

and that death occurred on the date stated above, at 7:00

The CAUSE OF DEATH* was as follows;

mal-nutrition due to premature birth

(Duration) yrs. mos. ds.

Contributory
(Secondary)

Premature birth

(Duration) yrs. mos. ds.

(Signed)

Geo. O. Kellogg M. D.

12/3/1913 (Address) Nampa, Ida.

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death yrs. mos. days. In the State yrs. mos. days.

Where was disease contracted if not at place of death?

Former or usual residence.

19. PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

Kohler Lawn

Dec 3 1913

20. UNDERTAKER

ADDRESS

F. K. Robinson

Nampa Ida

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. EXAMINER'S statement of OCCUPATION is very important. See instructions on back of certificate.

Form V. S. No. 5 20M.1-16-12

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics
7038

PLACE OF DEATH.

Registration District No.

Primary Registration District No.

File No.

Registered No.

City of

(No.

St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

Francis Maupin

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX

4. COLOR OR RACE

5. SINGLE, MARRIED, WIDOWED OR DIVORCED.

Female

White

Widow
(Write the word.)

6. DATE OF BIRTH

Feb.

6

1856

(Month)

(Day)

(Year)

7. AGE

57 yrs. 10 mos. 25 ds.

IF LESS than 1 day how many hrs. or mins.?

8. OCCUPATION

(a) Trade, profession or particular kind of work

House Keeper

(b) General nature of industry business, or establishment in which employed (or employer)

9. BIRTHPLACE

(State or Country)

Portland Ore

10. NAME OF FATHER

Mr. Sampson

11. BIRTHPLACE OF FATHER

(State or Country)

Not obtainable

12. MAIDEN NAME OF MOTHER

Not obtainable

13. BIRTHPLACE OF MOTHER

(State or Country)

Not obtainable

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

Earl C Maupin

(Address)

Boise

15.

Filed

1-2

1914

MS Parker

Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH

Dec

31

1913

(Month)

(Day)

(Year)

17. I HEREBY CERTIFY, That I attended deceased from

Oct 14

1913

to Dec 31

1913

that I last saw her alive on Dec 18 1913

and that death occurred on the date stated above, at 2 PM

The CAUSE OF DEATH* was as follows:

Arteriosclerosis with degenerative changes in heart and kidneys

(Duration) 2 yrs. mos. ds.

Contributory (Secondary)

(Duration) yrs. mos. ds.

(Signed) Maurice Henry Zellmer, M. D.

1-2-1913 (Address) Boise Idaho

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death

.....yrs.....mos.....days.

In the State

.....yrs.....mos.....days.

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

Masonic Cemetery

Jan 2 1914

20. UNDERTAKER

ADDRESS

Schreiber & Sidenfader

Boise

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Form V. S. No. 5 20M.1-16-12

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH.

Registration District No. 84

County of Bannock

Primary Registration District No. 2161

City of Pocatello

(No. hospital

St.)

File No. 3 7039

Registered No. 121

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Mary E. Irie

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX female

4. COLOR OR RACE White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED Married

6. DATE OF BIRTH January 19, 1874

(Month)

(Day)

(Year)

7. AGE 39 yrs. 10 mos. 16 ds.

IF LESS than 1 day
how many hrs. or mins.?

8. OCCUPATION

(a) Trade, profession or particular kind of work Housewife

(b) General nature of industry, business, or establishment in which employed (or employer) Rancher

9. BIRTHPLACE

(State or Country) Utah

10. NAME OF FATHER Charles Green

11. BIRTHPLACE OF FATHER unknown

(State or Country)

12. MAIDEN NAME OF MOTHER Mrs. Ruth Smith

13. BIRTHPLACE OF MOTHER England

(State or Country)

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) John Irie

(Address) Mackay Idaho

15.

Filed Dec 5th 1913

3

Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH December 5 1913

(Month)

(Day)

(Year)

17. I HEREBY CERTIFY, That I attended deceased from Nov. 26 1913 to Dec. 5 1913

that I last saw her alive on Dec. 5 1913

and that death occurred on the date stated above, at 3p M.

The CAUSE OF DEATH* was as follows:

Septic Endocarditis

(Duration) 10 yrs. 10 mos. 10 ds.

Contributory (Secondary) Pneumonia

(Duration) 10 yrs. 10 mos. 10 ds.

(Signed) W. J. Howard M. D.

(Address) Pocatello, Idaho

State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.) Pocatello Hospital

At place of death 10 yrs. 10 mos. 10 days. In the State 25 yrs. 10 mos. 10 days.

Where was disease contracted if not at place of death? Mackay Idaho

Former or usual residence Mackay Idaho

19. PLACE OF BURIAL OR REMOVAL DATE OF BURIAL

Mackay Idaho 12th 1913

20. UNDERTAKER Crawford Schumacher

ADDRESS City

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Form V. S. No. 5 20M.1-16-12

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics
File No. 3 704
Registered No. 122

1. PLACE OF DEATH.

Registration District No. _____

County of Bannock

Primary Registration District No. 12161

City of Pocatello

(No. 408)

(St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Mr. Jamie Newberry

Registered No. 122

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX Male

4. COLOR OR RACE White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED. Married

6. DATE OF BIRTH

(Month)

(Day)

(Year) 1845

7. AGE 68 yrs. 10 mos. 13 ds.

IF LESS than 1 day how many hrs. or mins.?

8. OCCUPATION

(a) Trade, profession or particular kind of work Domestic

(b) General nature of industry, business, or establishment in which employed (or employer) House Employee

9. BIRTHPLACE

(State or Country) England

10. NAME OF FATHER

11. BIRTHPLACE OF FATHER

(State or Country)

12. MAIDEN NAME OF MOTHER

13. BIRTHPLACE OF MOTHER

(State or Country)

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) M. F. Hapaska

(Address) Pocatello Ida

15. Filed Dec 24 1913

Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH

(Month)

(Day)

(Year) 1913

17. I HEREBY CERTIFY, That I attended deceased from Dec 24 1913, to Dec 24 1913

that I last saw her alive on Dec 24 1913

and that death occurred on the date stated above, at 2:30 P. M.

The CAUSE OF DEATH* was as follows:

Thrombus

(Duration)

yrs.

mos.

ds.

Contributory

(Secondary)

(Duration)

yrs.

mos.

ds.

(Signed) J. H. Hapaska

1913 (Address) Pocatello Idaho

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place

of death.....yrs.....mos.....days.

In the

State.....yrs.....mos.....days.

Where was disease contracted if not at place of death?.....

Former or usual residence.....

19. PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

St. New Cemetery

Dec 26 1913

20. UNDERTAKER

ADDRESS

H. H. Walker

Pocatello Ida

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Form V. S. No. 5 20M.1-16-12

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH.

Registration District No. 70

County of Shoshone

Primary Registration District No. 111

City of Wallace

(No. _____, St.)

File No. 7051

Registered No. 3

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

Wallace Joseph Newell

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX

male

4. COLOR OR RACE

white

5. SINGLE, MARRIED, WIDOWED OR DIVORCED.

single
(Write the word.)

6. DATE OF BIRTH

(Month) (Day) (Year)

7. AGE

4 yrs. 18 mos. 18 ds.

IF LESS than 1 day
how many hrs. or mins.?

8. OCCUPATION

(a) Trade, profession or particular kind of work

none

(b) General nature of industry business, or establishment in which employed (or employer)

9. BIRTHPLACE

(State or Country)

Wallace

10. NAME OF FATHER

Wm Newell

11. BIRTHPLACE OF FATHER

(State or Country)

Michigan

12. MAIDEN NAME OF MOTHER

Kathleen Quinn

13. BIRTHPLACE OF MOTHER

(State or Country)

Iowa

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

(Address)

Wm Newell
Wallace, Ida.

15.

Filed

191

Wm Newell
Wallace, Ida.

Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH

(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from

Jan 8 1913, to Jan 11 1913,

that I last saw him alive on Jan 11 1913,

and that death occurred on the date stated above, at M.

The CAUSE OF DEATH* was as follows:

Cerebro spinal, Meningitis

(Duration) yrs. mos. 4 ds.

Contributory (Secondary)

(Duration) yrs. mos. ds.

(Signed)

Jan 12 1913 (Address) Wallace, Ida.

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death yrs. mos. days. In the State yrs. mos. days.

Where was disease contracted if not at place of death?

Former or usual residence.

19. PLACE OF BURIAL OR REMOVAL DATE OF BURIAL

Wallace 2da Jan 13 1914

20. UNDERTAKER

ADDRESS

Ward Undertaking Wallace 2da

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Form V. S. No. 5 20M.1-16-12

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH.

Registration District No. 11

County of BannockPrimary Registration District No. 2046

City of _____

(No. _____, _____ St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

Ellawcase WebbFile No. 7075Registered No. 8

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX

Female

4. COLOR OR RACE

W

5. SINGLE, MARRIED, WIDOWED OR DIVORCED.

Married
(Write the word.)

6. DATE OF BIRTH

10

(Month)

8

(Day)

1

(Year)

7. AGE

40 yrs.mos. 13 ds.IF LESS than 1 day
how many hrs. or
..... mins.?

8. OCCUPATION

(a) Trade, profession or particular kind of work
(b) General nature of industry business, or establishment in which employed (or employer)Wife

9. BIRTHPLACE

(State or Country)

Kaysville Utah

10. NAME OF FATHER

Christopher Layton

11. BIRTHPLACE OF FATHER

(State or Country)

England

12. MAIDEN NAME OF MOTHER

Mary Jane Roberts

13. BIRTHPLACE OF MOTHER

(State or Country)

England

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

Geo E Webb

(Address)

Dorsey

15.

Filed

Feb 10, 1914

Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH

Oct

(Month)

2

(Day)

1913

(Year)

17. I HEREBY CERTIFY, That I attended deceased from

Oct 61913

to

Oct 191913that I last saw h. or alive on 19 1913and that death occurred on the date stated above, at 10 P.M.

The CAUSE OF DEATH* was as follows:

Carcinoma Uterus(Duration) yrs. 6 mos. — ds.

Contributory (Secondary)

Child - birth(Duration) yrs. 14 mos. — ds.

(Signed)

Ca Spencer M. D.1913, (Address) Dorsey Ida.

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death yrs. mos. days. In the State yrs. mos. days.

Where was disease contracted if not at place of death?

Former or usual residence.

19. PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

Woodland Cemetery10/24 1913

20. UNDERTAKER

ADDRESS

Geo E LaytonDorsey

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Form V. S. No. 5 20M.1-16-12

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH
County of Bannock
City of Downey

Registration District No. 11
Primary Registration District No. 2046
(No. _____ St.)

File No. 7077
Registered No. 13

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Edwin G Miller

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX Male 4. COLOR OR RACE White 5. SINGLE, MARRIED, WIDOWED OR DIVORCED. Widowed
(Write the word.)

6. DATE OF BIRTH June 30 1913
(Month) (Day) (Year)

7. AGE 22 yrs 6 mos 26 ds.
IF LESS than 1 day how many hrs. or mins.?

8. OCCUPATION
(a) Trade, profession or particular kind of work Farmer
(b) General nature of industry business, or establishment in which employed (or employer)

9. BIRTHPLACE Vermont
(State or Country)

10. NAME OF FATHER John Miller

11. BIRTHPLACE OF FATHER Vermont
(State or Country)

12. MAIDEN NAME OF MOTHER Nancy P Nelson

13. BIRTHPLACE OF MOTHER Vermont
(State or Country)

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Chester Miller
(Address) _____

15. Filed Feb 10 1914 E. S. Karsen
Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH June 30 1913
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from June 24 1913, to June 30 1913
that I last saw him alive on 30 day of June 1913
and that death occurred on the date stated above, at 12 M.

The CAUSE OF DEATH* was as follows:

Cerebral Hemorrhage
(Apparatus)
(Duration) yrs. mos. 6 ds.

Contributory old age
(Secondary)
(Duration) yrs. mos. ds.

(Signed) C. S. Karsen M. D.
June 1913 (Address) Downey, Ida.

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death yrs. mos. days. In the State yrs. mos. days.

Where was disease contracted if not at place of death? _____

Former or usual residence _____

19. PLACE OF BURIAL OR REMOVAL Downey DATE OF BURIAL July 2 1913
20. UNDERTAKER E. S. Karsen ADDRESS _____

E. S. Karsen

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. FIRST-CLANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Form V. S. No. 5 20M.1-16-12

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics
File No. **7078**

1. PLACE OF DEATH.

Registration District No. **11 2046**

County of **Bannock**

Primary Registration District No. **2046**

City of _____

(No. _____, _____ St.)

Registered No. **12**

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

Hyram Jones

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX _____ 4. COLOR OR RACE _____ 5. SINGLE, MARRIED, WID-
OWED OR DIVORCED.

(Write the word.)

6. DATE OF BIRTH

4 **9** **1851**
(Month) (Day) (Year)

7. AGE

62 yrs. **5** mos. **15** ds.

IF LESS than 1 day
how many hrs. or
..... mins.?

8. OCCUPATION

(a) Trade, profession or
particular kind of work

Farmer

(b) General nature of industry
business, or establishment in
which employed (or employer)

9. BIRTHPLACE

(State or Country)

Wales

10. NAME OF
FATHER

David R Jones

11. BIRTHPLACE
OF FATHER

(State or Country)

Wales

12. MAIDEN NAME
OF MOTHER

13. BIRTHPLACE
OF MOTHER

(State or Country)

Wales

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

Elizabeth Jones

(Address)

Idaho

15.

Filed **Feb 10,** 191**4**

H. Ellis Karce

Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH

Sept 24 191**3**
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from

Jan 10 191**3**, to **Sept 24** 191**3**

that I last saw him alive on **Sept 20** 191**3**

and that death occurred on the date stated above, at **5 P.M.**

The CAUSE OF DEATH* was as follows:

Cerebral Hemorrhage

(Duration) **1** yrs. **0** mos. **0** ds.

Contributory **Arterio Sclerosis**
(Secondary)

(Duration) _____ yrs. _____ mos. _____ ds.

(Signed) **C. S. Newton** M. D.

10 (Address)

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death yrs. mos. days. In the State yrs. mos. days.

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL DATE OF BURIAL

Cambria Road Cemetery **Sept 27** 191**3**

20. UNDERTAKER

ADDRESS

C. E. Layton **Idaho**

Form V. S. No. 5 20M.1-16-12

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH

Registration District No. 11

County of

Primary Registration District No. 2046

City of

(No. , St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

James D Browning

File No. 1040

Registered No. 14

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX

M

4. COLOR OR RACE

W

5. SINGLE, MARRIED, WIDOWED OR DIVORCED.

Married
(Write the word.)

6. DATE OF BIRTH

Nov
(Month)26
(Day)1862
(Year)

7. AGE

50

yrs.

4

mos.

29

ds.

IF LESS than 1 day
how many hrs. or
..... mins.

8. OCCUPATION

(a) Trade, profession or particular kind of work

Farmer

(b) General nature of industry business, or establishment in which employed (or employer)

9. BIRTHPLACE

(State or Country)

Utah

10. NAME OF FATHER

Isaac Browning

11. BIRTHPLACE OF FATHER

(State or Country)

Ill

12. MAIDEN NAME OF MOTHER

Martha Loyd

13. BIRTHPLACE OF MOTHER

(State or Country)

England

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

W J Browning

(Address)

Ogden Utah

15.

Filed

Feb 10, 1914

1914

Erie Karcy

Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH

April 26 1913
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from

April 24 1913 to Apr 26 1913

that I last saw him alive on 26 Apr 1913

and that death occurred on the date stated above, at 2 P.M.

The CAUSE OF DEATH* was as follows:

Excision of Cervical Spinal
Cord - Accidental

(Duration) yrs. mos. 2 ds.

Contributory
(Secondary)

(Duration) yrs. mos. ds.

(Signed) Cassius W. Taylor M. D.

1913 (Address) Downey, Ida.

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death yrs. mos. days. In the State yrs. mos. days.

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL

Cambridge

DATE OF BURIAL

April 27 1913

20. UNDERTAKER

L E Layton

ADDRESS

Downey

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Form V. S. No. 5 20M.1-16-12

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH

Registration District No. 11County of BannockPrimary Registration District No. 2046City of Village Lomery(No.)

St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Jennie L. ShumwayFile No. 7083Registered No. 15

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX

4. COLOR OR RACE

5. SINGLE, MARRIED, WIDOWED OR DIVORCED.

FemaleWhite

(Write the word.)

6. DATE OF BIRTH

Oct
(Month)19
(Day)1910
(Year)

7. AGE

2 yrs. 6 mos. 19 ds.IF LESS than 1 day
how many hrs. or
..... mins.?

8. OCCUPATION

(a) Trade, profession or particular kind of work

None

(b) General nature of industry business, or establishment in which employed (or employer)

9. BIRTHPLACE

(State or Country)

Bannock Co. Idaho

10. NAME OF FATHER

Andrew J. Shumway

11. BIRTHPLACE OF FATHER

(State or Country)

Franklin Idaho

12. MAIDEN NAME OF MOTHER

Lois Lawthers

13. BIRTHPLACE OF MOTHER

(State or Country)

Utah

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Jane Evans(Address) Downey

15.

Filed Feb 10, 191414141414141414141414141414141414

Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH

5/12

(Month)

(Day)

1910

(Year)

17. I HEREBY CERTIFY, That I attended deceased from

3/27 — 1913, to 5/9 — 1913,that I last saw her alive on 5/9 — 1913,

and that death occurred on the date stated above, at — M.

The CAUSE OF DEATH* was as follows:

Empyema(Duration) yrs. 2 mos. — ds.Contributory Pneumonia
(Secondary)(Duration) yrs. 1 mos. — ds.(Signed) W. C. Cooper M. D.19 (Address) W. C. Cooper, M. D.

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death yrs. mos. days. In the State yrs. mos. days.

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

Marsh Center May 14, 1913

20. UNDERTAKER

ADDRESS

W. E. Layton Downey

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Form V. S. No. 5 20M.1-16-12

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics
File No. 7081
Registered No. 9

1. PLACE OF DEATH.

County of Bannock
City of Bella

Registration District No. 11Primary Registration District No. 2046

(No. _____ St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

John Criddle

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX

Male

4. COLOR OR RACE

White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED.

Married
(Write the word.)

6. DATE OF BIRTH

April

(Month)

16

(Day)

1

(Year)

7. AGE

53

yrs.

6

mos.

14

ds.

IF LESS than 1 day
how many hrs. or
..... mins.?

8. OCCUPATION

(a) Trade, profession or
particular kind of work

Farmer

(b) General nature of industry
business, or establishment in
which employed (or employer)

9. BIRTHPLACE

(State or Country)

Utah

10. NAME OF FATHER

John Criddle

11. BIRTHPLACE OF FATHER

(State or Country)

England

12. MAIDEN NAME OF MOTHER

Elizabeth Ann Taylor

13. BIRTHPLACE OF MOTHER

(State or Country)

England

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

Mrs John Criddle

(Address)

Downey

15.

Filed

Feb 10, 1914

191

Edna Kacey

Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH

Nov

(Month)

1

(Day)

1913

(Year)

17. I HEREBY CERTIFY, That I attended deceased from

April 1, 1913 to Nov 1, 1913that I last saw him alive on Nov 1, 1913and that death occurred on the date stated above, at 5 P. M.

The CAUSE OF DEATH* was as follows:

Myocarditis, Endocarditis(Duration) 6 yrs. mos. ds.Contributory Chronic Infectious hepatitis
(Secondary)(Duration) 8 yrs. mos. ds.(Signed) Carpenwood M. D.Nov 1, 1913 (Address) Downey

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death yrs. mos. days. In the State yrs. mos. days.

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

Downey CemeteryNov 4, 1913

20. UNDERTAKER

ADDRESS

6 E Layton

CLANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Form V. S. No. 5 20M.1-16-12

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics
7098

1. PLACE OF DEATH.

Registration District No. 14

County of Adams

Primary Registration District No. 2011

City of Indian Valley

(No., St.)

File No. 2

Registered No. 73

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Sarah Addie Cornell

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX 4. COLOR OR RACE 5. SINGLE, MARRIED, WIDOWED OR DIVORCED.

Female White (Write the word.)

6. DATE OF BIRTH
May 14 1894
(Month) (Day) (Year)

7. AGE
69 yrs. 5 mos. 28 ds.
IF LESS than 1 day how many hrs. or mins.?

8. OCCUPATION
(a) Trade, profession or particular kind of work House Wife
(b) General nature of industry business, or establishment in which employed (or employer)

9. BIRTHPLACE
(State or Country) New Jersey

10. NAME OF FATHER Jacob Everson

11. BIRTHPLACE OF FATHER
(State or Country) Pennsylvania

12. MAIDEN NAME OF MOTHER

13. BIRTHPLACE OF MOTHER
(State or Country)

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Jacob Cornell
(Address) Indian Valley Ida

15. Filed 2-18 1914 Frank E. Benson
Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH
Nov 1 1913
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from 5 1912, to 7-4 1918 that I last saw her alive on 7-4 1918 and that death occurred on the date stated above, at M.

The CAUSE OF DEATH* was as follows:
apoplexy

(Duration) 7 yrs. mos. ds.

Contributory (Secondary)
(Duration) yrs. mos. ds.
(Signed) Frank E. Benson M. D.
3-31-1914 (Address) Cornell Idaho

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death yrs. mos. days. In the State yrs. mos. days.
Where was disease contracted if not at place of death?
Former or usual residence

19. PLACE OF BURIAL OR REMOVAL Indian Valley DATE OF BURIAL 191

20. UNDERTAKER J. H. Hudson ADDRESS Cambridge

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Form V. S. No. 5 20M.1-16-12

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH

Registration District No. 4County of AdamsPrimary Registration District No. 2011City of Goodrich

(No. _____, _____ St.)

File No. 24091Registered No. 48-

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

Henry Arthur Schoonover

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX

Male

4. COLOR OR RACE

White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED.

Single
(Write the word.)

6. DATE OF BIRTH

Nov
(Month)7
(Day)1911
(Year)

7. AGE

1
yrs.11
mos.16
ds.

IF LESS than 1 day
how many _____ hrs. or
_____ mins.?

8. OCCUPATION

(a) Trade, profession or particular kind of work

(b) General nature of industry business, or establishment in which employed (or employer)

9. BIRTHPLACE

(State or Country)

Crooked River Ida

10. NAME OF FATHER

R. E. Schoonover

11. BIRTHPLACE OF FATHER

(State or Country)

Penn

12. MAIDEN NAME OF MOTHER

Anne Stevenson

13. BIRTHPLACE OF MOTHER

(State or Country)

Kansas

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

Myrtle Schoonover

(Address)

Goodrich Idaho

15.

Filed

2-181914Frank E. Brown

Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH

Oct
(Month)22
(Day)1913
(Year)

17. I HEREBY CERTIFY, That I attended deceased from

Oct 22-1913,

to

191that I last saw him alive on Oct 22- 9:45 PM 1913,

and that death occurred on the date stated above, at _____ M.

The CAUSE OF DEATH* was as follows:

Cholera Infantum

(Duration)

yrs.

mos.

2 ds.Contributory
(Secondary)Branch pneumonia

(Duration)

yrs.

mos.

ds.

(Signed)

Clyde E. Watson

M. D.

Oct 23 1913

(Address)

Council

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place

of death

yrs.

mos.

days.

In the

State

yrs.

mos.

days.

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

191

20. UNDERTAKER

ADDRESS

J. A. WilsonCambridge

Form V. S. No. 5 20M.1-16-12

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH

Registration District No. 88 4County of AdamsPrimary Registration District No. 2164 2011File No. 2100City of Ledain Valley

(No. _____) (St. _____)

Registered No. 44

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

Baby Dunham

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX

4. COLOR OR RACE

5. SINGLE, MARRIED, WIDOWED OR DIVORCED.

Female CaucasianSingle
(Write the word.)

6. DATE OF BIRTH

Sept 26 1913
(Month) (Day) (Year)

7. AGE

36
yrs. mos. ds.IF LESS than 1 day
how many hrs. or mins.?

8. OCCUPATION

- (a) Trade, profession or particular kind of work
-
- (b) General nature of industry, business, or establishment in which employed (or employer)

9. BIRTHPLACE

(State or Country)

Ledain Valley

10. NAME OF FATHER

Robert Dunham

11. BIRTHPLACE OF FATHER

(State or Country)

Ill

12. MAIDEN NAME OF MOTHER

Minna Frederson

13. BIRTHPLACE OF MOTHER

(State or Country)

Washington

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

C. E. Schumtz

(Address)

Cambridge

15.

Filed

Sept 27 1913 C. E. Schumtz
Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

Sept 26 1913
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from

Sept 26 1913, to Sept 26 1913,that I last saw her alive on Sept 26 1913,and that death occurred on the date stated above, at 5 P.M.

The CAUSE OF DEATH* was as follows:

Immature

(Duration) yrs. mos. ds.

Contributory
(Secondary)

(Duration) yrs. mos. ds.

(Signed)

C. E. Schumtz

M. D.

Sept 27 1913 (Address) Cambridge

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death yrs. mos. days. In the State yrs. mos. days.

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

Madison1913

20. UNDERTAKER

ADDRESS

J. A. FredersonCambridge

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Form V. S. No. 5. 12½ M. 7-24-11

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics
File No. 7103
Registered No. 62

1. PLACE OF DEATH. Registration District No. 14
County of Custer Primary Registration District No. 2060
City of _____ (No. _____, St. _____)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Barthard Gramp

If death occurred in a hospital, institution or camp give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX male 4. COLOR OR RACE white 5. SINGLE, MARRIED, WIDOWED OR DIVORCED. single
(Write the word.)

6. DATE OF BIRTH Doubt know 1850
(Month) (Day) (Year)

7. AGE 63 yrs. mos. ds. IF LESS than 1 day how many hrs. or min?

8. OCCUPATION
(a) Trade, profession or particular kind of work. Miner
(b) General nature of industry business or establishment in which employed (or employer)

9. BIRTHPLACE Germany
(State or Country)

10. NAME OF FATHER Doubt know

11. BIRTHPLACE OF FATHER Germany
(State or Country)

12. MAIDEN NAME OF MOTHER Doubt know

13. BIRTHPLACE OF MOTHER Germany
(State or Country)

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) August Sargent
(Address) Clayton, Ida.

15. C. J. Rother
By R. B. Berner
Local Registrar

Filed Nov. 27 1913

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH Nov 27 1913
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from 191 , to 191

that I last saw him alive on 191

and that death occurred on the date stated above, at M.

The CAUSE OF DEATH* was as follows:

Myocarditis (probably)
"Was found dead in bed by friends"
(Duration) yrs. mos. ds.

Contributory Rheumatism
(Secondary)

(Duration) 20 yrs. mos. ds.
(Signed) J. W. Keller M. D.
Nov 28, 1913 (Address) Challis

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death yrs. mos. ds. In the State yrs. mos. ds.
Where was disease contracted,
If not at place of death?
Former or usual residence.

19. PLACE OF BURIAL OR REMOVAL Challis - Idaho DATE OF BURIAL Nov 29 1913

20. UNDERTAKER J. L. Eberle ADDRESS Challis, Ida

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK. THIS IS A PERMANENT RECORD. N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Form V. S. No. 5 20M.1-16-12

CERTIFICATE OF DEATH

1713
1913
12/8/2

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH. Registration District No. _____
County of Idaho Primary Registration District No. 1003
City of Conrad (No. _____ St.)

File No. 1111
Registered No. 357

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME W J Mc Elum

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX male 4. COLOR OR RACE white 5. SINGLE, MARRIED, WIDOWED OR DIVORCED. widow
(Write the word.)

6. DATE OF BIRTH _____
(Month) (Day) (Year) 1913

7. AGE 36 yrs. _____ mos. _____ ds. IF LESS than 1 day how many _____ hrs. or _____ mins.?

8. OCCUPATION
(a) Trade, profession or particular kind of work _____
(b) General nature of industry, business, or establishment in which employed (or employer) _____

9. BIRTHPLACE Ireland
(State or Country)

10. NAME OF FATHER _____

11. BIRTHPLACE OF FATHER _____
(State or Country)

12. MAIDEN NAME OF MOTHER _____

13. BIRTHPLACE OF MOTHER _____
(State or Country)

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) W J Mc Elum
(Address) Conrad

15. Filed 12/10 1913 W J Mc Elum
Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH Nov. 5 1913
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from Sept 29 1913, to Nov. 5 1913, that I last saw him alive on Nov. 4 1913, and that death occurred on the date stated above, at 1230 A.

The CAUSE OF DEATH* was as follows:

Chronic
Intermittent Nephritis

(Duration) _____ yrs. _____ mos. _____ ds.
Contributory (Secondary) _____

(Duration) _____ yrs. _____ mos. _____ ds.
(Signed) W J Mc Elum M. D.
Nov 5 1913 (Address) Conrad Idaho

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death _____ yrs. _____ mos. _____ days. In the State _____ yrs. _____ mos. _____ days.

Where was disease contracted if not at place of death? _____

Former or usual residence _____

19. PLACE OF BURIAL OR REMOVAL St Thomas Cem DATE OF BURIAL _____ 1913

20. UNDERTAKER W J Mc Elum ADDRESS Conrad

-SUPPLEMENTARY DEATH CERTIFICATE-

(Please reply on this sheet to
the registrar of Vital Statistics)

Death Certificate No. _____

Name _____ W. J. McClure

Date of Death _____ November 5, 1913.

Cause of Death *Chronic Interstitial Nephritis*

Contributory Cause of death _____

RECEIVED

DEC 22 1913

(Sign here) _____

J. C. Brown

M.D.

OFFICE
STATE BOARD OF HEALTH

Form V. S. No. 5. 10M. 6-20-11.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH.
County of Blaine
City of Belleue

Registration District No. 21
Primary Registration District No. 2022
(No. _____, St.)

File No. 1112
Registered No. 44

If death occurred in a hospital, institution or camp give its NAME instead of street and number.

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

Thomas Roark

PERSONAL AND STATISTICAL PARTICULARS

3. SEX M 4. COLOR OR RACE W 5. SINGLE, MARRIED, WIDOWED OR DIVORCED. Married
(Write the word.)

6. DATE OF BIRTH Aug 18 1867
(Month) (Day) (Year)

7. AGE 66 yrs. 0 mos. 0 ds. IF LESS than 1 day how many hrs. or min.?

8. OCCUPATION
(a) Trade, profession, or particular kind of work Minie Blacksmith
(b) General nature of industry business, or establishment in which employed (or employer)

9. BIRTHPLACE (State or Country) Mo

10. NAME OF FATHER Marion Roark

11. BIRTHPLACE OF FATHER (State or Country) Mo

12. MAIDEN NAME OF MOTHER Mercy Smith

13. BIRTHPLACE OF MOTHER (State or Country) Mo

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Mrs. T. Roark
(Address) Belleue Ida

15. Nov 12 1913 Robert H. Wright
Filed Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH Nov 8 1913
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from Nov 4 1913 to Nov 8 1913
that I last saw him alive on Nov 8 1913
and that death occurred on the date stated above, at 8 30 A.M.

The CAUSE OF DEATH* was as follows:

Pneumonia
Lobar
(Duration) yrs. mos. 4 ds.

Contributory Exposure - Recurrent attack
(Secondary) this being 5th severe attack

(Duration) yrs. mos. ds.
(Signed) E. H. Klemm M. D.
Nov 8 1913 (Address) Hailey

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions Transients or Recent Residents.)

At place In the
of death yrs. mos. ds. State yrs. mos. ds.
Where was Disease contracted,
If not at place of death?
Former or
usual residence.

19. PLACE OF BURIAL OR REMOVAL Belleue Ida DATE OF BURIAL Nov 10 1913

20. UNDERTAKER None ADDRESS -

-SUPPLEMENTARY DEATH CERTIFICATE-

(Please reply on this sheet to
the registrar of Vital Statistics)

Death Certificate No.

Name..... Thomas Roark

Date of Death..... November 8th, 1913.

Cause of Death..... *lobar Pneumonia*

Contributory Cause of death.....

(Sign here)

E. W. Kleiman M.D.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Form V. S. No. 5. 10M. 6-20-11.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH. Registration District No.
County of Canyon Primary Registration District No.
City of Idaho (No. St.)

File No. 7113
Registered No.

If death occurs away from usual residence, give facts called for under special information.

If death occurred in a hospital, institution or camp give its NAME instead of street and number.

2. FULL NAME

James Milligan

PERSONAL AND STATISTICAL PARTICULARS

3. SEX 4. COLOR OR RACE 5. SINGLE, MARRIED, WIDOWED OR DIVORCED.

Male White Single
(Write the word.)

6. DATE OF BIRTH

Dec 31 1906
(Month) (Day) (Year)

7. AGE

6 yrs. 11 mos. 7 ds.

IF LESS than 1 day
how many hrs. or
..... min.?

8. OCCUPATION

(a) Trade, profession, or particular kind of work

(b) General nature of industry business, or establishment in which employed (or employer)

None

9. BIRTHPLACE

(State or Country)

Idaho

10. NAME OF FATHER

Thos. Milligan

11. BIRTHPLACE OF FATHER

(State or Country)

Scotland

12. MAIDEN NAME OF MOTHER

Leah Roth

13. BIRTHPLACE OF MOTHER

(State or Country)

Ohio

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

Thomas Milligan
Nampa Ida
(Address)

15.

Filed Dec 4 1913 D. D. Calange
Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

December 31st 1913
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from Dec 1st 1913, to Dec 5 1913

that I last saw him alive on Dec 5 1913, and that death occurred on the date stated above, at 11:30 P.M.

The CAUSE OF DEATH* was as follows:

General Peritonitis

(Duration) yrs. mos. 5 ds.

Contributory (Secondary)

(Duration) yrs. mos. ds.

(Signed) H. P. Ross M. D.
Dec 5 1913 (Address) Nampa Ida

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place In the
of death yrs. mos. ds. State yrs. mos. ds.

Where was Disease contracted,
If not at place of death?
Former or usual residence.

19. PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

Kohlerlawn Cem 12/7 1913

20. UNDERTAKER

ADDRESS

F. H. Hume Nampa Ida

-SUPPLEMENTARY DEATH CERTIFICATE-

(Please reply on this sheet to
the registrar of Vital Statistics)

Death Certificate No.

Name.....James Milligan.....

Date of Death.....December 3.....

Cause of Death.....*General peritonitis (acute)*.....

Contributory Cause of death *Don't know positively as he was lightly disoriented
when I first saw him and lived only a short time
probably a ruptured appendix*

(Sign here)

H. P. Ross

M.D.

Form V. S. No. 5 20M.1-16-12

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH.

Registration District No. 96County of Key PercePrimary Registration District No. 1009City of Lewiston(No. 306, 3rd Ave St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

Michael MitchellFile No. 7111Registered No. 38

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX

male

4. COLOR OR RACE

white

5. SINGLE, MARRIED, WIDOWED OR DIVORCED.

married
(Write the word.)

6. DATE OF BIRTH

September 29 1838
(Month) (Day) (Year)

7. AGE

70 yrs. 1 mos. 9 ds.IF LESS than 1 day
how many hrs. or
mins.

8. OCCUPATION

(a) Trade, profession or particular kind of work

Laborer

(b) General nature of industry business, or establishment in which employed (or employer)

Lewiston (City)

9. BIRTHPLACE

(State or Country)

Ireland

10. NAME OF FATHER

Patrick Mitchell

11. BIRTHPLACE OF FATHER

(State or Country)

Ireland

12. MAIDEN NAME OF MOTHER

unknown

13. BIRTHPLACE OF MOTHER

(State or Country)

Ireland

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

Michael J. Mitchell

(Address)

306-3rd Ave
Lewiston, Idaho

15.

Filed

Dec 101913L. J. Perkins

Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH

Nov 6 1913
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from

Oct 5 1913 to Nov 6 1913that I last saw him alive on Nov 6 1913and that death occurred on the date stated above, at 4:15 P.M.

The CAUSE OF DEATH* was as follows:

Heart disease(Duration) Three yrs. — mos. — ds.Contributory
(Secondary)(Duration) — yrs. — mos. — ds.

(Signed)

J. M. O'Sullivan

M. D.

Nov 7 1913 (Address) Lewiston

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death — yrs. — mos. — days. In the State — yrs. — mos. — days.

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL

Lewiston

DATE OF BURIAL

Nov 8 1913

20. UNDERTAKER

C. J. Vassar

ADDRESS

Lewiston

-SUPPLEMENTARY DEATH CERTIFICATE-

(Please reply on this sheet to
the registrar of Vital Statistics)

Death Certificate No.

Name Michael Mitchell

Date of Death November 6th

Cause of Death Chronic endocarditis

Contributory Cause of death Brandulitis

(Sign here)

J. B. Morris

Form V. S. No. 5 20M.1-16-12

CERTIFICATE OF DEATH

 State of Idaho
 BOARD OF HEALTH
 Bureau of Vital Statistics

1. PLACE OF DEATH.

Registration District No. 42County of LemhiPrimary Registration District No. 2116City of Salmon

(No. _____ St.)

File No. 1115Registered No. 1115

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

Katherine Franz

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX

4. COLOR OR RACE

5. SINGLE, MARRIED, WIDOWED OR DIVORCED.

Female WhiteMarried
(Write the word.)

6. DATE OF BIRTH

June 8 1833
(Month) (Day) (Year)

7. AGE

80 yrs. 4 mos. 26 ds.
 IF LESS than 1 day
 how many hrs. or
 mins.

8. OCCUPATION

(a) Trade, profession or particular kind of work

Housewife

(b) General nature of industry, business, or establishment in which employed (or employer)

Woman Housewife

9. BIRTHPLACE

(State or Country)

Bohemia Europe

10. NAME OF FATHER

John Ostror Europe

11. BIRTHPLACE OF FATHER

(State or Country)

Europe

12. MAIDEN NAME OF MOTHER

Don't know

13. BIRTHPLACE OF MOTHER

(State or Country)

Europe

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

William Tadel

(Address)

Salmon, Ida.

15.

Filed

November 4 - 1913 Allen Smith

Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH

November 3 1913
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from

Oct 28th 1913, to November 3 1913.that I last saw her alive on November 3 1913.and that death occurred on the date stated above, at 80 M.

The CAUSE OF DEATH* was as follows:

Pneumonia(Duration) yrs. mos. 7 ds.

Contributory (Secondary)

Old age

(Duration) yrs. mos. ds.

(Signed)

Whitlock Wright

M. D.

11-4-1913

(Address)

Salmon

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death.....yrs.....mos.....days. In the State.....yrs.....mos.....days.

Where was disease contracted if not at place of death?.....

Former or usual residence.....

19. PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

SalmonNov. 4 1913

20. UNDERTAKER

ADDRESS

Am. C. Roebler Salmon

-SUPPLEMENTARY DEATH CERTIFICATE-

(Please reply on this sheet to
the registrar of Vital Statistics)

Death Certificate No. _____

Name _____ Catherine Fronz _____

Date of Death _____ November 3rd _____

Cause of Death _____ Bronch. pneumonia _____

Contributory Cause of death _____ old age _____

(Sign here) _____ *Robert H. Hylk* _____ M.D.

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSI-
CIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact state-
ment of OCCUPATION is very important. See instructions on back of certificate.

Form V. S. No. 5 20M.1-16-12

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH.

Registration District No.

County of *Bannock*

Primary Registration District No.

City of *Pocatello*

(No. *1357 N. 3rd ave.* St.)

File No.

Registered No. *98*

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

Marion George Edwards

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX

Male

4. COLOR OR RACE

White

5. SINGLE, MARRIED, WID-OWED OR DIVORCED.

Single
(Write the word.)

6. DATE OF BIRTH

May 15 1912
(Month) (Day) (Year)

7. AGE

1 yrs. *4* mos. *24* ds.

IF LESS than 1 day
how many hrs. or mins.?

8. OCCUPATION

(a) Trade, profession or particular kind of work

None.

(b) General nature of industry business, or establishment in which employed (or employer)

9. BIRTHPLACE

(State or Country)

Pocatello

10. NAME OF FATHER

Chas Edwards

11. BIRTHPLACE OF FATHER

(State or Country)

Melbourne Australia

12. MAIDEN NAME OF MOTHER

Laura Pearl Lockyer.

13. BIRTHPLACE OF MOTHER

(State or Country)

Idaho

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

Chas Edwards

(Address)

Pocatello

15.

Filed

Oct 10 1913

Local Registry

Local Registry

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH

Oct 9 1913
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from *Oct 2nd 1913* to *Oct 9 1913*

that I last saw him alive on *Oct 9 1913* and that death occurred on the date stated above, at *10 P.M.*

The CAUSE OF DEATH* was as follows:

Marasmus

(Duration) yrs. mos. ds.

Contributory (Secondary)

(Duration) yrs. mos. ds.

(Signed)

Oct 9 1913 (Address) *McCastle* M. D.

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death yrs. mos. days. In the State yrs. mos. days.

Where was disease contracted if not at place of death?

Former or usual residence.

19. PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

McCastle Cemetery

Oct 11 1913

20. UNDERTAKER

ADDRESS

M. M. Walker

Pocatello Idaho

111111

-SUPPLEMENTARY DEATH CERTIFICATE-

(Please reply on this sheet to
the registrar of Vital Statistics)

Death Certificate No.

Name Clarence Edwards

Date of Death October 9, 1913.

Cause of Death Tuberculosis of Bowels

Contributory Cause of death Insanitary Surrounding & Poverty

(Sign here) W. A. Cantle M.D.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Form V. S. No. 5. 12½ M. 7-24-11

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH. Registration District No.
County of Latah Primary Registration District No. 2148.
City of Julietta (No., St.)

File No. 7171
Registered No.

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME David Albert Jones

If death occurred in a hospital, institution or camp give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX M. 4. COLOR OR RACE W. 5. SINGLE, MARRIED, WIDOWED OR DIVORCED. married.
(Write the word.)

6. DATE OF BIRTH April 29, 18
(Month) (Day) (Year)

7. AGE 78 yrs. 6 mos. 7 ds. IF LESS than 1 day
how many hrs. or
..... min?

8. OCCUPATION Farmer.
(a) Trade, profession or particular kind of work.
(b) General nature of industry business or establishment in which employed (or employer)

9. BIRTHPLACE Indiana.
(State or Country)

10. NAME OF FATHER Jas. H. Jones

11. BIRTHPLACE OF FATHER
(State or Country)

12. MAIDEN NAME OF MOTHER

13. BIRTHPLACE OF MOTHER
(State or Country)

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Albert H. Jones
(Address)

15. Filed Oct 5th 1913 S. A. Roe
Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH Nov. 4 1913
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from February 1913, to Oct 28 1913
that I last saw him alive on Oct 28 1913
and that death occurred on the date stated above, at 10²⁰ P.M.
The CAUSE OF DEATH* was as follows:

Cancer of Rectum

(Duration) yrs. mos. ds.
Contributory (Secondary)

(Duration) 3 yrs. 6 mos. — ds.
(Signed) S. A. Roe M. D.
Nov 5 1913 (Address) Julietta, Ida

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place In the
of death yrs. mos. ds. State yrs. mos. ds.
Where was disease contracted,
If not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL Cameron, Ida DATE OF BURIAL Nov 6 1913

20. UNDERTAKER None ADDRESS

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Form V. S. No. 5. 12½ M. 7-24-11

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH LATAH
County of _____
City of _____
Registration District No. _____
Primary Registration District No. _____
(No. _____, St. _____)

File No. 1173

Registered No. _____

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Robert Bruce Vaughan

If death occurred in a hospital, institution or camp give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX M 4. COLOR OR RACE W 5. SINGLE, MARRIED, WIDOWED OR DIVORCED. Married
(Write the word.)

6. DATE OF BIRTH Aug 4 1863
(Month) (Day) (Year)

7. AGE 50 yrs 3 mos 17 ds. IF LESS than 1 day
how many hrs. or min?

8. OCCUPATION
(a) Trade, profession or particular kind of work Farmer
(b) General nature of industry business or establishment in which employed (or employer)

9. BIRTHPLACE Idaho
(State or Country)

10. NAME OF FATHER Neal Vaughan

11. BIRTHPLACE OF FATHER U. S.
(State or Country)

12. MAIDEN NAME OF MOTHER —

13. BIRTHPLACE OF MOTHER —
(State or Country)

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) R. B. Vaughan
(Address) Julietta, Ida

15. Filed Nov 22 1913 S. A. Roe
Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH Nov 21 1913
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from Oct 31 1913, to Nov 19 1913
that I last saw him alive on Nov 19 1913
and that death occurred on the date stated above, at _____ M.

The CAUSE OF DEATH* was as follows:
Pernicious Anemia

_____ (Duration) _____ yrs. _____ mos. _____ ds.

Contributory (Secondary) _____

_____ (Duration) _____ yrs. _____ mos. _____ ds.

(Signed) S. A. Roe M. D.
Nov 23 1914 (Address) Julietta

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place In the
of death _____ yrs. _____ mos. _____ ds. State _____ yrs. _____ mos. _____ ds.
Where was disease contracted,
If not at place of death? _____
Former or
usual residence _____

19. PLACE OF BURIAL OR REMOVAL Linden, Ida. DATE OF BURIAL Nov 23 1914

20. UNDERTAKER None ADDRESS _____

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Form V. S. No. 5. 12½ M. 7-24-11

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics
File No. 1173
Registered No. _____

1. PLACE OF DEATH
County of Latah
City of Julietta
Registration District No. _____
Primary Registration District No. 2148
(No. _____, St. _____)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME John Stump

If death occurred in a hospital, institution or camp give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX Male 4. COLOR OR RACE White 5. SINGLE, MARRIED, WIDOWED OR DIVORCED.
(Write the word.)
6. DATE OF BIRTH Oct 23 1824
(Month) (Day) (Year)

7. AGE 89 yrs. 24 ds. IF LESS than 1 day how many _____ hrs. or _____ min?

8. OCCUPATION
(a) Trade, profession or particular kind of work.
(b) General nature of industry business or establishment in which employed (or employer)

9. BIRTHPLACE Penn
(State or Country)

10. NAME OF FATHER Benj. Stump

11. BIRTHPLACE OF FATHER Penn
(State or Country)

12. MAIDEN NAME OF MOTHER Don't know

13. BIRTHPLACE OF MOTHER Don't know
(State or Country)

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) W. H. Stump
(Address) Julietta, Ida

15. Nov 17 1913
Filed sa Roe
Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH Nov 16 1913
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from _____ 191____, to _____ 191____
that I last saw h_____ alive on _____ 191____
and that death occurred on the date stated above, at _____ M.
The CAUSE OF DEATH* was as follows:

Died without medical attendance
(Duration) _____ yrs. _____ mos. _____ ds.
Contributory _____
(Secondary) _____
(Duration) _____ yrs. _____ mos. _____ ds.
(Signed) _____ M. D.
_____ 19____ (Address) _____

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; (2) whether ACCIDENTAL, SUICIDAL OR HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place _____ In the _____
of death _____ yrs. _____ mos. _____ ds. State _____ yrs. _____ mos. _____ ds.
Where was disease contracted;
If not at place of death? _____
Former or _____
usual residence _____

19. PLACE OF BURIAL OR REMOVAL Julietta, Ida. DATE OF BURIAL Nov 18 1913

20. UNDERTAKER J. C. Brown ADDRESS Julietta, Idaho

Form V. S. No. 5 20M.1-16-12

CERTIFICATE OF DEATH

 State of Idaho
 BOARD OF HEALTH
 Bureau of Vital Statistics

1. PLACE OF DEATH.

Registration District No. 3County of CanyonPrimary Registration District No. 2005City of near Caldwell

(No. _____ St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME John A. WebbFile No. 7375Registered No. 87

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX

Male

4. COLOR OR RACE

W.5. SINGLE, MARRIED, WID-
OWED OR DIVORCED.married
(Write the word.)

6. DATE OF BIRTH

May51858

(Month)

(Day)

(Year)

7. AGE

55 yrs. 5 mos. 3 ds.
 IF LESS than 1 day
 how many hrs. or
 mins.?

8. OCCUPATION

(a) Trade, profession or particular kind of work

Farmer

(b) General nature of industry business, or establishment in which employed (or employer)

9. BIRTHPLACE

(State or Country)

Russell Co Ky

10. NAME OF FATHER

Credwell Webb

11. BIRTHPLACE OF FATHER

(State or Country)

Ky

12. MAIDEN NAME OF MOTHER

Mary Smith

13. BIRTHPLACE OF MOTHER

(State or Country)

Ky

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

Ed. Mumford

(Address)

Caldwell

15.

Filed Oct. 17 1913John S. Meyer
Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH

Oct81913

(Month)

(Day)

(Year)

17. I HEREBY CERTIFY, That I attended deceased from

Oct 51913to Oct 81913that I last saw him alive on Oct 8 1913and that death occurred on the date stated above, at 10 P.M.

The CAUSE OF DEATH* was as follows:

Heart Failure

(Duration)

yrs.

mos.

ds.

Contributory
(Secondary)

(Duration)

yrs.

mos.

ds.

(Signed)

S. J. Miller

M. D.

Oct 17 1913(Address) Caldwell Idaho

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death

yrs.

mos.

days.

In the State

yrs.

mos.

days.

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

Pleasant RidgeOct 18 1913

20. UNDERTAKER

ADDRESS

W. G. DyerCaldwell

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Form V. S. No. 5 20M.1-16-12

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH.

Registration District No. 73

County of Bonanza

Primary Registration District No. 2157

City of Lab. Lee

(No. 73 St.)

File No. 7423

Registered No. 2157

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

Wm Hill

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX

Male

4. COLOR OR RACE

White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED.

Married
(Write the word.)

6. DATE OF BIRTH

1 (Month) 1 (Day) 1913 (Year)

7. AGE

28 yrs. 2 mos. 28 ds.

IF LESS than 1 day
how many hrs. or mins.

8. OCCUPATION

(a) Trade, profession or particular kind of work
(b) General nature of industry, business, or establishment in which employed (or employer)

Labored

9. BIRTHPLACE

(State or Country)

Idaho

10. NAME OF FATHER

Geo. Hill

11. BIRTHPLACE OF FATHER

(State or Country)

England

12. MAIDEN NAME OF MOTHER

13. BIRTHPLACE OF MOTHER

(State or Country)

England Utah

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

W. Jackson

(Address)

Lab. Lee, etc.

15.

Filed

3/13

1914

W. Hill

Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

Nov. 29 1913
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from

1913, to 1913,

that I last saw h. 1913 alive on 1913,

and that death occurred on the date stated above, at 1913.

The CAUSE OF DEATH* was as follows:

Accidental
Asphyxiation

(Duration) yrs. mos. ds.

Contributory

(Secondary)

(Duration) yrs. mos. ds.

(Signed)

3/13 1914 (Address) Idaho Falls Idaho

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death. yrs. mos. days. In the State. yrs. mos. days.

Where was disease contracted if not at place of death?

Former or usual residence.

19. PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

Peggy Idaho

3/14 1914

20. UNDERTAKER

ADDRESS

Linwood 2 G

Idaho Idaho

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Form V. S. No. 5. 10M. 6-20-11.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH.

Registration District No. 78County of BonnerPrimary Registration District No. 2153City of Clackfork

(No. _____, _____ St.)

File No. 7444Registered No. 478

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

Emma F. Boyd

If death occurred in a hospital, institution or camp give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX

F.

4. COLOR OR RACE 5. SINGLE, MARRIED, WIDOWED OR DIVORCED.

White(Write the word Widow)

6. DATE OF BIRTH

Apr271913

(Month)

(Day)

(Year)

7. AGE

65 yrs.6 mos.ds.

IF LESS than 1 day

how many _____ hrs. or _____ min.?

8. OCCUPATION

- (a) Trade, profession or particular kind of work
(b) General nature of industry business or establishment in which employed (or employer)

Housewife

9. BIRTHPLACE

(State or Country)

Clatsop Co. O.

10. NAME OF FATHER

Brown

11. BIRTHPLACE OF FATHER

(State or Country)

12. MAIDEN NAME OF MOTHER

13. BIRTHPLACE OF MOTHER

(State or Country)

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

Walter Flemming

(Address)

Clackfork

15.

Filed 2-20 1914 Wm M. Kinnon

Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

May

(Month)

3rd

(Day)

1913

(Year)

17. I HEREBY CERTIFY, That I attended deceased from

Nov. 2nd 1912, to May 3rd 1913that I last saw her alive on May 3rd 1913,and that death occurred on the date stated above, at 9 P.M.

The CAUSE OF DEATH* was as follows:

La Grippe(Duration) yrs. 3 weeks & ds.

Contributory (Secondary)

Mal-Nutrition(Duration) yrs. 8 mos. ds.

(Signed)

R. M. Kinnon M. D.5/6 1913 (Address) Hope

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death. _____ yrs. _____ mos. _____ ds. State. _____ yrs. _____ mos. _____ ds.

Where was disease contracted.

If not at place of death? _____

Former or

usual residence. _____

19. PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

Clackfork5/61913

20. UNDERTAKER

ADDRESS

B. W. Frank

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Form V. S. No. 5 20M.1-16-12

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH.

Registration District No.

County of

Primary Registration District No.

City of

(No.

St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

File No.

Registered No.

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX

4. COLOR OR RACE

5. SINGLE, MARRIED, WIDOWED OR DIVORCED.

6. DATE OF BIRTH

7. AGE

IF LESS than 1 day
how many hrs. or
mins.?

8. OCCUPATION

(a) Trade, profession or particular kind of work

(b) General nature of industry business, or establishment in which employed (or employer)

9. BIRTHPLACE

(State or Country)

10. NAME OF FATHER

11. BIRTHPLACE OF FATHER

(State or Country)

12. MAIDEN NAME OF MOTHER

13. BIRTHPLACE OF MOTHER

(State or Country)

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

(Address)

15.

Filed

1914

Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

17. I HEREBY CERTIFY, That I attended deceased from

191., to 191.,

that I last saw h. alive on 191.,

and that death occurred on the date stated above, at M.

The CAUSE OF DEATH* was as follows:

Accidental drowning

(Duration) yrs. mos. ds.

Contributory
(Secondary)

(Duration) yrs. mos. ds.

(Signed)

M. M. Knappe M. D.
Apr 19/14 (Address) Hope, Idaho

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death yrs. mos. days. In the State yrs. mos. days.

Where was disease contracted if not at place of death?

Former or usual residence.

19. PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

Missiona Mont 4/20 1914

20. UNDERTAKER

ADDRESS

E. M. Brown

J. C.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Form V. S. No. 5. 10M. 6-20-11.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH.

Registration District No. 11County of BannockPrimary Registration District No. 2048File No. 7663City of Bancroft(No. 1)Registered No. 23

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

George Washington McPhellan

If death occurred in a hospital, institution or camp give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX

m

4. COLOR OR RACE

w

5. SINGLE, MARRIED, WIDOWED OR DIVORCED.

Single
(Write the word.)

6. DATE OF BIRTH

Feb
(Month)24
(Day)1901
(Year)

7. AGE

12 yrs. 5 mos. 23 ds.IF LESS than 1 day
how many hrs. or min.

8. OCCUPATION

(a) Trade, profession or particular kind of work

none

(b) General nature of industry business or establishment in which employed (or employer)

9. BIRTHPLACE

(State or Country)

Idaho

10. NAME OF FATHER

Washington McPhellan

11. BIRTHPLACE OF FATHER

(State or Country)

England

12. MAIDEN NAME OF MOTHER

Sarah M.

13. BIRTHPLACE OF MOTHER

(State or Country)

Utah

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

Washington McPhellan

(Address)

Bancroft, Ida.

15.

Filed

April 19, 1914

Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

Aug
(Month)16
(Day)1913
(Year)

17. I HEREBY CERTIFY, That I attended deceased from

Aug. 15 1913, to Aug. 15 1913that I last saw him alive on Aug 15 1913and that death occurred on the date stated above, at 7 a. m.

The CAUSE OF DEATH* was as follows:

Tubercular Peritonitis5 minutes

(Duration) yrs. mos. ds.

Contributory (Secondary)

Suppurative Peritonitis

(Duration) yrs. mos. ds.

(Signed)

Russell SmithAug 16 1913 (Address) Bancroft, Ida.

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted,

If not at place of death?

Former or usual residence.

19. PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

BancroftAug 18 1913

20. UNDERTAKER

ADDRESS

B. C. JohnsonBancroft

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Form V. S. No. 5 20M.1-16-12

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH.

Registration District No. 112

County of Kootenai

Primary Registration District No. 2049

City of St. Maries

(No. _____, _____ St.)

File No. 773

Registered No. 398

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME James Owen Robertson

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX

4. COLOR OR RACE

5. SINGLE, MARRIED, WIDOWED OR DIVORCED.

6. DATE OF BIRTH

7. AGE

8. OCCUPATION

(a) Trade, profession or particular kind of work
(b) General nature of industry, business, or establishment in which employed (or employer)

9. BIRTHPLACE

(State or Country)

10. NAME OF FATHER

11. BIRTHPLACE OF FATHER

(State or Country)

12. MAIDEN NAME OF MOTHER

13. BIRTHPLACE OF MOTHER

(State or Country)

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

(Address)

15.

Filed

1913

Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH

17. I HEREBY CERTIFY, That I attended deceased from

July 7 - 1913, to July 19 - 1913.

that I last saw him alive on July 19 - 1913.

and that death occurred on the date stated above, at 8 P.M.

The CAUSE OF DEATH* was as follows:

Progressive Pernicious Anemia

(Duration) 2 yrs. — mos. — ds.

Contributory Progressive Pernicious Anemia (Secondary)

(Duration) 2 yrs. — mos. — ds.

(Signed) F. C. Gibson M. D.

July 19, 1913 (Address) St. Maries Idaho

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death _____ yrs. _____ mos. _____ days. In the State _____ yrs. _____ mos. _____ days.

Where was disease contracted if not at place of death?

Former or usual residence.

19. PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

St. Maries July 21, 1913

20. UNDERTAKER

ADDRESS

H. Le. Muleady St. Maries

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Form V. S. No. 5 20M.1-16-12

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics
File No. 7736
Registered No. 395

1. PLACE OF DEATH.

Registration District No. 2012County of St. MarisPrimary Registration District No. 2049City of St. Maris(No. 1)

St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Baby Herrick

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX m4. COLOR OR RACE White5. SINGLE, MARRIED, WID-
OWED OR DIVORCED.

(Write the word.)

6. DATE OF BIRTH

June
(Month)26
(Day)1913
(Year)

7. AGE

yrs. 3 mos. 3 ds.IF LESS than 1 day
how many hrs. or
mins.?

8. OCCUPATION

- (a) Trade, profession or particular kind of work
(b) General nature of industry business, or establishment in which employed (or employer)

9. BIRTHPLACE

(State or Country) St. Maris Idaho10. NAME OF FATHER Fred Herrick

11. BIRTHPLACE OF FATHER

(State or Country) Michigan12. MAIDEN NAME OF MOTHER Anna Johnson

13. BIRTHPLACE OF MOTHER

(State or Country) Wisconsin

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Dr. Clarnum(Address) St. Maris

15.

Filed 4/101914Local Registrar H. L. Moulton

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH

June
(Month)29
(Day)1913
(Year)

17. I HEREBY CERTIFY, That I attended deceased from June 26 1913, to June 29 1913, that I last saw him alive on June 29 1913, and that death occurred on the date stated above, at 6 P.M.

The CAUSE OF DEATH* was as follows:

Acute fatty degenerative liver
incidental to prolonged
instrumental labor
(Duration) yrs. 3 mos. 3 ds.

Contributory
(Secondary)

(Duration) yrs. 3 mos. 3 ds.
(Signed) Dr. Clarnum M. D.
1913 (Address) St. Maris Id.

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death yrs. 3 mos. 3 days. In the State yrs. 3 mos. 3 days.

Where was disease contracted if not at place of death?

Former or usual residence.

19. PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

Milwaukee Wis.1913

20. UNDERTAKER

ADDRESS

H. L. MoultonSt. Maris

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Form V. S. No. 5 20M.1-16-12

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH.

Registration District No. 12

County of Kootenai

Primary Registration District No. 2049

City of St. Maries

(No. _____, St.)

File No. 7737

Registered No. 394

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Bcky Valentura

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX

4. COLOR OR RACE

5. SINGLE, MARRIED, WIDOWED OR DIVORCED.

Male

White

Single
(Write the word.)

6. DATE OF BIRTH

6 - 20 - 1913
(Month) (Day) (Year)

7. AGE

..... yrs. mos. 1 ds.

IF LESS than 1 day
how many hrs. or
..... mins.?

8. OCCUPATION

(a) Trade, profession or particular kind of work

(b) General nature of industry business, or establishment in which employed (or employer)

9. BIRTHPLACE

(State or Country)

Kootenai Co. Idaho

10. NAME OF FATHER

P. H. Valentura

11. BIRTHPLACE OF FATHER

(State or Country)

Maine

12. MAIDEN NAME OF MOTHER

Matha Rohloff

13. BIRTHPLACE OF MOTHER

(State or Country)

Maine

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

(Address)

P. H. Valentura
St. Maries, Idaho

15.

Filed 4/30 1914 W. D. Drumm

Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH

6 - 21 - 1913
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from

June 20 1913 to June 21 1913
that I last saw him alive on 12 1913

and that death occurred on the date stated above, at 9 P. M.

The CAUSE OF DEATH* was as follows:

Spina Bifida & Deformity

(Duration) yrs. mos. ds.

Contributory

(Secondary)

(Duration) yrs. mos. ds.

(Signed)

H. K. Gibson M. D.

19 (Address) St. Maries, Idaho

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death yrs. mos. days. In the State yrs. mos. days.

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL DATE OF BURIAL

St. Maries June 22 1913

20. UNDERTAKER

ADDRESS

H. K. Gibson St. Maries

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Form V. S. No. 5 20M.1-16-12

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH.

Registration District No. 12

County of Kootenai

Primary Registration District No. 2049

City of St. Maries

(No. _____, _____ St.)

File No. 7738

Registered No. 7738

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Baby Billups

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX

4. COLOR OR RACE

5. SINGLE, MARRIED, WIDOWED OR DIVORCED.

Male

White

Single
(Write the word.)

6. DATE OF BIRTH

6 - 21 1913
(Month) (Day) (Year)

7. AGE

..... yrs. mos. ds.

IF LESS than 1 day
how many hrs. or
..... mins.?

8. OCCUPATION

(a) Trade, profession or particular kind of work

None

(b) General nature of industry business, or establishment in which employed (or employer)

9. BIRTHPLACE

(State or Country)

Kootenai Co. Idaho.

10. NAME OF FATHER

Francis Otto Billups

11. BIRTHPLACE OF FATHER

(State or Country)

West Virginia

12. MAIDEN NAME OF MOTHER

Madge Mary Garbar.

13. BIRTHPLACE OF MOTHER

(State or Country)

Michigan

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

F. O. Billups

(Address)

St. Maries Idaho 2049

15.

Filed

4/10

1914

J. H. Cannon

Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH

6 - 21 - 1913
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from

June 21 - 1913, to June 21 - 1913,

that I last saw him alive on 21 day of June 1913,

and that death occurred on the date stated above, at 12 PM.

The CAUSE OF DEATH* was as follows:

Prematurity (7 months)

..... (Duration) yrs. mos. ds.

Contributory
(Secondary)

..... (Duration) yrs. mos. ds.

(Signed) F. C. Nelson M. D.

1912 (Address) St. Maries

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death yrs. mos. days. In the State yrs. mos. days.

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

St. Maries June 23 1913

20. UNDERTAKER

ADDRESS

H. L. Mark St. Maries

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Form V. S. No. 5 20M.1-16-12

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH.

Registration District No.

County of KootenaiPrimary Registration District No. 2049City of Lotus

(No. _____ St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

Mary Sebata

File No.

Registered No.

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX

4. COLOR OR RACE

5. SINGLE, MARRIED, WIDOWED OR DIVORCED.

Female WhiteSingle
(Write the word.)

6. DATE OF BIRTH

April 9 1909
(Month) (Day) (Year)

7. AGE

4 yrs. _____ mos. _____ ds.IF LESS than 1 day
how many _____ hrs. or
_____ mins.?

8. OCCUPATION

(a) Trade, profession or particular kind of work

none

(b) General nature of industry business, or establishment in which employed (or employer)

9. BIRTHPLACE

(State or Country)

Coeur d'Alene, Idaho

10. NAME OF FATHER

Paul Sebata

11. BIRTHPLACE OF FATHER

(State or Country)

Hungary

12. MAIDEN NAME OF MOTHER

Mary Provak

13. BIRTHPLACE OF MOTHER

(State or Country)

Hungary

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

Paul Sebata

(Address)

Lotus, Idaho

15.

Filed

4/10 1914

Local Registrar

J. O. Spruance
Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH

June 12 1913
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from

1913, to 1913,that I last saw h. alive on June 12 1913,and that death occurred on the date stated above, at 7 P M.

The CAUSE OF DEATH* was as follows:

Seen body after death
ulcer of stomach

(Duration) yrs. _____ mos. _____ ds.

Contributory Eating Phosphorus matches
(Secondary) a few matches ago(Duration) yrs. 6 mos. _____ ds.(Signed) J. D. Platt M. D.June 1913 (Address) St. Maries, Ida

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death _____ yrs. _____ mos. _____ days. In the State _____ yrs. _____ mos. _____ days.

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

St. Maries June 16 1913

20. UNDERTAKER

ADDRESS

H. Le Mulcahy St. Maries

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Form V. S. No. 5 20M.1-16-12

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH.

Registration District No. 12County of ButtePrimary Registration District No. 2049City of St. Maries

(No. _____, _____ St.)

File No. 734Registered No. 374

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

Boby Harris

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX

Male

4. COLOR OR RACE

White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED.

Single
(Write the word.)

6. DATE OF BIRTH

May 24 1913
(Month) (Day) (Year)

7. AGE

_____ yrs. _____ mos. 1 ds.

IF LESS than 1 day
how many _____ hrs. or
_____ mins.?

8. OCCUPATION

(a) Trade, profession or particular kind of work

(b) General nature of industry business, or establishment in which employed (or employer)

9. BIRTHPLACE

(State or Country)

St. Maries Idaho

10. NAME OF FATHER

Charles A. Harris

11. BIRTHPLACE OF FATHER

(State or Country)

Pa

12. MAIDEN NAME OF MOTHER

Miss L. Leefe

13. BIRTHPLACE OF MOTHER

(State or Country)

Ohio

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

Charles A. Harris

(Address)

Malden, Mass.

15.

Filed

4/101913D. J. Greenman

Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH

May 25 1913
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from

May 24 1913, to May 25 1913

that I last saw him alive on _____ 1913and that death occurred on the date stated above, at 8 P M.

The CAUSE OF DEATH* was as follows:

Prematurity

(Duration) _____ yrs. _____ mos. _____ ds.

Contributory
(Secondary)

(Duration) _____ yrs. _____ mos. _____ ds.

(Signed)

D. O. Cornwall

M. D.

May 24 1913 (Address) St. Maries Idaho

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death _____ yrs. _____ mos. _____ days. In the State _____ yrs. _____ mos. _____ days.

Where was disease contracted if not at place of death?

Former or usual residence.

19. PLACE OF BURIAL OR REMOVAL DATE OF BURIAL

St. Maries May 29 1913

20. UNDERTAKER

ADDRESS

H. L. Mulcahy St. Maries

Form V. S. No. 5 20M.1-16-12

CERTIFICATE OF DEATH

 State of Idaho
 BOARD OF HEALTH
 Bureau of Vital Statistics

1. PLACE OF DEATH. Registration District No. 14
 County of Kootenai Primary Registration District No. 2049
 City of St. Maries (No. 1 St.)
 If death occurs away from usual residence, give facts called for under special information. 2. FULL NAME Jane Lukovich

File No. 774
 Registered No. 390
 If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX M 4. COLOR OR RACE W 5. SINGLE, MARRIED, WIDOWED OR DIVORCED.
 (Write the word.)

6. DATE OF BIRTH
 (Month) (Day) (Year)

7. AGE 23 yrs. 0 mos. 0 ds.
 IF LESS than 1 day how many hrs. or mins.?

8. OCCUPATION
 (a) Trade, profession or particular kind of work Worked in woods
 (b) General nature of industry, business, or establishment in which employed (or employer)

9. BIRTHPLACE
 (State or Country) Canada

10. NAME OF FATHER Don't know

11. BIRTHPLACE OF FATHER
 (State or Country) "

12. MAIDEN NAME OF MOTHER "

13. BIRTHPLACE OF MOTHER
 (State or Country) "

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
 (Informant) H. L. Muleady
 (Address) St. Maries

15. Filed 4/10 1913 H. L. Muleady
 Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH
May 30 1913
 (Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from May 14 1913, to May 30 1913, that I last saw him alive on May 30 1913, and that death occurred on the date stated above, at 11 A.M.
 The CAUSE OF DEATH* was as follows:

Tubercular meningitis
 (Duration) yrs. mos. 20 ds.

Contributory (Secondary)
 (Duration) yrs. mos. ds.
 (Signed) H. L. Muleady M. D.
 19 (Address) St. Maries

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death. yrs. mos. 16 days. In the State. yrs. mos. days.
 Where was disease contracted if not at place of death? Do not know
 Former or usual residence.

19. PLACE OF BURIAL OR REMOVAL DATE OF BURIAL
St. Maries June 1 1913
 20. UNDERTAKER ADDRESS
H. L. Muleady St. Maries

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Form V. S. No. 5 20M.1-16-12

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH

Registration District No.

County of *Kootenai*Primary Registration District No. *2049*City of *Plummer*

(No. _____) (St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

*Harriet Elizabeth Moore*File No. *7743*Registered No. *388*

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX

Female

4. COLOR OR RACE

white

5. SINGLE, MARRIED, WIDOWED OR DIVORCED.

Widowed.
(Write the word.)

6. DATE OF BIRTH

October 17th 1854
(Month) (Day) (Year)

7. AGE

*58 yrs. 4 mos. 8 ds.*IF LESS than 1 day
how many _____ hrs. or
_____ mins.?

8. OCCUPATION

(a) Trade, profession or particular kind of work

Dressmaker & Milliner

(b) General nature of industry, business, or establishment in which employed (or employer)

at home

9. BIRTHPLACE

(State or Country)

Michigan

10. NAME OF FATHER

Hiram Truep.

11. BIRTHPLACE OF FATHER

(State or Country)

12. MAIDEN NAME OF MOTHER

Eliza Anne Howe

13. BIRTHPLACE OF MOTHER

(State or Country)

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

Arthur S. Moore

(Address)

Plummer Idaho.

15.

Filed

4/10

1913

J. J. Spencer
Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

February 28th 1913
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from

at home 191... to 191...
that I last saw him alive on *Feb 28th* 191...and that death occurred on the date stated above, at *11* M.

The CAUSE OF DEATH* was as follows:

Apoplexy(Duration) *1* yrs. *1* mos. *1* ds.Contributory
(Secondary)

(Duration) _____ yrs. _____ mos. _____ ds.

(Signed)

W. J. Cusick M. D.
2/28/13 (Address) *Plummer Idaho*

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death *2* yrs. *6* mos. *11* days. In the State *2* yrs. *6* mos. *11* days.

Where was disease contracted if not at place of death?

Former or usual residence

Fairbanks, Alaska.

19. PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

Section 34, Township 46, Range 4, Plummer Idaho *March 4th 1913*

20. UNDERTAKER

ADDRESS

H. L. Mulcahy *Plummer*

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Form V. S. No. 5 20M.1-16-12

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH.

Registration District No. 12

County of Portneui

Primary Registration District No. 2049

City of St. Maurice

(No. _____, St.)

File No. 7944

Registered No. 377

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

Trickem Peterson

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX

Female

4. COLOR OR RACE

White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED.

Married
(Write the word.)

6. DATE OF BIRTH

Dec. 24 1865
(Month) (Day) (Year)

7. AGE

48 yrs. _____ mos. _____ ds.

IF LESS than 1 day
how many _____ hrs. or
_____ mins.

8. OCCUPATION

(a) Trade, profession or particular kind of work

House wife

(b) General nature of industry business, or establishment in which employed (or employer)

9. BIRTHPLACE

(State or Country)

Hannover

10. NAME OF FATHER

S. Madison

11. BIRTHPLACE OF FATHER

(State or Country)

Hannover

12. MAIDEN NAME OF MOTHER

Helen No

13. BIRTHPLACE OF MOTHER

(State or Country)

"

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

L. P. Peterson

(Address)

St. Maurice

15.

Filed

4/10 1914

J. D. Newman
Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH

Jan. 18 1913
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from

Jan 8th 1913, to Jan 18th 1913

that I last saw h. _____ alive on Jan 18th 1913

and that death occurred on the date stated above, at 7:30 P.M.

The CAUSE OF DEATH* was as follows:

Local Impaction

(Duration) 15 yrs. _____ mos. 10 ds.

Contributory

(Secondary)

(Duration) _____ yrs. _____ mos. _____ ds.

(Signed)

Wm. D. Platt M. D.

Jan 14 1913 (Address) St. Maurice Idaho

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL OR HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death

_____ yrs. _____ mos. _____ days.

In the State

_____ yrs. _____ mos. _____ days.

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

Walla Walla

Nov 18 1913

20. UNDERTAKER

ADDRESS

H. L. Trulcamp St. Maurice

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Form V. S. No. 5 20M.1-16-12

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH.

Registration District No. 12

County of Kootenai

Primary Registration District No. 2049

City of St. Maries

(No. _____, _____ St.)

File No. 7745

Registered No. 376

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME John Fry

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX

4. COLOR OR RACE

5. SINGLE, MARRIED, WIDOWED OR DIVORCED.

Male White

Married
(Write the word.)

6. DATE OF BIRTH

Feb. 15 1893
(Month) (Day) (Year)

7. AGE

18 yrs. 2 mos. 0 ds.

IF LESS than 1 day
how many _____ hrs. or
_____ mins.

8. OCCUPATION

(a) Trade, profession or particular kind of work

(b) General nature of industry business, or establishment in which employed (or employer)

Worked in Lumber
Plant

9. BIRTHPLACE

(State or Country)

Id.

10. NAME OF FATHER

John Fry

11. BIRTHPLACE OF FATHER

(State or Country)

Id.

12. MAIDEN NAME OF MOTHER

A. Habgood

13. BIRTHPLACE OF MOTHER

(State or Country)

Ireland

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

(Address)

John Fry
St. Maries

15.

Filed

2/27/02 1914 J. D. Drumm
Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH

Jan. 16 1913
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from

Jan. 13 1913 to Jan. 16 1913

that I last saw him alive on Jan. 16 1913

and that death occurred on the date stated above, at 6 P. M.

The CAUSE OF DEATH* was as follows:

Appendicular Abscess

(Duration) _____ yrs. _____ mos. 10 ds.

Contributory

(Secondary)

(Duration) _____ yrs. _____ mos. _____ ds.

(Signed)

St. Maries M. D.

19

(Address)

St. Maries

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death

_____ yrs. _____ mos. _____ days.

In the State

_____ yrs. _____ mos. _____ days.

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

St. Maries

Jan. 21 1913

20. UNDERTAKER

ADDRESS

W. E. Mackay St. Maries

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Form V. S. No. 5 20M.1-16-12

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH.

Registration District No.

County of Gooding

Primary Registration District No.

City of

(No. St.)

File No. 7762

Registered No.

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME John B Smith
If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX

4. COLOR OR RACE

5. SINGLE, MARRIED, WIDOWED OR DIVORCED.

Male white married (Write the word.)

6. DATE OF BIRTH

October 18 1841
(Month) (Day) (Year)

7. AGE

71 yrs. 7 mos. 13 ds.

IF LESS than 1 day
how many hrs. or
..... mins.?

8. OCCUPATION

(a) Trade, profession or particular kind of work

Farmer

(b) General nature of industry business, or establishment in which employed (or employer)

9. BIRTHPLACE

(State or Country)

England

10. NAME OF FATHER

11. BIRTHPLACE OF FATHER

(State or Country)

12. MAIDEN NAME OF MOTHER

13. BIRTHPLACE OF MOTHER

(State or Country)

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Jane Griffith

(Address) Ketchikan Idaho

15.

Filed 191

F. T. Cary MD
Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH

May 31 1913
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from

May 28 1913, to May 31 1913
that I last saw him alive on May 31 1913

and that death occurred on the date stated above, at 6 P.M.

The CAUSE OF DEATH* was as follows:

Pneumonia

(Duration) yrs. mos. 7 ds.

Contributory
(Secondary)

(Duration) yrs. mos. ds.

(Signed) J. H. Cromwell M.D.

1913 (Address) Gooding Ida

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death yrs. mos. days. In the State yrs. mos. days.

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

Bliss. Idaho

June 24 1913

20. UNDERTAKER

ADDRESS

None

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Form V. S. No. 5 20M.1-16-12

CERTIFICATE OF DEATH

1. PLACE OF DEATH

County of *Montana*City of *St. Joe*Registration District No. *32*Primary Registration District No. *2099*

(No. _____, _____ St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

*John Resovich*State of Idaho
BOARD OF HEALTH
Bureau of Vital StatisticsFile No. *8217*

Registered No. _____

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX

Male

4. COLOR OR RACE

White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED.

Single
(Write the word.)

6. DATE OF BIRTH

(Month) _____ (Day) _____ (Year) _____

7. AGE

25 yrs. _____ mos. _____ ds.IF LESS than 1 day
how many _____ hrs. or
_____ mins.?

8. OCCUPATION

(a) Trade, profession or particular kind of work

Woodman

(b) General nature of industry business, or establishment in which employed (or employer)

9. BIRTHPLACE

(State or Country)

Austria

10. NAME OF FATHER

John A. no

11. BIRTHPLACE OF FATHER

(State or Country)

Austria

12. MAIDEN NAME OF MOTHER

John A. no

13. BIRTHPLACE OF MOTHER

(State or Country)

Idaho

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

H. E. Mulcahy

(Address)

Idaho

15.

Filed

Sept 2

1914

H. E. Mulcahy
Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH

Sept 1 191*3*
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from

191*3*, to 191*3*,that I last saw h. _____ alive on 191*3*,

and that death occurred on the date stated above, at _____ M.

The CAUSE OF DEATH* was as follows:

*Accidentally hit by log.
died on train to Hospital.*

(Duration) _____ yrs. _____ mos. _____ ds.

Contributory

(Secondary)

(Duration) _____ yrs. _____ mos. _____ ds.

(Signed) *W. C. Lamborn* M. D.*Sept 12* 191*3* (Address) *St Joe, Idaho*

State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death _____ yrs. _____ mos. _____ days. In the State _____ yrs. _____ mos. _____ days.

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL

Idaho

DATE OF BURIAL

Sept 3 191*3*

20. UNDERTAKER

H. E. Mulcahy

ADDRESS

Idaho

Form V. S. No. 5 20M.1-16-12

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH

Registration District No. 32

County of *Kootenai*

Primary Registration District No. 2049

City of *St. Maries*

(No. , St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

Carl Stiff

Registered No. _____

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX

Male

4. COLOR OR RACE

White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED

Married
(Write the word.)

6. DATE OF BIRTH

(Month) (Day) (Year)

7. AGE

37 yrs. *0* mos. *0* ds.IF LESS than 1 day
how many hrs. or
..... mins.?

8. OCCUPATION

(a) Trade, profession or particular kind of work

Farmer on Section

(b) General nature of industry, business, or establishment in which employed (or employer)

9. BIRTHPLACE

(State or Country)

10. NAME OF FATHER

11. BIRTHPLACE OF FATHER

(State or Country)

12. MAIDEN NAME OF MOTHER

13. BIRTHPLACE OF MOTHER

(State or Country)

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) *Mrs. H. Stiff*(Address) *Evansville, Wis.*

15.

Filed

Oct 13

1914

H. L. Mulecay

Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

Oct. 11 191*3*
(Month) (Day) (Year)17. I HEREBY CERTIFY, That I attended deceased from
Oct. 10 191*3*, to *Oct. 11* 191*3*that I last saw him alive on _____ 191*3*and that death occurred on the date stated above, at *5 P.M.*

The CAUSE OF DEATH* was as follows:

Appendicitis

(Duration) _____ yrs. _____ mos. _____ ds.

Contributory
(Secondary)

(Duration) _____ yrs. _____ mos. _____ ds.

(Signed) *H. L. Mulecay* M. D.*Oct 11 1913* (Address) *St. Maries, Ida*

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL; SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death _____ yrs. _____ mos. _____ days. In the State _____ yrs. _____ mos. _____ days.

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

*Wisconsin**Oct 11* 191*3*

20. UNDERTAKER

ADDRESS

*H. L. Mulecay**St. Maries*

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Form V. S. No. 5 20M.1-16-12

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH.

Registration District No. 32County of MontanaPrimary Registration District No. 2049City of St. Maries

(No. _____, St.)

File No. 8219

Registered No. _____

If death occurs away from usual residence, give facts called for under special information.

2.

FULL NAME

S. G. Harkness

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX

4. COLOR OR RACE

5. SINGLE, MARRIED, WIDOWED OR DIVORCED.

Female WhiteMarried
(Write the word.)

6. DATE OF BIRTH

Sept. 27 1847
(Month) (Day) (Year)

7. AGE

66 yrs. 6 mos. 6 ds.IF LESS than 1 day
how many _____ hrs. or
_____ mins.?

8. OCCUPATION

(a) Trade, profession or particular kind of work

House wife

(b) General nature of industry business, or establishment in which employed (or employer)

9. BIRTHPLACE

(State or Country)

N. Y.

10. NAME OF FATHER

Henry Whipple

11. BIRTHPLACE OF FATHER

(State or Country)

Mass.

12. MAIDEN NAME OF MOTHER

S. Whipple

13. BIRTHPLACE OF MOTHER

(State or Country)

Conn. no

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

Ellen Henao

(Address)

Berlin, N. H.

15.

Filed

Dec 29 1914 H. H. Muleady
Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH

Dec. 28 1913
(Month) (Day) (Year)17. I HEREBY CERTIFY, That I attended deceased from Dec 22 1913, to Dec. 28 1913that I last saw him alive on Dec. 28 1913and that death occurred on the date stated above, at 7 P.M.

The CAUSE OF DEATH* was as follows:

Pneumonia(Duration) _____ yrs. _____ mos. 10 ds.Contributory
(Secondary)

(Duration) _____ yrs. _____ mos. _____ ds.

(Signed)

Owen D. Platt M. D.Dec 25/13 (Address) St. Maries, Ida

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death _____ yrs. _____ mos. _____ days. In the State _____ yrs. _____ mos. _____ days.

Where was disease contracted if not at place of death? _____

Former or usual residence _____

19. PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

St. Maries, IdahoDec. 31 1913

20. UNDERTAKER

ADDRESS

H. H. Muleady St. Maries

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Form V. S. No. 5 20M.1-16-12

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH.

Registration District No. 32County of FootwallPrimary Registration District No. 2049File No. 8229City of St. Marks

(No. _____, _____ St.)

Registered No. _____

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

Mrs. A. Mutch

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX

4. COLOR OR RACE

5. SINGLE, MARRIED, WIDOWED OR DIVORCED.

MaleWhiteMarried
(Write the word.)

6. DATE OF BIRTH

Sept. 4 1867
(Month) (Day) (Year)

7. AGE

46 yrs. 3 mos. 4 ds.IF LESS than 1 day
how many hrs. or
..... mins.?

8. OCCUPATION

(a) Trade, profession or particular kind of work

Rancher &

(b) General nature of industry business, or establishment in which employed (or employer)

Transistor

9. BIRTHPLACE

(State or Country)

New Castle, New Brunswick, Canada

10. NAME OF FATHER

11. BIRTHPLACE OF FATHER
(State or Country)

12. MAIDEN NAME OF MOTHER

13. BIRTHPLACE OF MOTHER
(State or Country)

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

Mrs. G. J. Jorgensen

(Address)

St. Marks, Idaho

15.

Filed

Dec. 9 1914H. L. Muleady
Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

Dec. 8 1913
(Month) (Day) (Year)17. I HEREBY CERTIFY, That I attended deceased from Dec 25th 1913, to Dec 8th 1913, that I last saw him alive on Dec 8th 1913, and that death occurred on the date stated above, at 4 P.M.

The CAUSE OF DEATH* was as follows:

Valvular heart disease
hard work(Duration) 2 yrs. — mos. — ds.Contributory hard work
(Secondary)(Duration) — yrs. — mos. — ds.(Signed) C. J. Kinsolving M. D.725 1914 (Address) St. Marks, Idaho

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death yrs. mos. days. In the State yrs. mos. days.

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL DATE OF BURIAL

St. Marks Dec. 10 1914

20. UNDERTAKER ADDRESS

H. L. Muleady St. Marks

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Form V. S. No. 5 20M.1-16-12

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH.

Registration District No. 32County of KootenaiPrimary Registration District No. 2049File No. 8230City of St. Maries

(No. _____, St.)

Registered No. _____

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Mabel E. Mutch

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX Female4. COLOR OR RACE White5. SINGLE, MARRIED, WIDOWED OR DIVORCED. Married
(Write the word.)6. DATE OF BIRTH May 29 1877
(Month) (Day) (Year)7. AGE 35 yrs. 6 mos. 12 ds.IF LESS than 1 day
how many _____ hrs. or
_____ mins.?

8. OCCUPATION

(a) Trade, profession or particular kind of work Housewife

(b) General nature of industry business, or establishment in which employed (or employer)

9. BIRTHPLACE

(State or Country)

10. NAME OF FATHER Eaton

11. BIRTHPLACE OF FATHER

(State or Country)

12. MAIDEN NAME OF MOTHER Naldon

13. BIRTHPLACE OF MOTHER

(State or Country)

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Family Record

(Address) _____

15.

Filed Dec. 12 1914Local Registrar J. H. Muleady

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH Dec 11 1913
(Month) (Day) (Year)17. I HEREBY CERTIFY, That I attended deceased from Nov 10 1913, to Dec 11 1913,
that I last saw her alive on Dec 11 1913,
and that death occurred on the date stated above, at 1 A.M.

The CAUSE OF DEATH* was as follows:

Uremic poisoning from
pyrexia following
delivery.
(Duration) _____ yrs. 3 mos. _____ ds.Contributory Pyrexia
(Secondary)(Duration) _____ yrs. 9 mos. _____ ds.(Signed) C. J. Kinsolving, M. D.3/25/14 (Address) St. Maries Idaho

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death _____ yrs. _____ mos. _____ days. In the State _____ yrs. _____ mos. _____ days.

Where was disease contracted if not at place of death? _____

Former or usual residence _____

19. PLACE OF BURIAL OR REMOVAL St. MariesDATE OF BURIAL Dec. 13 191420. UNDERTAKER J. H. MuleadyADDRESS St. Maries

CERTIFICATE OF DEATH.

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH.

County of Butte
City of MarionRegistration District No. 22Primary Registration District No. 2049

(No. _____ St.)

File No. 8381

Registered No. _____

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

Marion O'Brien

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX

Female

4. COLOR OR RACE 5. SINGLE, MARRIED, WIDOWED, OR DIVORCED.

WhiteSingle
(Write the word.)

6. DATE OF BIRTH.

(Month) _____ (Day) _____ (Year) _____

7. AGE

Yrs. 9 Mos. _____ ds. _____IF LESS than 1 day
how many _____ hrs. or
_____ min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work...
(b) General nature of industry, business, or establishment in which employed (or employer).....

9. BIRTHPLACE

(State or Country) Idaho

10. NAME OF FATHER

J. J. O'Brien

11. BIRTHPLACE OF FATHER

(State or Country) _____

12. MAIDEN NAME OF MOTHER

13. BIRTHPLACE OF MOTHER

(State or Country) _____

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) H. J. O'Brien(Address) Idaho

15. Filed

July 29 19141H. J. O'Brien
Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

Dec. 4 1913
(Month) (Day) (Year)17. I HEREBY CERTIFY, That I attended deceased from Nov. 25 1913, to Dec. 4 1913, that I last saw him alive on " " 1913, and that death occurred on the date stated above, at 2 P.M.
The CAUSE OF DEATH* was as follows:Enterocolitis(Duration) _____ Yrs. 15 mos. _____ ds.Contributory
(Secondary)

(Duration) _____ yrs. _____ mos. _____ ds.

(Signed) H. J. O'Brien M. D.19. (Address) Idaho

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death.....yrs.....mos.....days In the State.....yrs.....mos.....days

Where was disease contracted if not at place of death? _____

Former or usual residence _____

19. PLACE OF BURIAL OR REMOVAL

St. Maries

DATE OF BURIAL

Dec. 7 1913

20. UNDERTAKER

H. J. O'Brien

ADDRESS

St. Maries

CERTIFICATE OF DEATH.

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

File No. 8383

Registered No.

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

1. PLACE OF DEATH.

County of Kootenai
City of St. Maries

Registration District No. 32

Primary Registration District No. 2049

(No. St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME *Wm M. Ratelton*

PERSONAL AND STATISTICAL PARTICULARS

MEDICAL CERTIFICATE OF DEATH

3. SEX

Male

4. COLOR OR RACE

White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED.

Single
(Write the word.)

6. DATE OF BIRTH.

Don't know
(Month) (Day) (Year)

7. AGE

72 Yrs. Mos. ds.

IF LESS than 1 day
how many hrs. or
min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work.
(b) General nature of industry, business, or establishment in which employed (or employer).Homesteader in
Marble Creek

9. BIRTHPLACE

(State or Country)

Pa.

10. NAME OF FATHER

Don't know

11. BIRTHPLACE OF FATHER

(State or Country)

12. MAIDEN NAME OF MOTHER

13. BIRTHPLACE OF MOTHER

(State or Country)

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant)

(Address)

15.

Filed

July 29 1914

Local Registrar

16. DATE OF DEATH

Dec 1 1913
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from Nov 25 1913 to Dec 1 1913

that I last saw him alive on Dec 1 1913

and that death occurred on the date stated above, at 7 P. M.

The CAUSE OF DEATH* was as follows:

Cerebral Hem.

(Duration) Yrs. mos. 6 ds.

Contributory
(Secondary)

Old age

(Duration) Yrs. mos. ds.

(Signed) Owen D. Platt M. D.

July 29 1914 (Address) St. Maries, Ida.

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL OR HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place In the
of death.....yrs.....mos.....days State.....yrs.....mos.....daysWhere was disease contracted
if not at place of death?Former or
usual residence

19. PLACE OF BURIAL OR REMOVAL

St. Maries Ida.

DATE OF BURIAL

Dec 4 1913

20. UNDERTAKER

W. J. Mulcahy

ADDRESS

St. Maries

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

I. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Form V. S. No. 5. 10M. 6-20-11.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics
File No. 10850
Registered No. 15

1. PLACE OF DEATH.

Registration District No. 109

County of Custer

Primary Registration District No. 2187

City of Goldburg

(No. _____ St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Thomas Benjamin Davis

If death occurred in a hospital, institution or camp give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX

male

4. COLOR OR RACE

white

5. SINGLE, MARRIED, WID-
OWED OR DIVORCED.
married
(Write the word.)

6. DATE OF BIRTH

Aug.

8

1870

(Month)

(Day)

(Year)

7. AGE

42

yrs.

7

mos.

29

ds.

IF LESS than 1 day
how many _____ hrs. or
_____ min.?

8. OCCUPATION

(a) Trade, profession or
particular kind of work

Ranchman

(b) General nature of industry
business or establishment in
which employed (or employer)

9. BIRTHPLACE

(State or Country)

Missouri

10. NAME OF
FATHER

Marguerite L Davis

11. BIRTHPLACE
OF FATHER

(State or Country)

Kentucky

12. MAIDEN NAME
OF MOTHER

Louisa Boyle

13. BIRTHPLACE
OF MOTHER

(State or Country)

Missouri

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

Henry D Davis

(Address)

Goldburg, Ida.

15.

Filed

June 30 1913

F. P. Richards

Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

June

(Month)

29

(Day)

1913

(Year)

17. I HEREBY CERTIFY, That I attended deceased from

June 25 1913, to June 29 1913

that I last saw him alive on June 29 1913,

and that death occurred on the date stated above, at 11 A. M.

The CAUSE OF DEATH* was as follows:

mitral & aortic regurgitation
of heart

(Duration)

yrs.

14 ds.

Contributory
(Secondary)

La Grippe

(Duration)

yrs.

14 ds.

(Signed)

R. E. Mason M. D.

June 30 1913 (Address) Mackay, Ida.

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place

In the

of death

yrs.

mos.

ds. State

yrs.

mos.

ds.

Where was disease contracted,

If not at place of death?

Former or

usual residence.

19. PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

Bluefoot Idaho

7/2

1913

20. UNDERTAKER

ADDRESS

E. J. Prex

Bluefoot,

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH.

Registration District No. 117

County of Cassia

Primary Registration District No. 2196

City of Hale

(No. , St.)

File No.

Registered No. 34

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Edman Patrick Ridge

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX 4. COLOR OR RACE 5. SINGLE, MARRIED, WIDOWED OR DIVORCED.

Male white Married

6. DATE OF BIRTH

May 12 1859
(Month) (Day) (Year)

7. AGE

54 yrs. mos. ds.

IF LESS than 1 day
how many hrs. or mins.?

8. OCCUPATION

(a) Trade, profession or particular kind of work

(b) General nature of industry business, or establishment in which employed (or employer)

Boiler maker.

9. BIRTHPLACE

(State or Country)

Ireland

10. NAME OF FATHER

Michael Ridge

11. BIRTHPLACE OF FATHER

(State or Country)

Ireland

12. MAIDEN NAME OF MOTHER

Bridget Ridge

13. BIRTHPLACE OF MOTHER

(State or Country)

Ireland

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

Mrs Anna Butler

(Address)

645-2 Harrison St. Pocatello

15.

Filed

10-1-14

191

Dr. J. L. Patterson

Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH

Probably May 1913
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from

191, to 191,

that I last saw h. alive on 191,

and that death occurred on the date stated above, at M.

The CAUSE OF DEATH* was as follows:

Probably Murder

(Duration) yrs. mos. ds.

Contributory

(Secondary)

(Duration) yrs. mos. ds.

(Signed) L. B. Gallagher, Coroner

Sept 1914 (Address) Burley Ida.

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death yrs. mos. days. In the State yrs. mos. days.

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

Burley Ida

Sept 3 1914

20. UNDERTAKER

ADDRESS

L. B. Gallagher

Burley Ida

-SUPPLEMENTARY DEATH CERTIFICATE-

(Please reply on this sheet to
the registrar of Vital Statistics)

Death Certificate No. 8934

Name Coleman Patrick Ridge

Date of Death About May 1913

Cause of Death Probably Murder?

Contributory Cause of death

Nothing but the
bones, a few clothes
and paper enough
to identify the
remains were found.
On account of a certain paper found
murder was suspected

(Sign here)

J. C. Patterson

M.D.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

FORM V. S. No. 5-25 M. 1-16-13

CERTIFICATE OF DEATH.

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH.

Registration District No. 277

County of _____

Primary Registration District No. 2176City of Victor

(No. _____ St.)

File No. 920Registered No. 121

If death occurs away from usual residence, give facts called for under special information.

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME

Mary Hannah Bagley

PERSONAL AND STATISTICAL PARTICULARS

MEDICAL CERTIFICATE OF DEATH

3. SEX

Female

4. COLOR OR RACE

White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED.

Single
(Write the word.)

6. DATE OF BIRTH.

Feb.191891

(Month)

(Day)

(Year)

7. AGE

22 Yrs. 10 Mos. 11 ds.IF LESS than 1 day
how many hrs. or
..... min. 2)

8. OCCUPATION

(a) Trade, profession or particular kind of work...
(b) General nature of industry, business, or establishment in which employed (or employer).....House work

9. BIRTHPLACE

(State or Country)

Charleston, Utah

10. NAME OF FATHER

George Henry Bagley

11. BIRTHPLACE OF FATHER

(State or Country)

Salt Lake City

12. MAIDEN NAME OF MOTHER

Mary Eliza Edwards

13. BIRTHPLACE OF MOTHER

(State or Country)

Salt Lake City

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Nettie Bagley(Address) Victor

15.

Filed 12-30 1913Lecherrington
Local Registrar

16. DATE OF DEATH

Dec.301913

(Month)

(Day)

(Year)

17. I HEREBY CERTIFY, That I attended deceased from

Dec 29 1913 to Dec 30 1913,
that I last saw her alive on Dec 30 1913
and that death occurred on the date stated above, at 11:30 A.M.

The CAUSE OF DEATH* was as follows:

Chronic parenchymatous nephritis
(Sequel of Scarlatina when 15 yrs of age)(Duration) 7 Yrs. mos. ds.Contributory Acute dilatation of heart
(Secondary)(Duration) yrs. 4 mos. ds.(Signed) Robert W. King M. D.19 (Address) Victor, Idaho

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death. 6 yrs. mos. days. In the State. yrs. mos. daysWhere was disease contracted if not at place of death? Charleston, UtahFormer or usual residence Charleston, Utah

19. PLACE OF BURIAL OR REMOVAL

Victor, Idaho

DATE OF BURIAL

Jan 20 1914

20. UNDERTAKER

Mom Hatch

ADDRESS

Victor

Form V. S. No. 5 20M.1-16-12

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH.

Registration District No. 47

County of Spencer

Primary Registration District No. 2176

City of Blackfoot(No. 1)

St.)

File No. 13Registered No. 13

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Donald Speed

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX Male4. COLOR OR RACE White5. SINGLE, MARRIED, WIDOWED OR DIVORCED. Single
(Write the word.)6. DATE OF BIRTH Dec 25 1902

(Month)

(Day)

(Year)

7. AGE 10 yrs. 11 mos. 19 ds.IF LESS than 1 day
how many hrs. or
..... mins.?

8. OCCUPATION

(a) Trade, profession or particular kind of work Worked at home
(b) General nature of industry, business, or establishment in which employed (or employer)

9. BIRTHPLACE

(State or Country) Minnesota10. NAME OF FATHER Hubert M. Speed11. BIRTHPLACE OF FATHER Wisconsin

(State or Country)

12. MAIDEN NAME OF MOTHER Marguerite Lapp13. BIRTHPLACE OF MOTHER Wisconsin

(State or Country)

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) x A. H. Wyckoff(Address) Hiramdale, Ida.

15.

Filed Dec. 14 - 1913m. a. c. i. s. l. e. n.

Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH Dec 14 1913

(Month)

(Day)

(Year)

17. I HEREBY CERTIFY, That I attended deceased from Dec 12 1912, to Dec 14 1913that I last saw him alive on Dec 12 1913,and that death occurred on the date stated above, at 5:00 P.M.

The CAUSE OF DEATH* was as follows:

An internal abdominal surgery due to falling & striking abdomen on a large stone - Accidental.(Duration) yrs. mos. 2 1/2 ds.

Contributory (Secondary)

(Duration) yrs. mos. ds.

(Signed) Dr. A. H. Wyckoff

M. D.

12/14 1913 (Address) Duggs, Ida.

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death yrs. mos. days. In the State yrs. mos. days.

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL CadgerDATE OF BURIAL 12-16-191320. UNDERTAKER CheneyADDRESS Tripps

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Form V. S. No. 5 20M.1-16-12

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH.

Registration District No. 77

County of Sherburne

Primary Registration District No. 2176

City of Idaho Falls

(No. _____ St.)

File No. 9210

Registered No. 12

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Engel Petron

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX Male

4. COLOR OR RACE White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED. Married

6. DATE OF BIRTH July 12 1895

7. AGE 88 yrs. 4 mos. 15 ds.

IF LESS than 1 day how many hrs. or mins.?

8. OCCUPATION

(a) Trade, profession or particular kind of work

(b) General nature of industry, business, or establishment in which employed (or employer)

9. BIRTHPLACE

(State or Country) Sweden

10. NAME OF FATHER Per Hoganson

11. BIRTHPLACE OF FATHER

(State or Country) Sweden

12. MAIDEN NAME OF MOTHER Engel Johanson

13. BIRTHPLACE OF MOTHER

(State or Country) Sweden

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Albertina Peterson

(Address) Idaho Falls, Idaho

15.

Filed 11.27.1978

Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH Nov 27 1913

(Month)

(Day)

(Year)

17. I HEREBY CERTIFY, That I attended deceased from

191., to 191.,

that I last saw h. alive on 191.,

and that death occurred on the date stated above, at M.

The CAUSE OF DEATH* was as follows:

Don't know.

Had no doctor

(Duration) yrs. mos. ds.

Contributory (Secondary)

(Duration) yrs. mos. ds.

(Signed) M. D.

19 (Address)

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death yrs. mos. days. In the State yrs. mos. days.

Where was disease contracted if not at place of death?

Former or usual residence.

19. PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

20. UNDERTAKER

ADDRESS

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Form V. S. No. 5. 12½ M. 7-24-11

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics
File No. 9211
Registered No. 11

1. PLACE OF DEATH. Registration District No. 177
County of Fremont Primary Registration District No. 2176
City of Victor (No. , St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

Hambler

If death occurred in a hospital, institution or camp give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX 4. COLOR OR RACE 5. SINGLE, MARRIED, WIDOWED OR DIVORCED.

Male White Single
(Write the word.)

6. DATE OF BIRTH

June 4 1913
(Month) (Day) (Year)

7. AGE

1 yrs. mos. ds.

IF LESS than 1 day
how many hrs. or min?

8. OCCUPATION

(a) Trade, profession or particular kind of work
(b) General nature of industry business or establishment in which employed (or employer)

None

9. BIRTHPLACE

(State or Country)

Idaho Fremont

10. NAME OF FATHER

J. P. Hamblin

11. BIRTHPLACE OF FATHER

(State or Country)

Utah Iron Co

12. MAIDEN NAME OF MOTHER

Charlotte Adair

13. BIRTHPLACE OF MOTHER

(State or Country)

Idaho Washington

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

(Address)

Owen Blarke
Victor

15.

Filed 6-4-1913

Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH

June 4 1913
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from

1913, to 1913

that I last saw him alive on 191

and that death occurred on the date stated above, at M.

The CAUSE OF DEATH* was as follows:

(Duration) yrs. mos. ds.

Contributory
(Secondary)

(Duration) yrs. mos. ds.

(Signed) M. D.

19 (Address)

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions Transients or Recent Residents.)

At place In the
of death yrs. mos. ds. State yrs. mos. ds.

Where was disease contracted,

If not at place of death?

Former or

usual residence.

19. PLACE OF BURIAL OR REMOVAL DATE OF BURIAL

Victor Cemetery June 6 1913

20. UNDERTAKER

ADDRESS

H. P. Griffes Victor Id

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Form V. S. No. 5. 12½ M. 7-24-11

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH. Registration District No. 75
County of Pomeroy Primary Registration District No. 2074
City of _____ (No. _____, _____ St.)

File No. 1511
Registered No. _____

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

August Weyer

If death occurred in a hospital, institution or camp give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX Male 4. COLOR OR RACE white 5. SINGLE, MARRIED, WIDOWED OR DIVORCED. Single
(Write the word.)

6. DATE OF BIRTH 25 Aug 1911
(Month) (Day) (Year)

7. AGE 2 yrs. 2 mos. 6 ds. IF LESS than 1 day how many _____ hrs. or _____ min?

8. OCCUPATION

- (a) Trade, profession or particular kind of work _____
(b) General nature of industry business or establishment in which employed (or employer) _____

9. BIRTHPLACE (State or Country) Pleasant Valley Idaho

10. NAME OF FATHER Gottlieb Weyer

11. BIRTHPLACE OF FATHER (State or Country) Russia

12. MAIDEN NAME OF MOTHER Anna Wackenkunt

13. BIRTHPLACE OF MOTHER (State or Country) Russia

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Gottlieb Weyer
(Address) Pleasant Valley, Id.

15. Nov 2 1913 Richard F. Hobb
Filed _____ Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH Nov 1 1913
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from _____ 191____, to _____ 191____
that I last saw h_____ alive on _____ 191____
and that death occurred on the date stated above, at _____ M.
The CAUSE OF DEATH* was as follows:

Accidental Drowning
(Duration) _____ yrs. _____ mos. _____ ds.

Contributory (Secondary) _____
(Duration) _____ yrs. _____ mos. _____ ds.
(Signed) H. K. Hager Coroner M. D.
11/2 1913 (Address) Pomeroy

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place _____ In the _____
of death _____ yrs. _____ mos. _____ ds. State _____ yrs. _____ mos. _____ ds.
Where was disease contracted, _____
If not at place of death? _____
Former or usual residence _____

19. PLACE OF BURIAL OR REMOVAL Pleasant Valley DATE OF BURIAL Nov 2 1913

20. UNDERTAKER H. K. Hager ADDRESS h. k. hager

Form V. S. No. 5. 10M. 6-20-11.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital StatisticsFile No. 109
Registered No. 19

If death occurred in a hospital, institution or camp give its NAME instead of street and number.

1. PLACE OF DEATH.

Registration District No. 3County of LincolnPrimary Registration District No. 2016City of Richfield

(No. _____, _____ St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

Ruth Dahlberg

PERSONAL AND STATISTICAL PARTICULARS

3. SEX

Female

4. COLOR OR RACE

White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED.

Wife
(Write the word.)6. DATE OF BIRTH May 21

(Month) (Day) (Year)

7. AGE

25 yrs. 5 mos. 5 ds.IF LESS than 1 day
how many hrs. or
..... min.?

8. OCCUPATION

(a) Trade, profession, or particular kind of work

Maids

(b) General nature of industry, business, or establishment in which employed (or employer)

9. BIRTHPLACE

(State or Country)

Colorado

10. NAME OF FATHER

John Nelson

11. BIRTHPLACE OF FATHER

(State or Country)

Sweden

12. MAIDEN NAME OF MOTHER

Unknown

13. BIRTHPLACE OF MOTHER

(State or Country)

Sweden

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

Jose Dahlberg

(Address)

Richfield, Ida

15.

Filed May 24 1913C. F. Zeller

Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

May 22 1913
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from

May 18 1913, to May 22 1913that I last saw her alive on May 22 1913,and that death occurred on the date stated above, at 4 a. M.

The CAUSE OF DEATH* was as follows:

Septic Infection following
fastidious

(Duration) yrs. mos. ds.

Contributory
(Secondary)

(Duration) yrs. mos. ds.

(Signed)

Dr. Harn M. D.5722 1915 (Address) Richfield Ida

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place

In the

of death yrs. mos. ds. State yrs. mos. ds.

Where was Disease contracted,

If not at place of death?

Former or

usual residence.

19. PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

Union Colorado1913

20. UNDERTAKER

ADDRESS

Dr. HarnShoshone Idaho

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Form V. S. No. 5 20M.1-16-12

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics
File No. 10937
Registered No. _____

1. PLACE OF DEATH
County of Lincoln Registration District No. 16
City of Idaho Primary Registration District No. 2016
(No. _____ St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Reis J. Shellman

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX male 4. COLOR OR RACE white 5. SINGLE, MARRIED, WIDOWED OR DIVORCED.
not married
(Write the word.)

6. DATE OF BIRTH July 8 1911
2 years 10 months 13 days
Month Day Year

7. AGE 2 yrs. IF LESS than 1 day
yrs. mos. ds. hrs. or mins.

8. OCCUPATION

(a) Trade, profession or particular kind of work
(b) General nature of industry, business, or establishment in which employed (or employer)

9. BIRTHPLACE Colorado
(State or Country)

10. NAME OF FATHER Vance Shellman

11. BIRTHPLACE OF FATHER Ohio
(State or Country)

12. MAIDEN NAME OF MOTHER Larson Smith

13. BIRTHPLACE OF MOTHER Michigan
(State or Country)

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Vance Shellman
(Address) Idaho

15. Filed May 23 1913 C. F. Zeller
Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

May 21 1913
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from May 20 1913 to May 21 1913,
that I last saw him alive on May 20 1913.

and that death occurred on the date stated above, at M.

THE CAUSE OF DEATH* was as follows:

Intestinal

(Duration) yrs. mos. ds.
Contributory (Secondary) supp

(Duration) yrs. mos. ds.
(Signed) Dr. Deice M. D.
19 (Address) Shoshone Ida

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death.....yrs.....mos.....days. In the State.....yrs.....mos.....days.

Where was disease contracted if not at place of death?.....

Former or usual residence.....

19. PLACE OF BURIAL OR REMOVAL DATE OF BURIAL

Shoshone May 22 1914

20. UNDERTAKER ADDRESS

O J Burman Shoshone

-SUPPLEMENTARY DEATH CERTIFICATE-

(Please reply on this sheet to
the registrar of Vital Statistics)

Death Certificate No. ~~XXXXXXXX~~ 10952

Name Reis F. Shellman

Date of Death May 21, 1913

Cause of Death Gastric enteritis.

Contributory Cause of death Improper food supply

(Sign here) C. L. Kiel M.D.

Form V. S. No. 5 20M.1-16-12

CERTIFICATE OF DEATH

 State of Idaho
 BOARD OF HEALTH
 Bureau of Vital Statistics

1. PLACE OF DEATH

Registration District No.

32

County of

Butte

Primary Registration District No.

2049

City of

Arma

(No.

St.)

File No.

Registered No.

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

Wm. M. Ralston

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX

4. COLOR OR RACE

5. SINGLE, MARRIED, WIDOWED OR DIVORCED.

M

White

Single
(Write the word.)

6. DATE OF BIRTH

(Month) (Day) (Year)

7. AGE

72 yrs. mos. ds.

 IF LESS than 1 day
 how many hrs. or mins.

8. OCCUPATION

(a) Trade, profession or particular kind of work

Leived on Homestead

(b) General nature of industry business, or establishment in which employed (or employer)

9. BIRTHPLACE

(State or Country)

Hon't no

10. NAME OF FATHER

11. BIRTHPLACE OF FATHER

(State or Country)

Hon't no

12. MAIDEN NAME OF MOTHER

13. BIRTHPLACE OF MOTHER

(State or Country)

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

Fred Carlson

(Address)

St. Joe Idaho

15.

Filed

191

 W. P. Mulcahy
 Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH

 Dec 1 1913
 (Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from

Nov. 25 1913, to Dec 1 1913

that I last saw him alive on Dec 1 1913

and that death occurred on the date stated above, at 2:30 P.M.

The CAUSE OF DEATH* was as follows:

Cerebral Hem

(Duration) yrs. mos. ds.

Contributory
(Secondary)

(Duration) yrs. mos. ds.

(Signed)

O. H. Platt

M. D.

19

(Address)

St. Joe

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place

of death. yrs. mos. days.

In the

State. yrs. mos. days.

Where was disease contracted if not at place of death?

Former or

usual residence.

19. PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

St. Joe

Dec 1 1913

20. UNDERTAKER

ADDRESS

W. P. Mulcahy

St. Joe

CERTIFICATE OF DEATH.

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH.

Registration District No. I2ICounty of Bonneville
City of Idaho FallsPrimary Registration District No. 1007
(No. _____ St.)File No. 113-3
Registered No. 3If death occurs away from
usual residence, give facts
called for under special
information.2. FULL NAME George H. NealIf death occurred in a hos-
pital, institution or camp,
give its NAME instead of
street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX

male

4. COLOR OR RACE

white5. SINGLE, MARRIED, WID-
OWED OR DIVORCED.single
(Write the word.)

6. DATE OF BIRTH.

Nov23 1872
(Month) (Day) (Year)

7. AGE

40 Yrs. 10 Mos. 23 ds.IF LESS than 1 day
how many hrs. or
..... min.?

8. OCCUPATION

(a) Trade, profession or
particular kind of work... Hotel keeper
(b) General nature of in-
dustry, business, or estab-
lishment in which employ-
ed (or employer)

9. BIRTHPLACE

(State or Country) New York10. NAME OF
FATHERAlfred H. Neal11. BIRTHPLACE
OF FATHER(State or Country) England12. MAIDEN NAME
OF MOTHERSarah Wilcox13. BIRTHPLACE
OF MOTHER(State or Country) Canada

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) G. E. Drummond
(Address) Idaho Falls

15.

Filed June 25 1915 W. E. White
Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

Sept 16 1915
(Month) (Day) (Year)17. I HEREBY CERTIFY, That I attended deceased from
XXXXXXXXXXXXXXXXXXXXXXXXXXXX 1915that I last saw h XXXXXXXXXXXXXXXXXXXX 1915
and that death occurred on the date stated above, at _____ M.The CAUSE OF DEATH* was as follows:
From information obtained by
investigation death occurred by
drowning in Snake river near
Idaho Falls, Body recovered 3 miles
below Shelly from river June 24. 15 ds.Choking (accidental)
(Secondary)

(Duration yrs. mos. ds.)

(Signed) E. T. Peck M. D.19. (Address) Blackfoot Idaho*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1)
MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.18. LENGTH OF RESIDENCE (For Hospitals, Institutions,
Transients or Recent Residents.)At place In the
of death.....yrs.....mos.....days. State.....yrs.....mos.....daysWhere was disease contracted
if not at place of death?Former or
usual residence

19. PLACE OF BURIAL OR REMOVAL DATE OF BURIAL

Idaho Falls, Ida June 26 1915

20. UNDERTAKER ADDRESS

E. T. Peck Blackfoot, Id

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS
should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement
of OCCUPATION is very important. See instructions on back of certificate.

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Form V. S. No. 5 20M.1-16-12

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH
County of Bingham
City of Shelly
Registration District No. 69
Primary Registration District No. 2147
(No. _____, St.)

File No. 13878

Registered No. _____
If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Charles K. Holm

PERSONAL AND STATISTICAL PARTICULARS

3. SEX M 4. COLOR OR RACE W 5. SINGLE, MARRIED, WIDOWED OR DIVORCED.
married
(Write the word.)

6. DATE OF BIRTH
Nov. 19 1887
(Month) (Day) (Year)

7. AGE 80 yrs. 10 mos. 19 ds.
IF LESS than 1 day how many _____ hrs. or _____ mins.?

8. OCCUPATION
(a) Trade, profession or particular kind of work Farmer
(b) General nature of industry business, or establishment in which employed (or employer)

9. BIRTHPLACE
(State or Country) Ohio

10. NAME OF FATHER John Jacob Holm

11. BIRTHPLACE OF FATHER
(State or Country) Germany

12. MAIDEN NAME OF MOTHER Catherina

13. BIRTHPLACE OF MOTHER
(State or Country) Germany

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) J. W. Baguin
(Address) Shelly R. #1

15. Filed 7-29 1913 Edwards Cuthers
Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH
9 28 1913
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from 191 to 191, that I last saw h. alive on 191, and that death occurred on the date stated above, at M. The CAUSE OF DEATH* was as follows:

(Duration) _____ yrs. _____ mos. _____ ds.
Contributory (Secondary)
(Duration) _____ yrs. _____ mos. _____ ds.
(Signed) _____ M. D.
19 (Address)

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death _____ yrs. _____ mos. _____ days. In the State _____ yrs. _____ mos. _____ days.
Where was disease contracted if not at place of death?
Former or usual residence.

19. PLACE OF BURIAL OR REMOVAL Idaho Falls DATE OF BURIAL 7-29 1913

20. UNDERTAKER C. E. Danwood ADDRESS Idaho Falls

1. PLACE OF DEATH.

County of Franklin
City of Preston

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

Pete Boco

PERSONAL AND STATISTICAL PARTICULARS

3. SEX

Male

4. COLOR OR RACE

White

5. SINGLE, MARRIED, WID-OWED OR DIVORCED.

Married

(Write the word.)

6. DATE OF BIRTH.

Not Known

(Month)

(Day)

(Year)

7. AGE

about 40 Yrs. Mos. ds.

IF LESS than 1 day
how many hrs. or
..... min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work...
(b) General nature of industry, business, or establishment in which employed (or employer).....

laborer

9. BIRTHPLACE

(State or Country)

Italy

10. NAME OF FATHER

Not known

11. BIRTHPLACE OF FATHER

(State or Country)

Not known

12. MAIDEN NAME OF MOTHER

Not known

13. BIRTHPLACE OF MOTHER

(State or Country)

Not known

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Dr. C.A. Canfield(Address) Preston, Idaho.

15.

7/61913

Filed

Local Registrar

CERTIFICATE OF DEATH

Registration District No. 11Primary Registration District No. 11(No. 11)

St.)

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

File No. 148891Registered No. 2

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

753

(Month)

(Day)

(Year)

17. I HEREBY CERTIFY, That I attended deceased from

7/41913to 7/51913that I last saw him alive on 7/5 1913

and that death occurred on the date stated above, at M.

The CAUSE OF DEATH* was as follows:

Fr. of skull in several places
by an accidental explosion

(Duration) Yrs. mos. ds.

Contributory (Secondary)

(Duration) yrs. mos. ds.

(Signed) Dr. C. A. Canfield M. D.7/5 1913 (Address) Preston, Idaho.

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL OR HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death yrs. mos. days. In the State yrs. mos. days

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL

Preston, Idaho.

DATE OF BURIAL

7-6 1913

20. UNDERTAKER

P J. Hansen

ADDRESS

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

FORM V. S. No. 5-12 M. 6-15-17.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH

Bureau of Vital Statistics

File No. 22109

Registered No. 131

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

1. PLACE OF DEATH

County of Ada

City of Boise

If death occurs away from usual residence, give facts called for under special information.

Registration District No. 2

Primary Registration District No. 1004

(No. 914 Jefferson St.)

2. FULL NAME Frederick Weiss

PERSONAL AND STATISTICAL PARTICULARS

3. SEX

Female White

4. COLOR OR RACE

5. SINGLE, MARRIED, WIDOWED, OR DIVORCED.

Married (Write the word.)

6. DATE OF BIRTH.

March 16 1893
(Month) (Day) (Year)

7. AGE

70 Yrs. 1 Mos. 26 ds.

IF LESS than 1 day
how many hrs. or
min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work
(b) General nature of industry, business, or establishment in which employed (or employer)

Housewife

9. BIRTHPLACE

(State or Country)

Prussia

10. NAME OF FATHER

Benjamin Shelling

11. BIRTHPLACE OF FATHER

(State or Country)

Prussia

12. MAIDEN NAME OF MOTHER

Not obtainable

13. BIRTHPLACE OF MOTHER

(State or Country)

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Henry Otto Weiss

(Address) Boise

15.

Filed 5/12 1913 M. S. Parker Local Registrar.

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

May 12 1913
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from

May 11 1913 to May 11 1913
that I last saw him alive on May 11 1913

and that death occurred on the date stated above, at M.

The CAUSE OF DEATH* was as follows:

aprop. lary

(Duration) Yrs. mos. ds.

Contributory
(Secondary)

(Duration) Yrs. mos. ds.

(Signed) Mrs. Callister M. D.

19 (Address) Boise

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place In the
of death . . . yrs. . . mos. . . days, State . . . yrs. . . mos. . . daysWhere was disease contracted
if not at place of death?Former or
usual residence

19. PLACE OF BURIAL OR REMOVAL

Morris Hill Cem May 13 1913

20. UNDERTAKER

Try & Lunn Boise

DATE OF BURIAL

May 13 1913

ADDRESS

Boise

STATE OF IDAHO, BOARD OF HEALTH
BUREAU OF VITAL STATISTICS

File No. 131

CERTIFICATE OF DEATH

Registered No. _____

REGISTRATION DISTRICT No. 2
PRIMARY REGISTRATION DISTRICT No. 1004

PERSONAL AND STATISTICAL PARTICULARS

1. Place of Death: County of Ada, City of Boise, Idaho.

If death occurs away from usual residence, give facts called for under special information.

2. Full Name Frederick Weiss No. 914 Jefferson Street

If death occurred in a hospital, institution or camp, give its name instead of street and number.

3. Sex Female 4. Race or Color white 5. Single, Married, Widowed or Divorced married
(Write the word)

6. Date of Birth March 16 1893 7. Age 1 yrs. 1 mos. 26 days
(Month) (Day) (Year) If less than 1 day, how many.....hrs. or.....min.?

8. Occupation:

(a) Trade, profession or particular kind of work

(b) General nature of industry, business or establishment in which employed (or employer)

9. Birthplace

(State or Country)

10. Name of Father

11. Birthplace of Father

(State or Country)

12. Maiden Name of Mother

13. Birthplace of Mother

(State or Country)

14. The above is true to the best of my knowledge and belief.

Informant

Address

MEDICAL CERTIFICATE OF DEATH

15. Date of Death May 12 1913
(Month) (Day) (Year)

16. I Hereby Certify that I attended deceased from May 11th, 1913,
to May 11th, 1913; that I last saw her alive on May 11th, 1913,
and that death occurred on the date stated above at Boise. The Cause of Death* was
as follows: Apoplexy

(Duration) _____ years _____ months _____ days

Contributory
(Secondary)

(Duration) _____ years _____ months _____ days

(Signed) Geo. Colclister, M. D.

_____, 19____

Address _____

*State the disease causing death; or in deaths from violent causes, state (1) means of injury, and (2) whether accidental, suicidal or homicidal.

17. Length of Residence. (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death.....years.....months.....days
Where was disease contracted
if not at place of death?.....

In the state.....years.....months.....days
Former or usual
residence.....

18. Place of Burial or Removal Morris Hill Cem. Date of Burial May 13th, 1913

19. Undertaker Fry & Summers Address Boise

Filed 5/12, 1913

M. B. Parker
per L. Hoffman
Local Registrar.

FORM V. S. No. 5-25 M. 1-16-13

RECEIVED

CERTIFICATE OF DEATH.

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH.

County of *Latol*
City of *Bozell*

MAR 5 1923

Registration District No. *66*Registration District No. *2176*File No. *41060*

Registered No.

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

William Holmes

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

MEDICAL CERTIFICATE OF DEATH

3. SEX

Male

4. COLOR OR RACE

*White*5. SINGLE, MARRIED, WID-
OWED OR DIVORCED*Married*
(Write the word.)

6. DATE OF BIRTH.

March
(Month)*15*
(Day)*1872*
(Year)

7. AGE

50 Yrs. *10* Mos. *25* ds.IF LESS than 1 day
how many.....hrs. or
.....min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work.
(b) General nature of industry, business, or establishment in which employed (or employer)*Machinist*

9. BIRTHPLACE

(State or Country)

Wisconsin

10. NAME OF FATHER

Albert G. Holmes

11. BIRTHPLACE OF FATHER

(State or Country)

Don't know

12. MAIDEN NAME OF MOTHER

Don't know

13. BIRTHPLACE OF MOTHER

(State or Country)

Don't know

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant)

Edna Holmes

(Address)

Bozell Idaho

15.

Filed *Feb 26* 1923*Mrs J.C. Gibson*
Local Registrar

16. DATE OF DEATH

February
(Month)*25*
(Day)*1923*
(Year)

17. I HEREBY CERTIFY, That I attended deceased from

February 25 - 1923 to *Feb 25 - 1923*

that I last saw h..... alive on..... 191.....

and that death occurred on the date stated above, at *2:30 PM*

The CAUSE OF DEATH* was as follows:

Chronic Heart disease

(Duration)

Yrs.

mos.

ds.

Contributory
(Secondary)

(Duration)

Yrs.

mos.

ds.

(Signed)

J.C. Gibson

M. D.

2/24/1923 (Address) *Bozell Idaho*

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place

of death.....yrs.....mos.....days

In the

State.....yrs.....mos.....days

Where was disease contracted
if not at place of death?Former or
usual residence

19. PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

191.....

20. UNDERTAKER

ADDRESS

Wm. J. Gibson *Bozell Idaho*